ccs disability action
Including all people

TE HUNGA HAUĀ MAURI MŌ NGĀ TĀNGATA KATOA

National Service Pathway

Delivering quality supports to all people

Last updated 18 March 2023

Table of Contents

1 Introduction 5

1.1 Why have a service pathway 5

1.2 What is the National Service Pathway 5

1.3 Contract pathways 6

2 Our approach to delivering support 7

2.1 How we work with people 7

2.2 Disability rights and leadership 8

2.3 Working with Māori and whānau 9

2.4 Working with Pasefika peoples 10

2.5 Working with children and young people 10

3 Enquiries and referrals 11

3.1 Introduction 11

3.2 Receiving enquiries 11

3.3 Responding to enquiries 12

3.4 Receiving referrals 12

3.5 Branch to branch transfers 14

4 Service / Intake meeting 16

4.1 Introduction 16

4.2 The meeting 16

4.3 After the meeting 17

4.4 Referral is accepted 17

4.5 Referral is waitlisted 18

4.6 Referral is declined 19

5 Starting support 20

5.1 Making contact 20

5.1.1 First contact with person or whānau regarding starting support 20

5.1.2 Unable to make contact 21

5.2 First meeting 21

5.2.1 At the visit 22

5.2.2 Following the meeting 23
5.2.3 Person / whānau decides not to use our services 24
5.2.4 Information packs 24
5.2.5 Information to update on our systems or save in e-files 25
6 Planning with people and whānau 26
6.1 Introduction 26
6.2 Developing a support plan 26
6.2.1 Person directed planning: 27
6.2.2 Writing the plan 28
6.2.3 Signing off the plan 28
6.3 Actions 29
6.4 Safety for the people we support and our staff 29
6.5 Money handling 30
6.6 Medication 30
6.7 Access to a person's home 31
6.7.1 Actions when holding keys or codes to a person's home 31
6.8 Identifying Support Workers who 'fit' best 32
6.9 Scheduling support for people 33
7 Providing support 34
7.1 Putting the support plan into action 34
7.2 Incidents and concerns 34
7.3 Support handover 36
7.3.1 Change of Service Coordinator 36
7.3.2 Change of Support Worker 37
8 Reviewing support 38
8.1 Introduction 38
8.1.1 Renewing consent 38
8.2 Support reviews 38
8.2.1 Preparation for the review meeting 39
8.2.2 At the review meeting 39
8.2.3 After the Review Meeting 40
8.3 Support Summary form 40
8.4 Support summary administration and review 41
8.5 Support Summary follow up 42
9 Completing support 43

9.1 Introduction 43
9.2 Planned completion of support 43
9.3 Transferring to another branch or service provider 44
9.4 Unexpected completion of support 45
9.4.1 When a person we support dies 46
9.5 Withdrawal from services 49
10 Other information 50
10.1 Complaints 50
10.1.1 Receiving and responding to a complaint 50
10.1.2 Immediate resolution 51
10.1.3 Investigation 51
10.1.4 Clarifying the complaints process 53
10.1.5 Referring complaints for acknowledgment and investigation 53
10.2 Health and Safety 54
10.3 Te Puna Kōrero 54
10.4 People's information 55
10.4.1 Sensitive information 55
10.4.2 Reports of Concern 56
10.4.3 Te Puna Kōrero Alert 56
11 Closing statement 57

1 Introduction

1.1 Why have a service pathway

CCS Disability Action exists to serve disabled people/whānau hauā. We support people to make tangible differences to their lives. Our staff are genuinely invested in doing a good job and meeting the needs of those they support and work alongside.

We strive to enhance mana and leadership, be authentic in our intentions and interactions, follow tikanga & best practices and show empathy as we learn, reflect, grow, refine and change.

We aim to provide well managed services and connected supports that meet individual needs and desires. A service pathway details what this looks like. It is explicit about how we intend to 'show up' for disabled people/whānau hauā as we work alongside them.

1.2 What is the National Service Pathway

The National Service Pathway (also known as the NSP or Service Pathway) is a practical 'how-to' guide for all staff. It is based on a best practice approach to service delivery. The focus is squarely on the disabled person's experience of engaging and working with us. The pathway describes how we work with the person and internally with each other. It clearly states timeframes, responsibilities, and actions as it follows a person's support journey from service entry to completing supports and everything in between.

Ultimately this is about disabled people/whānau hauā being satisfied and receiving a quality service. They know what to expect - people can rely on us to work in a certain way and be consistent in how we respond to and engage them in support delivery.

An outcome is that disabled people/whānau hauā have similar experiences of the organisation, no matter where they live around the country. Consistency means we are reliable in our values, work practices and approach to service

delivery. It also means we can be depended upon to work creatively with people to meet their goals.

The National Service Pathway reflects our values and core documents, including:

- Our Vision
- Te Aronui - Our Strategic Priorities.
- Rangatira Maha - Disability Leadership Framework.
- Manawa - Māori Disability Framework.
- Te Tiriti o Waitangi.
- The Convention on the Rights of Persons with Disabilities.
- The New Zealand Disability Strategy.
- Te Whakapai Ānga – Quality Framework

The National Service Pathway is not a stand-alone document. It is used alongside the following national policies manuals, appendices, resources, and instructions:

- National Service Policies Manual.
- Health and Safety Manual.
- Te Puna Kōrero Manual.
- Service Contract Pathways.
- Human Resources Policies Handbook.

1.3 Contract pathways

Some national and regional contracts have requirements and timeframes that differ from the National Service Pathway best practices. These differences are specified in the contract pathways. Requirements and timeframes in contract pathways override the National Service Pathway. For example, under the ACC Living My Life Contract referrals decisions are made within two days.

You can find the contract pathways in the National Service Contracts folder in National Documents: S:\1National Documents\National Service Contracts

2 Our approach to delivering support

2.1 How we work with people

It is a privilege to be in a person's life, therefore we:

- Recognise disabled people/whānau hauā as decision makers.
- Develop reciprocal relationships, that are equitable and uphold dignity.
- Listen, listen and then listen some more to the person.
- Are curious and ask open-ended questions in a respectful manner, making no assumptions. People will share their story with us at their pace.
- Accept what is important to the person, even if this differs from what is important to us as individuals or as an organisation.
- Understand our boundaries. Our role is to support people to live the lives they want – we are not experts or advisors.
- Work with intention when we connect with disabled people /whānau hauā and each other.
- Are invested in positive outcomes for disabled people/whānau hauā and their family or whānau. We celebrate the wins.
- Role model best practice when working with disabled people/whānau hauā and their family or whānau.
- Recognise the tikanga of the individual whānau we are working with.
- Record information a person shares with us, so the person does not have to repeat it to any other staff member.
- Follow standards, policy and procedures as well as legal obligations.
- Align our work practices with an enabling good lives approach.
- Check in with the person that we understand them correctly, are doing what was agreed and within the expected timeframe.
- Welcome feedback and feedforward – it is valued. We show empathy as we learn, refine, reflect and improve.

- Encourage self-advocacy and if advocating for a person do so in an empowering way according to the person's will and preference.
- Share challenging or complex situations with line managers, supervisors and/or peers (while respecting people's right to privacy) as part of reflective practice.
- Escalate concerns of abuse, neglect and safety to appropriate team members such as the Service Manager or Child Protection Advisor.

2.2 Disability rights and leadership

We uphold and promote disabled people's rights when working with them. We also support disabled people to take leadership positions within their whānau, hapu, iwi, and communities as well as within our organisation.

All staff should be familiar with the following framework and service policies which explain our commitment to disability rights and leadership:

- **Rangatira Maha -** Disability Leadership Framework
    - Rangatira Maha will develop disability and disabled leadership both within CCS Disability Action and in our communities.
    - Rangatira Maha means many leaders; all types of leadership, by disabled people and their whānau, in all areas of our organisation and in our communities.
    - Rangatira Maha reflects mana motuhake; identity, dignity, self-determination, choice and control.
- **1.1 Human/Disability Rights** (in the National Service Policies Manual).
- **1.3 Supporting Disabled Leadership** (in the National Service Policies Manual).

2.3 Working with Māori and whānau

CCS Disability Action acknowledges Māori as tāngata whenua of Aotearoa New Zealand. We acknowledge that this nation was built on a partnership between Māori and the Crown, based on Te Tiriti O Waitangi. Our vision to include all people cannot be achieved without acknowledging the partnership this nation was built on, and the values that it signifies.

Te Tiriti O Waitangi is a core document for our organisation and for the rights of the citizens of Aotearoa New Zealand. It sets out the core ideals of self-determination, partnership and the protection of rights. Everyone should be able to participate in decisions that affect them, to participate in their community and society and to have their fundamental wellbeing protected.

We recognise that whānau hauā Māori, (disabled Māori) face social inequalities and other barriers specific to their culture and needs. As an organisation, we have made a commitment to address these barriers. Māori culture has strengths in how it approaches disability.

We aim to ensure that our services are responsive to whānau hauā Māori. We work to ensure that our organisation presents a proactive and cohesive approach to Māori strategy across all developments - local, regional and national.

All staff should be familiar with the following framework and service policies which explain our commitment to Māori rights and leadership:

- **Manawa –** Māori Framework

  The Manawa framework is anchored to stories and kōrero of engaging and working alongside whānau hauā Māori.
  Manawa mai te Mauri! *Gather the Lifeforce* – this whakatauakī relates to understanding what is important in order to understand the 'hearts' of whānau hauā Māori. This serves as an anchor to remind us why we are here and guides staff in the work (mahi)

- **1.4 Cultural Responsiveness –whānau hauā,** (disabled Māori) (in the National Service Policies Manual).

- **1.5 Contribution and Leadership by whānau hauā** (disabled Māori) (in the National Service Policies Manual).

2.4 Working with Pasefika peoples

Team members will recognise the importance of engaging with Pasefika peoples in a way that is appropriate for each person and their āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili.

We recognise that Pasefika families' experience of disability support is influenced by Pasefika world views, cultural beliefs and values. Culture is identified as 'expressions of knowledge', beliefs, customs, morals, arts and personality. Team members also need to be aware that for most Pasefika peoples, āiga, kāiga, magafaoa, kōpū tangata, vuvale, fāmili is the centre of the community and way of life.

Family provides identity, status, honour, prescribed roles, care and support. Support for disabled family members or for older family members is often informally provided within the family. Pasefika culture have a holistic view of health and wellbeing.

Team members need to focus on what works for Pasefika peoples and those from other cultures in meeting the needs of the people we support. This may be through networking and / or working in partnership with other organisations and agencies which provide more appropriate, culturally competent support.

All staff should be familiar with Policy 1.6 Cultural Responsiveness – Pasefika in the National Service Policies Manual.

2.5 Working with children and young people

When working with disabled children and young people, we uphold and promote their rights, including the right to have a say on matters affecting them. As a child grows older and becomes a young person, they should gain more independence, voice, and choice over their life.

All staff should be familiar with our 1.2 Children and Young People's Rights in the National Service Policies Manual.

3 Enquiries and referrals

3.1 Introduction

People may ask about our support / services without a formal referral. We call these enquires.

Administrators and front office staff are often the first people to receive enquiries. They provide general information and forward to Service Coordinators.

3.2 Receiving enquiries

Administrator

- Provide general information and brochures (if relevant) on the day an enquiry is received.
- Gather the information listed below to support the Service Coordinator or Service Manager to respond:
    - Whether the enquiry is from the person or on behalf of someone else.
    - What support the person wants / what they want assistance to do.
    - What area they live in.
    - The age of the person (some services are age limited).
    - How to contact them and any communication preferences or needs.
- Provide the 0800 number – 0800 227 2255 (This goes through to the nearest branch) and the CCS Disability Action website: http://ccsdisabilityaction.org.nz/
- Speak directly to the most appropriate senior team member and enter the enquiry into Te Puna Kōrero and allocate to the appropriate team member best placed to respond. Alternatively, email details about enquiries to the

team member on the day they are received. This provides a written record of enquiries.

- Type “New enquiry” and put the date in the subject line – do not put the person’s name in the subject line.
- If the Service Coordinator responsible for the service is not available, forward the enquiry to their line manager.

All staff receiving phone enquiries

- If a caller is linked to the wrong branch, the team member answering the call should advise the person they are not the nearest branch, offer to take the caller’s details and phone through to the branch, or transfer them to the correct branch.

3.3 Responding to enquiries

Service Coordinator

- Contact the person making the enquiry. Find out if they have any communication preferences or needs and meet those.
- Find out if CCS Disability Action is the best organisation to provide support to the person.
  - If it appears that we are the most suitable organisation, have the person, whānau or referring agency complete a Referral Form (National Service Pathway\Appendices and templates). Support the person / whānau, if requested, to complete the Referral Form.
  - If we are not the appropriate organisation, discuss a possible referral to another agency, if needed, refer the person to an appropriate agency and advise your line manager.

3.4 Receiving referrals

People may be formally referred to us for support/services. This may be either by another organisation or they may refer themselves (self-referrals).

Note, sometimes other organisations (such as Needs Assessment and Service Coordination agencies) will send a referral using their own template or with no referral form at all. In these situations, the CCS Disability Action Referral Form needs to be completed. This is done to ensure we have all the information we need to support a person. It also fulfils required contract funding requirements. This information is collected and entered into Te Puna Kōrero.

Service Manager / Service Coordinator

- Seek further information if necessary, from the referrer. This task may be delegated to another team member.
- Accept or decline high priority referrals on the day they are received, and allocate a team member if the referral is accepted.
- All referrals are taken to the Service Intake meeting each week for acceptance or decline. Priority referrals that may have been accepted prior to the weekly meeting should also be recorded in the next Service Intake Meeting.
- Provide the Referral Form to the Administrator following the Service Intake Meeting.

Service Coordinator / Administrator

- Input the information collected on the Referral Form into Te Puna Kōrero as soon as possible (when the Referral Form is received).
- Sign and date the Referral Form with the date the information was entered into Te Puna Kōrero.
- Scan and file the Referral Form into the “People We Support\[Branch name]\3 Referrals” folder. Refer to the E-Filing Guide (National Service Pathway\Appendices and templates) for more information.
- Return the Referral Form to the Service Coordinator/Administrator.

Service Coordinator / Administrator

- Acknowledge the referral in writing (by email or letter) within two working days of receiving the referral. Use the Referral Acknowledgement Letter template (National Service Pathway\Appendices and templates). Self-referrals are to be acknowledged in the same way.

- Scan and save the Referral Acknowledgement Letter / e-mail in the person's e- file in the "People We Support\[Branch name]\3 Referrals" folder. Refer to the E-Filing Guide (National Service Pathway\Appendices and templates) for more information.

3.5 Branch to branch transfers

(moving a person's support and their information)

A person we support may move and require support from another branch.

The previous branch will:

- phone the receiving branch to identify the staff member who will manage the transfer of support for the person.

- ensure a conversation has been had with the person we support so they have new staff contact details and know what to expect.

- arrange for the person's e-file (person we support folder) to be transferred in a secure and immediate way. This is done using the File Transfer folder on the S\Company Drive - S:\File Transfer

    - The branches contact each other by phone to carry out the transfer in real time so they each know it is complete and remains protected.

    - In The S\Company Drive, the previous branch removes 'cuts' the e-file from their folder and pastes it into the File Transfer folder. The new branch immediately picks up 'cuts' the e-file and saves it to the person's new folder.

    - No information of any kind is saved or remains in the File Transfer folder on the S\Company Drive, it should be empty, and only used when instantly moving information.

Sometimes a person moves and contacts the new CCS Disability Action branch for support without the previous branch knowing. The new branch should contact the previous branch to arrange for the person's e-files to be transferred (using the steps outlined above). If the person does not want the previous branch contacted and/or their e-files transferred, talk to your Privacy Officer.

4 Service / Intake meeting

4.1 Introduction

Each branch or team must have a weekly Service / Intake meeting that looks at new referrals and waitlisted referrals. The team members involved will include Service Managers, Senior Coordinators and Service Coordinators. The Service / Intake meeting is a priority for each branch or team.

4.2 The meeting

Service Manager or Service Coordinator

- Will set the agenda and chair the meeting. If not available, delegate to a senior staff member. An optional Service / Intake Meeting Agenda template is available in National Service Pathway\Appendices and templates.
- Work with the team to decide if the referral is to be accepted, waitlisted (or kept on the waitlist, if already waitlisted) or declined. When discussing referrals, the Service Manager will consider the following:
    - What the support that the person is requesting.
    - Branch contracts and funding.
    - Staff expertise and capacity.
    - The length of the waitlist.
    - Other agencies that may be able to provide the requested support.
- Staff must declare any conflicts of interest. For example, if the staff member is friends or family with a person being referred.
- If the referral is accepted, a Service Coordinator for the support will be decided and the referral will be allocated to a contract. A start date of service will be determined with the person (if known).

Appointed Minute Taker

- Record minutes of the meeting. An optional Service / Intake Meeting Minute template is available in National Service Pathway\Appendices and templates. Minutes must be completed within three working days after the meeting. Save the minutes in a folder within the branch or team folder.

4.3 After the meeting

Service Manager

- Inform the Te Puna Kōrero Administrator where the record of the meeting is. This allows them to process the accepted referrals.
- Inform the Service Coordinator that they will be working with the person.

Administrator

- Enter and update the referral information in Te Puna Kōrero.

4.4 Referral is accepted

Service Coordinator

- Send a referral acceptance letter/email to the person and referrer, so that the person knows who their key contact is. If the person prefers or needs another type of communication (such as a phone call or text message) do that as well.
- Begin the Starting Support process in section 5 below.

Administrator

- Set up the person's e-file under the "People We Support/[Branch name]/1 Actively Supported" folder.
- Scan documents including the service authorisation (if applicable) and move the referral forms from the "3 Referrals" folder into the person's e-file. Refer to the E-Filing Guide for more information.

4.5 Referral is waitlisted

Branches use waitlists when they accept a referral but cannot provide support immediately due to capacity or funding issues.

People are able to go on a waitlist if the branch expects to be able to provide support **within four weeks of referral**. The only exception is for Early Intervention Services, where people can be put on the waitlist if the branch expects to provide support within **eight weeks**. The waitlist is reviewed at each weekly Service / Intake meeting.

Service Manager

- Waitlist referral in Te Puna Kōrero. Enter a note giving a reason.
- Contact the person / referring agency within three working days after the Service Intake meeting, advising their referral has been waitlisted and provide further information and options if applicable.
- Provide the person (and the referring agency if applicable) with updates every four-weeks and find out if their support requirements have changed.
- If the support requirements of the person / whānau change, review the waitlist status or consider what other options are available.
- Monitor the waitlist weekly. Provide a report to the General Manager if the wait time has been exceeded, outlining the reasons why the person has been waitlisted and actions taken to reduce waiting times. The Service Manager may put in place additional strategies to reduce wait times.
- People are moved from the waitlist by accepting or declining a referral at a Service / Intake meeting.

Administrator

- Transfer the person's referral form from the Referral Folder into the "People We Support/[Branch name]/4 Waitlist" folder. Refer to the E-Filing Guide for more information.

4.6 Referral is declined

Service Manager

- Contact the person / referring agency within three working days after the Service Intake meeting, advising their referral has been declined and provide further information and options if applicable.
- Decline referral in Te Puna Kōrero. Enter a note giving a reason and deactivate record.
- Destroy any hard copies of the declined referral.

Administrator

- Transfer the person's information into the "People We Support/[Branch name]/5 Not Accepted For Support" folder. Refer to the E-Filing Guide for more information.

5 Starting support

5.1 Making contact

5.1.1 First contact with person or whānau regarding starting support

Service Coordinator / Early Intervention Teacher

- Make contact with the person or whānau within three working days of referral acceptance (usually in the Service Intake Meeting). Find out if the person has any communication preferences or needs and meet those.
- Explain how we begin working together
- Provide contact details and hours of work.
- Organise the first visit to their home or a location of the person's choosing. This should be the place the person feels most comfortable and it respects privacy.
- Ask if there are other people who will be there, maybe whānau or family members.
- If the first meeting is held in a person's home check if there is anything that staff should know. For example, dogs who do not like strangers, long driveways or unmarked addresses. Also:
    - All branches must follow safe practices to ensure that any concerns regarding staff safety are identified. Staff may be monitored during home visits. Refer to Section 9 of the Health and Safety Manual for more information.
    - If it is considered unsafe for staff to go to the person's home, the person/whānau will be invited to meet instead with staff at our branch or another public location.

- If the referrer or staff members have concerns about a person's safety or the safety of a child, two staff members must make visits together.

5.1.2 Unable to make contact

Service Coordinator, Early Intervention Teacher

- Make three attempts to contact the person / whānau by phone or using the preferred method of communication.
- Notify the referrer (if not self-referral) that it has not been possible to make contact and request assistance / other contact details.
- Make two more attempts at contact.
- Write a letter to the person / whānau advising them that CCS Disability Action is unable to make contact and support cannot be provided without a response. An optional Unable to Contact Letter template is available in National Service Pathway appendices (National Service Pathway\Appendices and templates).
- If no response has been received in fifteen working days of sending the letter, advise the Service Manager or Service Coordinator that the referral cannot be progressed due to inability to contact.
- Begin the Completing Support process. Refer to section 9, Completing support.
- Advise the referrer that CCS Disability Action cannot progress the referral and provide a reason for this.

5.2 First meeting

People who have been referred urgently are visited within two working days. Otherwise, the first meeting should occur within ten working days of the referral being accepted (and assigned to the Service Coordinator). This means

we are responsive and available to the person If this does not suit the person, another time is arranged and the reason for this recorded in Te Puna Kōrero.

5.2.1 At the visit

Service Coordinator

- Meet with the person / whānau and take time for whanaungatanga to get to know them. This creates a shared understanding and connection to begin building the relationship.
- Explain that it is important the person has choice and control over their supports and how their information is managed and used. For this to happen we need their informed consent and permission before we can arrange any supports.
    - Template 1- Consent for Services and Sharing Information needs to be signed and dated by the person. Give the person time to ask questions. Talk to the person so they understand what we are asking them to consent to and what their rights are. The Your Information section of Template 1 can help.
    - When supporting adults, we check the decision-making rights of legal guardians (for example that Enduring Powers of Attorney have been activated and whether the legal guardian is a welfare guardian and/or a property manager). We keep a copy of the proof of guardianship on the person's e-file. We only give guardians the decision-making powers they have been legally granted.
    - The Template 1 does not cover consent to the public use of any stories and images about this person. Consent should be sought each time an image or story is used (an Image Consent template is available from the Communications Team).
- Talk with the person about the services we could offer them and explain how we could work with them.

- Verify if the person's wants and needs are reflected in the referral recommendations from the NASC. (if relevant).
- Outline how we work with person to uphold their rights and deliver a good service. Explain that we are obliged to uphold the Health and Disability Services Consumers' Rights (provide HDC rights brochure).
- Consider any requirements under the specific contract. Provide any forms for signing. If the person requests it, assist the person to complete any forms. If the person prefers to complete the forms later, leave the forms with the person and arrange a follow-up visit to collect the signed form.
- Ensure that all information and sections (relevant to the person) is completed on the Referral Form. For example emergency contact details or personal contact details; phone, email etc.
- Explain how we encourage people to have their say and make a complaint if they wish to (provide our Complaints Brochure). Talk through the steps on how to do this.
- Also explain that as an organisation we provide support, information and advocacy. The Information Pack holds a variety of brochures explaining our services e.g. Information Service (incl. Library) and Mobility Parking Permits. The person can read this information as and when they see fit.
- Book in the next visit to progress the planning stage. Go at person's pace though. Some people may need more time to get to know you before they can create their plan

5.2.2 Following the meeting

Service Coordinator

- Update Te Puna Kōrero notes as close to when the meeting occurred.

- Begin preparing for the planning conversation, If appropriate, begin drafting the support plan for the person / whānau (National Service Pathway\Appendices and templates).
- Carry out any actions from the first visit and update the person / whānau as you complete them.

5.2.3 Person / whānau decides not to use our services

Service Coordinator / Early Intervention Teacher

- Give the referral back to the Administrator and let them know that the person will be completing services.
- Begin the Completion of Support Process. Refer to section 9, Completing support.

Administrator

- Update Te Puna Kōrero.

5.2.4 Information packs

We give all people an information pack on the first visit. Packs can also be given / sent to people enquiring about services.

Contents of information packs:

- Service Coordinator's business card.
- Template 1 Consent for Services and Sharing Information and Your Information Form.
- Code of Health and Disability Services Consumer Rights.
- Template 3 Concerns, Compliments and Complaints Brochure.
- CCS Disability Action Information Service Brochure.
- The National Newsletter Reflections.

- Mobility Parking Permit Application Form.
- Brochures on specific services e.g. Supported Lifestyles.
- Any additional Branch / Regional Information.

5.2.5 Information to update on our systems or save in e-files

Service Coordinator

- Scan the completed Referral form and Template 1 Consent for Services and Sharing Information Form into the person's referral and funding information folder.
- Delete any previous incomplete versions of the Referral form. Refer to the E-Filing Guide for more information.

6 Planning with people and whānau

6.1 Introduction

Respecting the person as not only the ‘customer with the money’, but the designer and leader in how support and work together is key to planning.

Planning involves conversation(s) with the person to identify what it is they want to achieve for their life. It is also about being clear on the support they want us to deliver, so it is custom-made for the person. The support needs to make sense for the person. Our role is to provide all information on the service and support options available.

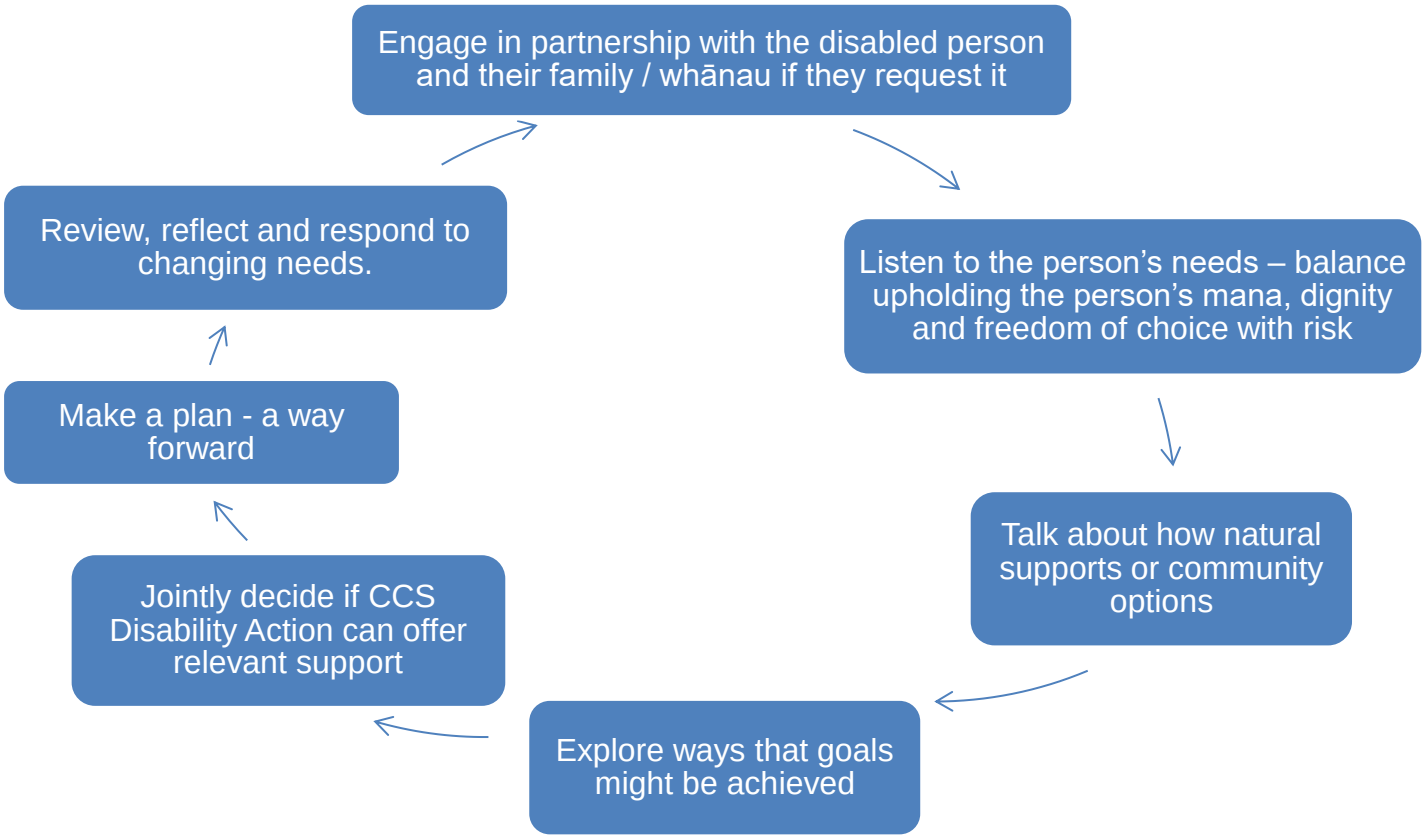
Writing down a person’s choices, needs and wants, detailing how outcomes will be achieved and who is part of the support delivered is planning. It is an agreement with the person and staff member/s so everyone is clear on what is expected and how they are involved. Therefore all people being supported must have a current personal plan.

If a person does not want a plan, that is their choice. We are directed by the person. Talk to your line manager about other options. We still need a record of a person’s support requests, goals and outcomes. This is important as it provides evidence of the support expectations and is part of our accountability to the person as well as our funders.

6.2 Developing a support plan

Our intention is that we complete a support plan with the person within four weeks of the first visit with them. Unless the relevant contract sets a shorter timeframe.

6.2.1 Person directed planning:



This means:

- The person controls their planning process.
- The person gets to choose who they would like to be involved in their planning sessions.
- The planning process reflects the person's preferences, beliefs and culture(s)
- The person sets their own goals, although staff members may offer suggestions, information, and ideas.
- The planning process considers the role of natural/community supports in achieving a person's goals and how these supports can be developed.
- When more than one organisation is involved in a person's life, we work to ensure the whole planning process is well coordinated.

6.2.2 Writing the plan

Service Coordinator

Having had the planning conversations with the person, the Service Coordinator will write the plan and consider the following questions:

- Was the plan developed in a way that works for the person? For example, face to face visits, conversations, using photos, video, notes and drawings.
- Are what's important to the person and their goals clearly identified?
- Who is in control here?
- Where does the power sit – with the person or somewhere else?
- Is the plan flexible and responsive?
- Do the actions enhance the person's mana?
- Have a range of choices been offered or just one?
- Do goals include ordinary life outcomes?
- Are there any further supports required e.g. medication, home access, money handling or transport. If so, please refer to sections 6.5, 6.6 and 6.7 below.

Each contract will have a planning template to use e.g. the My/Our Plan template is used for Supported Living and the Individual Plan (IP) is used for Early Intervention.

Check the relevant Contract Pathway to see if the funder requires their plan template to be used. If you cannot locate a plan template here then use the My/Our Plan template (S:\1National Documents\National Service Pathway\Appendices and templates\2. My Our Plan Templates)

6.2.3 Signing off the plan

Service Coordinator

- Arrange for the plan to be approved and signed by the person / whānau. This may require some time for questions or clarity to ensure it is understood. A signed copy is offered to the person / whānau to keep.
- Set and confirm a review date with the person / whānau (minimum of twelve months between reviews). Reviews can be earlier if a concern arises or the person's goals change. This review meeting is diarised and rostered in Te Puna Kōrero.

6.3 Actions

Service Coordinator

- Save the signed support plan (and any other agreements) into the person's e-file (People We Support\2. Planning & Reviews\1. Plans).
- Ensure all notes on any planning meetings are entered into Te Puna Kōrero
- Spend time with any Support Workers working with the person to understand the support request and how it is to be delivered so it aligns to the person's goals. Support Workers sign the plan before they start work with the person or whānau.

6.4 Safety for the people we support and our staff

Work with the person / whānau to identify any safety issues and agree on how these will be managed / mitigated.

Service Coordinator

- Record any safety issues and how staff have agreed to address these in the My/Our Plan (What could go wrong? What could we do?).
- Involve other agencies if required (and agreed).
- Monitor the effectiveness of strategies in place and discuss with the Service Manager at the Service Intake Meeting. If necessary, identify other ways of addressing risks to the person, staff and others involved.

Support Worker(s)

- Read the person's / whānau support plan.
- Sign the person's / whānau plan to say they understand the person's / whānau needs and any safety concerns.
- Notify the Service Coordinator that they need more information / training to enable them to undertake their support role, and participate in required / requested training.

6.5 Money handling

If staff will handle a person's money, then the person's Service Coordinator and any Support Worker(s) who will handle the person's money must read and sign our Money Handling Policy (Policy 2.5 in the National Service Policies Manual).

The Service Coordinator must then:

- Scan the signed Money Handling Policy into the person's electronic file.
- Complete a Money Handling Agreement (National Service Pathway\Appendices and templates) with the person/whānau.
- Review the Agreement each time the person's My/Our Plan is reviewed.

6.6 Medication

If staff will provide medication support, the person's Service Coordinator and any Support Worker(s) who will give medication must read and sign our Medication Policy (Policy 2.10 in the National Service Policies Manual).

The Service Coordinator must then:

- Scan the signed Medication Policy into the person's electronic file.
- Complete Template 7. Individual Medication Plan with the person / whānau.

- Ensure any Support Worker(s) who will give medication support receive medication training and a medication competency assessment.

6.7 Access to a person's home

We always respect a person's authority to tell us how, when and whether we can enter their home. This means we:

- Follow the person's choices about us visiting their home
- Discuss any visit changes with the person beforehand, e.g. who is coming or when
- Never enter a person's home without being invited, we always knock or ring the doorbell.
- Respect a person's identity, belief, culture and customs. When visiting whānau hauā and their whānau, we follow our Tikanga Guidelines.
- Let the person know when we are leaving their home (and if the person asks, secure any windows, doors or gates)
- Only ever hold keys or access codes to a person's home with their permission.

6.7.1 Actions when holding keys or codes to a person's home

- We only have keys or codes to a person's home if they have requested it in relation to their support.
- We have an agreement with the person in writing so everyone involved is clear and understands their part. This is safe practice.
- To support the person's decision we talk with them about any potential risks or insurance implications so we can be sure we have informed consent.
- The Service Manager must also give approval for staff to hold keys and/or codes to a person's home. They will consider any risks from on our part. The keys and codes must be stored securely.

- If we lose the keys or they are stolen, we will notify the person as soon as possible. If we believe a code is known to someone who should not have it, we will tell the person as soon as possible. In both cases, if needed, we will work with the person to make their home secure again.

The Service Coordinator will:

- Arrange for a Home Access / Security Agreement (National Service Pathway\Appendices and templates) to be talked through and signed by the person. This gives permission and describes the situations where we are given access to the person's home.
- Arrange for any staff members who will hold keys or codes to access the person's home to also sign the Agreement along with the Service Manager. The completed Agreement is filed electronically with the person's plan.
- Review the Agreement each time a person's plan is reviewed or sooner at the person's request.

6.8 Identifying Support Workers who 'fit' best

The person will direct and guide us on who they want to support them. Staff who best meet the person's personality, needs and preferences will be considered. This can also include the:

- Age, gender and ethnicity of the person and their preferences in terms of support.
- Culture(s) and belief(s) of the person / whānau.
- Interests and hobbies
- Times / days the person wants support.
- Physical nature and risks around the support required.
- Skills, experience and training that staff currently have and whether additional training is required.

6.9 Scheduling support for people

All work undertaken with people will be rostered in Te Puna Kōrero. Work shifts are updated by Service Coordinators when changes to support occur, e.g. illness, a change in hours, people going on holiday, etc.

All efforts will be made to provide support services to people as agreed. This may involve asking Support Workers to undertake more shifts, moving workloads or having Service Coordinators provide support as appropriate.

7 Providing support

We provide person-directed support. This means the person decides and directs how we support them. Power, control, and decisions belong with the person we support, not our organisation or staff members.

We are careful not to influence the person's choices with our own values, biases, and beliefs. In order to do this, we must be aware of how our values, biases, and beliefs affect our thinking and work.

7.1 Putting the support plan into action

Service Coordinator

- Work in partnership with the person / whānau alongside support workers, colleagues, other agencies, and community representatives to implement the support.
- Make regular contact with the person / whānau so they are informed and up to date. The minimum expectation is that a Service Coordinator will make contact monthly by phone, video conference (Zoom or Ms Teams meeting) or a face to face visit. Ask the person which option works best for them.
- Enter progress notes in Te Puna Kōrero as soon as possible or at most within five working days of any activity, planning or contact. (Refer to the Te Puna Kōrero manual - S:\1National Documents\Te Puna Kōrero\User Manual\Te Puna Kōrero Training Manual.docx for more information).
- Use the Writing Effective Notes e-module to write notes. (Refer to S:\1National Documents\National Training\Training material and workshops\Effective Case note workshop for more information).

7.2 Incidents and concerns

Service Coordinator

- Understand and use the reporting processes in the following policies in the National Service Policies Manual:
    - 1.7 Child and Young Person Protection (for concerns about child protection).
    - 1.9 Recognising and Responding to Adult Abuse and Neglect (for concerns about adult abuse and neglect).
    - 1.13 Sexuality, gender identity and intimate relationships (for concerns about sexual abuse and domestic violence).
    - 2.5 Money Handling and financial independence (for concerns about financial abuse).
    - 2.8 When a person dies (for reporting the death of a person).
    - 2.9 Enablers and Restraint Minimisation (for concerns about restraint/enabler use).
    - 2.10 Medication (for medication concerns and lost/split medication)
    - 2.11 Damage to property when supporting a person (for damage to property).
- If you have any doubts about whether to report a concern or incident or are unsure how to report it, talk to your line manager or another senior member of staff, e.g. a Senior Coordinator or Service Manager (if your line manager is unavailable).
- Ensure any accidents / incidents or near misses are documented using the Incident Reporting form (Appendix 13.1 of the Health and Safety Manual).

Support Worker

- Understand and use the reporting processes in the policies listed above.
- If you have any doubts about whether to report a concern or incident or are unsure how to report it, talk to your Service Coordinator or another Coordinator (if your Service is unavailable).

- Document any accidents / incidents or near misses using the Incident Reporting Form (Appendix 13.1 of the Health and Safety Manual). Also, report these verbally to your Service Coordinator.
- Please note: if an emergency occurs, dial 111, provide first aid (if it is safe to do so), and then contact your Service Coordinator.

7.3 Support handover

If the person has a staff member change, we will make sure that:

- The person is involved in deciding who they will work with.
- There is minimal or no gap in the support being provided during the handover.

7.3.1 Change of Service Coordinator

Current Service Coordinator

- Contact the person to advise them who their new Service Coordinator will be. Explain why there will be a change if they do not already know.
- Meet with the new Service Coordinator and provide information about the person and discuss how support is provided.
- Make a time with the person to introduce the new Service Coordinator.

New Service Coordinator

- Introduce themselves to the person.
- Read the person's file to become familiar with the person, their plan and their support requirements.

Administrator

- Reassign the Service Coordinator in Te Puna Kōrero .

7.3.2 Change of Support Worker

Service Coordinator

- Contact the person to advise them there will be a change of Support Worker. Explain why there will be a change if they do not already know.
- Follow the process in 7.3 Matching for Support.
- Meet with the new Support Worker and the person / whānau. Discuss the person's plan and their support requirements.
- Consider whether the new Support Worker should buddy with the current Support Worker when providing support during this handover period.
- Update Te Puna Kōrero by ending old delivery plans (for the former Support Worker) and creating new ones for the new Support Worker.

New Support Worker

- Read the person's plan to become familiar with the support required.
- Sign the persons plan to indicate that the plan is understood.
- Discuss any areas that need clarification or cause concern with the Coordinator.

8 Reviewing support

8.1 Introduction

It is important that CCS Disability Action listens and responds to the people we support. The people we support direct and control the support we provide.

8.1.1 Renewing consent

It is good practice to regularly check in with people and ensure that they are still comfortable with the service and supports they receive as well as verbally confirming their ongoing consent. Without consent we can do nothing.

Consent needs to be formally renewed when a person's capability to give informed consent changes or when there is a significant change to the nature of the service or support they originally agreed to.

If you think a person's ability to legally consent may have changed, discuss this with your line manager. This needs to be worked through with your line manager and the person we support.

Renewing consent with a person is carried out annually alongside reviewing support and plans. The person needs to give us written consent. Use Template 1 Consent for Services and Sharing Information with the person or whānau. If there is a welfare guardian or people appointed under an Enduring Power of Attorney in place, this too needs to be checked at the same time.

8.2 Support reviews

Please refer to section 6.2 Developing a Support Plan above to apply the same person-directed planning practice and approach to reviewing a person's support with them.

Service Coordinator

- Complete a review with the person within a minimum of twelve months of the current supports and funding in place. It is suggested that conversations begin two months prior so that any new needs, goals or specific supports can be identified. Any new funding will require approval prior to the yearly finish date. This ensures supports are seamless and continue to be delivered without interruption or waiting for be new funding renewals. The plan reviews can be held earlier if the person / whānau requests it or if specified in the Contract.
- Begin a plan review whenever there is a significant change in the person's / whānau circumstances.
- Note in Te Puna Kōrero the reasons why any review occurs later than annually.

8.2.1 Preparation for the review meeting

Service Coordinator

- Arrange a face to face review meeting with the person / whānau.
    - Before the meeting, the person must agree on who will be at their review meeting.
    - The review meeting attendees include the person we support and (if the person wants) whānau members and/or friends, Support Workers, advocates and other agencies.
- Work with the person / whānau to make sure all attendees are invited and the meeting is held at a place of the person's choosing.

8.2.2 At the review meeting

Service Coordinator

- Discuss with the person / whānau at the meeting:
    - What has been achieved.
    - What is still to be achieved.

- How each person at the meeting measures and sees success.
- What the next steps are.

- Record the meeting discussions and update support plan.
- Review with the person / whānau whether completing service with CCS Disability Action is appropriate.
- Annually renew Consent as without it nothing can happen. Complete the Template 1 Consent for Services and Sharing Information Form with the person or whānau.
- Review all agreements / safety plans at this time and update these if required.

8.2.3 After the Review Meeting

Service Coordinator

- Provide a copy of the updated support plan to the person/ whānau for sign off and approval.
- Scan any meeting notes and the updated support plan into the person's / whānau electronic folder in The S\Company Drive; People We Support\[XXX branch]\1 Actively Supported\ [Person's name]\ 2 Planning & Reviews folder.
- Enter a support note of the meeting and key actions into Te Puna Kōrero .

8.3 Support Summary form

The Support Summary form (National Service Pathway\Appendices and templates) records how each Support Worker is working with a person/ whānau to support them towards achieving the person's goals. The support summary needs to be kept secure at all times. These forms contain private and confidential information. Once scanned into the person's e-file, the physical form must be securely destroyed.

Service Coordinator

- Introduce the Support Summary form to the person and Support Worker.

Support Worker

- Complete the Support Summary form together with the person being supported.
- Co-sign the Support Summary form with the person being supported to show that you both agree with what has been written.
- Check the Support Summary form is complete and send it to the branch office with timesheet, by email, fax or in person, at the end of each pay period. If faxed or emailed, give the original Support Summary form to the person to decide what to do with it, as it is their information.
- Document any accidents / incidents or near misses using the Incident Reporting form (Appendix 13.1 of the Health and Safety Manual). Also report these verbally to your Service Coordinator.
- Raise any concerns about safety, abuse, and neglect to your Service Coordinator.

8.4 Support summary administration and review

Coordinator

- Prepare the information in the first part of the Support Summary forms by entering the names of the person, Service Coordinator and Support Worker, dates from and to and the person's goals and/or sub-goals (as per the My/Our Plan and/or relevant contract). There must only be one Support Worker named on each form. If two or more Support Workers provide support to the same person, they each receive and complete a separate Support Summary form.
- Ensure Support Workers are given prepared Support Summary forms with each new Timesheet.

Administrator / Service Coordinator

- Collect Support Summary forms and provide to the Service Coordinator or Service Manager. In smaller branches, the Administrator may provide forms directly to Service Coordinators.

Service Coordinator

- Read and sign each Support Summary form.
- Scan the Support Summary form:
    - Save the scan with the person's name and date received e.g. SMITH Jack 2014Apr10.
    - If more than one Support Worker provides a Support Summary for the same person then the Support Worker's initials for each Support Summary are added at the end of the file name, e.g. "SMITH Jack 2014Apr10BF" and "SMITH Jack 2014Apr10MC".
    - Save the scanned Support Summary in The S\Company Drive under People We Support\[XXX branch]\1 Actively Supported\ [Person's name]\ 2 Planning & Reviews \ Support Summary Form.
- Destroy the hard copy of the Support Summary form.

8.5 Support Summary follow up

Service Coordinator

- Immediately follow up on any accidents / incidents or concerns identified on the form. Notify the Senior Coordinator or Service Manager.
- Follow up with Support Workers with positive feedback, discuss work being done, or discuss where support is not in line with the identified goals.
- Use Support Summary forms as a basis for monitoring and reporting on our direct support to people / whānau.

9 Completing support

9.1 Introduction

Is it important that we take time with the person, if appropriate to acknowledge the journey together and the end of our working relationship.

Having a conversation/kōrero over a cup of tea can be a mana enhancing way to bring the time spent together, no matter how long or short, to a close. It is an opportunity for the disabled person/whānau hauā to share anything that is present for them. Sometimes this is not appropriate as supports can end for many reasons.

It is also important that we finish all tasks and administration processes at our end to ensure everything is fully complete for the person, the staff and the funder so there are no loose ends and everyone can be complete.

9.2 Planned completion of support

Service Coordinator

- Meets with the person / whānau to talk through ending supports so everyone is clear on what will happen.
- Talk about the person's completion of support with their Senior Coordinator or Service Manager.
- Enter a note in Te Puna Kōrero detailing the person's decision as to how support will end.
- Ensure any service invoices are received, shifts are completed and approved in Te Puna Kōrero and any staff mileage signed off for payment
- E-mail or send written confirmation that supports are ending and invite the person to share any feedback. The feedback link - https://www.surveymonkey.com/r/CCSDAcomplete is in the e-mail template (or send by post including a self- addressed envelope if preferred

by the person/whānau). The e-mail and letter templates are in the National Service Pathway\Appendices and templates. Give any returned paper questionnaires to the Regional Quality Coordinator.

- Complete the Coordinator section of the Completing Support Checklist and give it to your Service Manager to begin their part of the process.
- Move the person's e-file under People We Support, from Actively Supported folder to No Longer Supported folder under each branch. Refer to the E-Filing Guide(National Service Pathway\Appendices and templates) for more information.

Service Manager

- Complete the Service Manager section of the Completing Support Checklist and give to Business Support Team to complete their actions. Ensure the Service End Date is entered into the person we support details screen on Te Puna Kōrero.

Business Support

- Complete the Business Support /Finance section of the Completing Support Checklist.
- Once all areas of completing supports are confirmed as finished save the Completing Support Checklist on the person's e-file under People We Support, from Actively Supported folder to No Longer Supported folder under each branch.

9.3 Transferring to another branch or service provider

Service Coordinator

- If needed, meet with the person / whānau and the organisation(s) they are transferring to. Agree on how and when support will end. The goal is a smooth transition where the person's support needs continue to be met without interruption.

- If the person/whānau transitions to another service within CCS Disability Action, complete the Coordinator section of the Completing Support Checklist and give to the Service Manager and Business Support Team to complete their actions.
- Follow the steps in section 7.3.1, Change of Service Coordinator.
- If the person/whānau is moving to another branch, refer to section 3.5, Branch to branch transfers.
- Contact the Te Puna Kōrero Helpdesk to process the transfer of the person's information on the system to the new branch. This is done once the Business Support Team have completed their actions to complete supports and invoicing.

9.4 Unexpected completion of support

Reasons for this may include:

- Working relationship is no longer possible.
- CCS Disability Action is unable to provide the service requested.
- Changes in funding of service contracts.
- The person dies.

Service Coordinator

- Where appropriate, confirm with the person / whānau that support will no longer continue.
- Follow the steps on the Completing Support Checklist to ensure all people are notified, service and finance processes are complete and the relevant systems are updated. Complete the Coordinator section of the Completing Support Checklist and give to the Service Manager and Business Support Team to complete their actions.
- Enter a note in Te Puna Kōrero to record the conversations, actions taken and completing support agreements

- Refer to section 9.1, Introduction
- Is it important that we take time with the person, if appropriate to acknowledge the journey together and the end of our working relationship.

  Having a conversation/kōrero over a cup of tea can be a mana enhancing way to bring the time spent together, no matter how long or short, to a close. It is an opportunity for the disabled person/whānau hauā to share anything that is present for them. Sometimes this is not appropriate as supports can end for many reasons.

  It is also important that we finish all tasks and administration processes at our end to ensure everything is fully complete for the person, the staff and the funder so there are no loose ends and everyone can be complete.

- Planned completion of support.

9.4.1 When a person we support dies

When a person dies, we respond with respect and aroha. This is a significant time for the disabled person's whānau, so we need to be prepared and available. The means we respond in a collective way.

It is important we maintain clear communication with the person's family/ whānau to ensure they know the supports and options available to them.

Our staff may react in many different ways to this news. Upholding their wellbeing during this time is also considered and prepared for.

Whichever staff member is first notified of the person we support's death they

- Offer the person's family/whānau our sincerest condolences and extend our offer of support during this time.
- Inform the Service Manager immediately (or General Manager, if Service Manager is on leave)

Service Manager

- Contacts the General Manager to notify them that the person has died and to begin making a plan.

- Draws on key relationships and strengths within the team, the branch, and the Regional Leadership Team. It is important that the Service Manager has support also at this time.

Person's family/whānau - considerations and decisions

- Decide who will liaise with the family/whānau during this time. They will visit the family if appropriate, extend our condolences, find out what other supports are needed and details of the funeral/tangi.
- The Regional Pou Arahi or Te Pou Whirinaki members will guide the tikanga in this space ~~along with any other cultural needs~~.
- Decide who is best to respond to any cultural needs. Contact the Regional Pou Arahi for advice. When it is whānau hauā Māori who have died, always contact the Regional Pou Arahi.
- Decide who will arrange for flowers to be sent and/or koha to be given to the family/whānau.

Staff - considerations and decisions

- Decide who will tell the staff members that the person has died, especially those who were working directly with them.
- Take a moment to pause. Gathering staff for karakia – providing time to reflect or check in can be comforting. Sometimes our teams just don't know what to do. The regional Pou Arahi or regional member of Te Pou Whirinaki can guide or lead here or maybe another team member who is comfortable in this space. Feeling connected can be important at this time.
- Offer team members immediate support. Find out what it is they need and how they wish to be involved with the family/whānau in the immediate and going forward e.g. if they are attending the funeral/tangi. Whatever they choose is up to them and is respected. When a person we support dies it can affect each staff member in different ways.

- The regional Pou Arahi or Te Pou Whirinaki members will guide and support the tikanga for when the team attends the tangi/ funeral.
- Ensure staff know that the Employee Assisted Program (EAP) through Workplace Support is also available to them. This means that three initial free of charge, confidential sessions are available with a trained counsellor. Staff call 0800 333 200, the nationwide toll-free number for 24 hour support to access the program. If further support is needed, contact the Human Resources team to find out if there are further options available.

Other considerations and decisions

- What support or cover (shifts) is needed, if any, for the work to continue during this this time. Identify who will do which tasks from the wider team.
- Provide Support Workers with notice of a change in work hours as per the region's HR processes.
- Use the Completing Support Checklist to guide you on who to notify and the tasks to be completed in Te Puna Kōrero.
- Advise the Financial Administrator of the person's death.
- If the person was supported by a government contract, advise the NASC, applicable Ministry or ACC that the person has died and the date of death. Also advise our CCS Disability Action National Contracts Manager.
- Talk to the General Manager if needed, regarding support/ funding options if the whānau have asked us to support them beyond the funeral/tangi. The timeframe and nature of the support requested is considered.
- Debrief with the staff when appropriate. Take some time to reflect on what worked, what didn't, what can we do differently in how we respond when a person we support dies.

Please refer to policy 2.8 When a Person Dies in the National Service Policies Manual for more information This will provide you with our intention and approach to supporting the person's whānau and staff.

9.5 Withdrawal from services

Service Coordinator

- Proactively outline the complaints process to the person and offer them the chance to talk to the Service Manager or General Manager: For more information refer to Policy 3.1 Complaints in the National Service Policies Manual. Let the person know about their right to complain to the Health and Disability Commissioner (HDC) if they choose to.
- Complete the Coordinator section of the Completing Support Checklist and give to the Service Manager and Business Support Team to complete their actions.
- Enter a note into Te Puna Kōrero to record the conversations, actions taken and outcomes around completing support.

10 Other information

10.1 Complaints

Having a safe and effective complaints process is part of maintaining healthy relationships with disabled people / whānau hauā, their whānau or indeed a member of the public.

People have the right to make a complaint without fear of any negative consequences. We will never treat someone unfairly or withdraw support because they have made a complaint. Our intention is to resolve the complaint or upset directly with the person.

We treat complaints with the respect, time and the attention they deserve. We value the opportunity to find out what happened and to investigate, where needed. Complaints help to identify areas in our organisation or our relationships that may need changing or doing differently.

10.1.1 Receiving and responding to a complaint

Complaints can be made in many ways, so that it works for the person.

- In person, in writing, over the phone, by e-mail to feedback@ccsdisabilityaction.org.nz or via the CCS Disability Action website
- Through a support person, interpreter, or advocate or
- Through an external source e.g., the Health and Disability Commissioner.

Any staff member within the organisation can receive a complaint from a person we support, whānau or family member or a member of the public. The key here is to minimise the number of times the person must re-tell their complaint to staff members. Ensuring confidentiality and upholding mana is important in this process.

10.1.2 Immediate resolution

If the complaint **can** be resolved immediately and the complainant is satisfied, the complaint is closed, and no further action is needed. In this case, the staff member sends a brief summary of the complaint, the person's name, area it relates to e.g. contract name and the actions taken to resolve it to CCS Disability Action website Feedback Form. The National Quality Coordinator will review for trend analysis.

10.1.3 Investigation

If the complaint **cannot** be resolved immediately by the staff member and it requires investigation, there are two options available:

10.1.3.1 Person submits their complaint independently.

Staff member invites the person to file their complaint independently via the website Feedback Form; This supports the person to exercise self-determination.

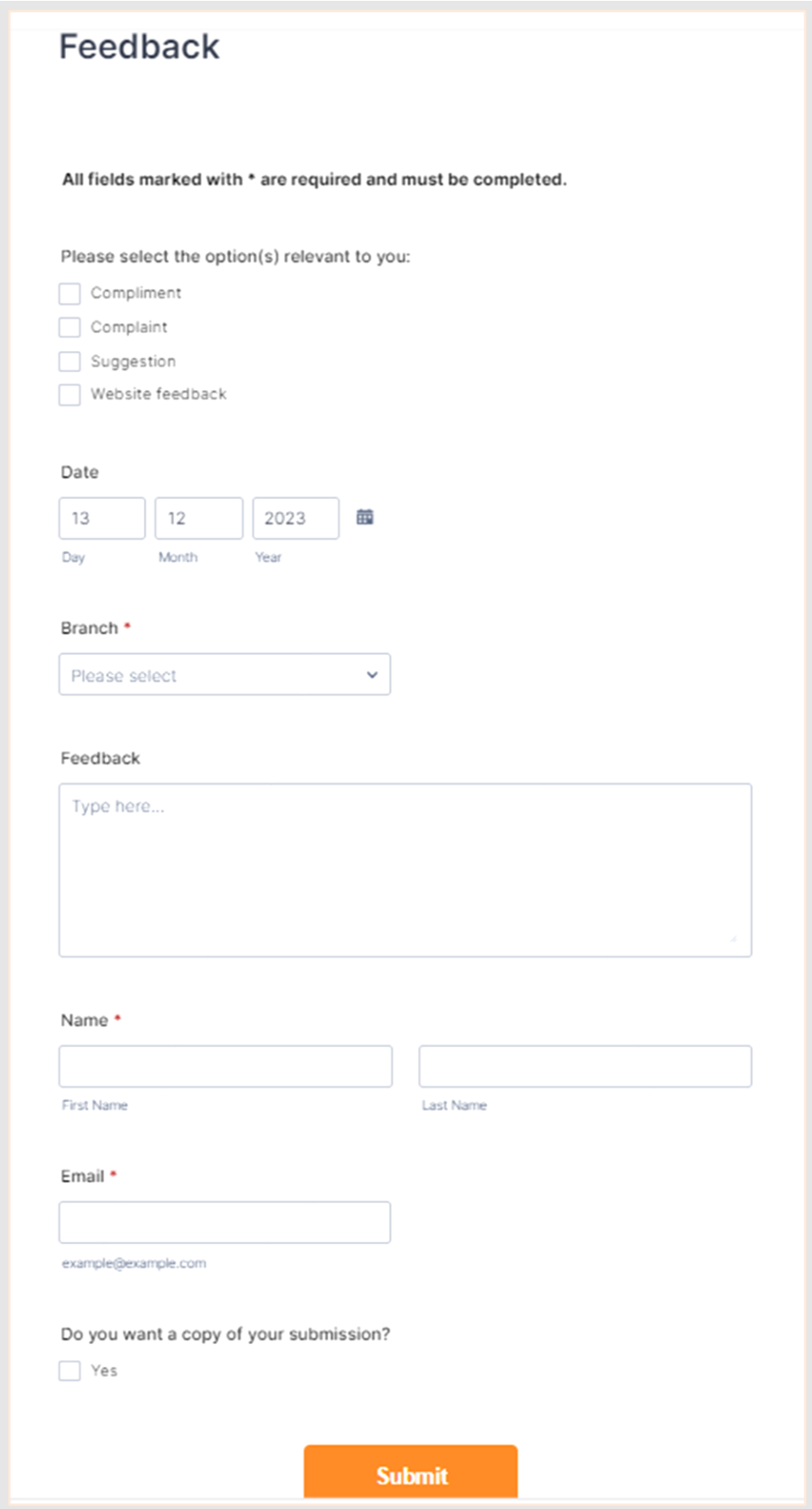
10.1.3.2 Staff member submits complaint on person's behalf.

If the person prefers, the staff member can submit the complaint on their behalf. The staff member requests the following information from them:

- their name
- the nature of the complaint (to identify the service or area)
- contact details and
- preferred way of communicating.

The staff member records these details on the website Feedback Form.

A sample of the form is below;


Feedback
All fields marked with * are required and must be completed.
Please select the option(s) relevant to you:
Compliment
Complaint
Suggestion
Website feedback
Date
13
12
2023
Day
Month
Year
Branch *
Please select
Feedback
Type here...
Name *
First Name
Last Name
Email *
example@example.com
Do you want a copy of your submission?
Yes
Submit

10.1.4 Clarifying the complaints process

When the staff member is speaking to the person they

- Ask the person if they require any support throughout the process.
- Explain expectations around privacy (e.g. confirm the complainant is okay with the investigating officer accessing their information and knowing their identity).
- Explain that we follow the HDC (Health & Disability Commissioner) Code of Rights which means the complaint is acknowledged within 5 working days, investigated within 10 working days and a written outcome is provided. If more time is needed for investigation, we will request this from the person.
  Refer to the Complaints Brochure for more details.
- Thank the person for taking the time to tell us their complaint as we value the opportunity.

10.1.5 Referring complaints for acknowledgment and investigation

Who investigates which complaint?

- All complaints submitted via the CCS Disability Action website are received by the National Quality Coordinator. The National Quality Coordinator will identify the most appropriate and impartial person to investigate the complaint and tracks that the complaint has been resolved.

As a general practice;

- If the complaint is about a Service Manager, it is investigated by their General Manager and/or the National Quality Coordinator;
- If the complaint is about an area/portfolio covered by a National Office staff member, such as policy, fundraising, finance or human resources, the complaint is investigated by the National Leadership Team portfolio holder and/or the National Quality Coordinator;
- If the complaint is about a General Manager or a direct report of the Chief Executive, it is investigated by the Chief Executive with support from the National Quality Coordinator;

- If the complaint is about the Chief Executive or governance related, the complaint is investigated by the National Board President.

Exceptions

- If the complaint is about the Mobility Parking scheme and it requires follow up, the person or staff member submits the complaint by email to mobilityparking@ccsDisabilityAction.org.nz with the subject Complaint – confidential in the title.
  - If a staff member is receiving the complaint, the staff member requests the following information from the person:
    - their name
    - the nature of the complaint
    - contact details and
    - preferred way of communicating.
  - Complaints can also be made by phone *0800 662 7275* (0800 MOB PARK)
  - The National Manager Access and Infrastructure will escalate any complaint, where needed to the National Quality Coordinator.
- If the complaint is from a staff member, contractor or volunteer and it is about another staff member, contractor or volunteer, the complaint is sent to the appropriate manager in line with our HR Policies.

CCS Disability Action is committed to a fair, accessible, responsive and efficient complaint management process. See **Policy 3.1 Complaints** in the National Service Policies Manual for more about complaints.

10.2 Health and Safety

At all times, including when providing support, staff must comply with the Health and Safety at Work Act 2015 and follow policies contained in the Health and Safety Manual.

10.3 Te Puna Kōrero

Te Puna Kōrero is our client management system used to record information about people we support and service delivery. Te Puna Kōrero is an internet-

based application. It is split into several components, the main Te Puna Kōrero website, a Coordinator's portal website, and two mobile apps; one for Support Workers and one for people we support. The aim is to be transparent and provide people we support with information about their support so they can make informed choices.

We are accountable to disabled people. It is important that we record the way we support people and how their funding has been allocated and spent. Te Puna Kōrero also captures contract requirements, legislative obligations and quality assurance information to provide to people we support and/or governance.

Processes and guidance for using Te Puna Kōrero is found in the Te Puna Korero Manual.

10.4 People's information

We need to keep people's information safe and respect their right to privacy. This means staff only collect and access people's information if they need to know it to do their job. If you have a concern about privacy or are uncertain about whether to share information with another staff member, talk to your local privacy officer. Contact details are in the Branch Directory.

See Policy 2.2 People's Privacy and Confidentiality in the National Service Policies Manual for more, including how to respond to information requests.

10.4.1 Sensitive information

A sensitive information folder exists in the Regional Leadership Team restricted permissions folder on the S\Company Drive. All sensitive information (e.g. allegations of abuse of adults, custody status for a child) is saved here. The file can only be accessed by the relevant Regional Leadership Team member e.g. Service Manager and the General Manager.

10.4.2 Reports of Concern

A report of concern relates to any suspected abuse and / or neglect of a child. All ROC are kept in a centralised restricted permissions folder on - S\Company\1National Documents\National Reports of Concern. Access permissions to this folder are predetermined by role e.g. Regional Management Team member or Child Protection Advisor. CCS Disability Action notifies Oranga Tamariki by submitting a Report of Concern. All information and correspondence relating to the concern is saved in a designated folder inside the centralised Reports of Concern, restricted permissions folder.

Please refer to policy 1.7 Child Protection in the National Service Policies Manual for more information.

10.4.3 Te Puna Kōrero Alert

If there is sensitive information or a report of concern relating to a person or child, we support an entry is made in Te Puna Kōrero. This grey box appears on the top of the screen and is titled sensitive information. It is an internal alert only that will not appear on the Support Worker App or the person we support App.
This alert tells staff that there sensitive information (or a report of concern) that exists outside of Te Puna Kōrero or the person's e-file. A staff member may request this information which is solely granted at the discretion of the Service Manager or General Manager.

Please refer to the Te Puna Kōrero manual for details on how to active the alert flag.

11 Closing statement

Thank you for reading and using these National Service Pathway practices in your work. It is important that we provide support that is person directed, respectful and mana enhancing for disabled people/whānau hauā and their family or whānau.

Disabled people/whānau hauā desire to have support they can rely on, and to have confidence in the people working with them and to know that support experience has a level of consistently.

This Pathway is designed to resource you in your work, to provide guidance and expectations so that we are responsive to disabled people/whānau hauā and meet their needs are met. Ultimately, they are satisfied with the quality support they receive.

Please feel free to send any feedback or questions about the National Service Pathway to your Regional Quality Coordinator. This Pathway is updated regularly to ensure practice remains current and relevant to provide the best possible support and service to the disabled people/whānau hauā we serve.