## Report writing tips

## Make your report a one stop shop for the planner

## Highlight importance of Coordination

## Include budget calculations where able

## Support Coordinator Details:

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| --- | --- |
| Service provider name: |  |
| Contact name: |  |
| Address: |  |
| State: | Queensland |
| Phone Number: |  |
| Email Address: |  |
| Is this a new or existing support coordination arrangement? | Existing |

## Participant statement

### Living arrangements, Relationships and supports

Describe your current living arrangements (For example: Who do you usually live with? Type of accommodation? Any changes to your living arrangements?)

Describe the family and friends you see regularly, the people who play an important role in your life and how they help you. Have your relationships and supports changed?

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| --- | --- |
| Current Plan  This is from the RFS or Plan  To remove/edit I use strike-through | I am currently at Seasons Aged Care Facility and would like to locate appropriate long term accommodation with appropriate supports to ensure that I do not need to return. I was living with my sister but due to my complex needs, this is no longer possible and I am now looking for alternative appropriate accommodation.  ~~My sister is a good emotional support for me.~~ |
| Any new information to be included  Highlight necessity for CoS in this section.  Where you need Co S for children this is especially important. You must address the argument of ‘parental responsibility’. | My sister Donna visits me around every fortnight at Seasons, and we can speak on the phone. Donna has been very busy lately, and I rely more on my formal/paid supports such as my coordinator.  I am looking forward to moving out into the community, as being surrounded by people significantly older and more unwell has been very isolating, and impacted negatively on my mental health. I am frequently unable to exit my unit independently.  Examples:   * *Mum has four children* * *Mum does not have the minimum capacity to effectively engage with necessary NDIS processes, liaise with Service Providers, manage budget effectively* * *Without coordination there will not be effective engagement with supports and interventions will be delayed to the detriment of participant capacity building/health wellbeing* |

## One stop shop for recommendations and Service Provider progress reports in this section.

## Daily life – Describe your day to day life

Describe the activities you participate in (For example: education, training, work, volunteering, social activities). What is working well for you? What would you like to change or improve? What do you enjoy? Have there been changes to your activities of daily life?

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| Current Plan | I like to get up each morning and either read or watch TV. I would like to get out more and join a social group. I would also like to learn how to cook nice meals for myself. |
| Any new information to be included.  Note; Core/CAS providers are not used to and not technically required to provide a report. I request information via email:  Good afternoon Ro,  *Participant \_\_\_\_\_\_\_ is scheduled for a plan review in just under two weeks. We are requesting from all service providers a brief progress report to include in the review.*  *Please include:*   * *Supports delivered this plan period* * *Progress towards goals* * *Barriers* * *Recommendations/quote for next plan period*   *Should you have any questions please do not hesitate to contact us.*  OR  Schedule a phone meeting, take notes as per a case conference, save as a document and attach with the rest of your evidence for the review.  This client did not have progress reports as I took over at the time of review.  In this section include:   * Supports delivered this plan period * Progress towards goals * Barriers * Recommendations/quote for next plan period   Preferably cut and paste from the report, and include references with page numbers so that the planner knows this is direct quotes. | Suzanne’s statement:  *Due to the impact of Covid 19 and repeated lockdowns I have been unable to participate in social events and activities that I would enjoy.*  **Core**  Community Access  Suzanne is supported 2-3 days per week to access community, by her support workers Fiona and Sonia. Having supports separate to the Aged Care facility has been much more effective at protecting Suzanne’s choice and control, and ensuring that supports scheduled do go ahead.  Due to difficulties booking taxi’s that are able to manage Suzanne’s wheelchair, outings are typically restricted to going to the nearby shopping centre. If able to access transport more easily, or moving to a location closer to activities of interest, Suzanne would like to engage in the following CAS activities:   * Swimming/Hydrotherapy * Markets * Movies * Art/Craft group based activities * Social groups * Go to the library   **Capacity Building**  Podiatry  Due to a negative experience with a Podiatrist early in the plan period, Suzanne has been reluctant to re-engage with this necessary intervention.  Suzanne schedule an initial appointment with a new Podiatrist on 26.03.2021, and dependent on the success of this appointment will continue with this intervention.  Occupational Therapy  During this plan period Suzanne has engaged with OT Ro (Wesley Mission) predominantly for the purpose of accessing necessary AT – Wheelchairs. Suzanne is currently scheduled to receive her Motorised Wheel Chair on 14.4.21, with extended delays occurring due to Covid 19 Response Restrictions.  Physiotherapy  Due to prior experiences with physiotherapy resulting in bruises and muscle pain Suzanne has not commenced with this support during this plan period. SC discussed with Suzanne accessing hydrotherapy as a low-impact alternative. Suzanne was concerned about pool access, and SC sourced a suitable location with hoist and ramp for pool access/egress (Goodna Pool).  Home Nursing  Due to lack of mobility and deterioration of joints (arthritis) Suzanne is at high risk of pressure sores, requires significant assistance with self-care and hygiene, and has required a large amount of L1/2 AT to increase her safety and independence.  Please see attached report from nurse Lisa Ball. |

## How to lay out new goals:

| **Area of Need** | **Your New Plan Goal** | **Interventions Required** | **Measurable Outcomes** |
| --- | --- | --- | --- |
| Daily Living | Have respite somewhere I find calming and relaxing, with appropriate accommodation and equipment for my support needs. | Core budget for respite and support workers to assist Suzanne to achieve this goal. | Suzanne is able to experience a holiday with appropriate facilities and equipment to meet her care needs.  Suzanne is able to have a break from her current accommodation which is very limiting, and refresh her mental state. |

*\*This is not in the template, I have just been using this format due to having success with it.*

## Requesting CoS budget:

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| --- | --- | --- | --- | --- | --- | --- |
| Support Coordination | Weekly | NDIA Managed | $6008.40 |  | Yes | Request to increase coordination budget for 12 month period:  L2 Coordination of Supports: 96 hours  60 hours Exploring Housing to negotiate with SDA providers  36 hours for general CoS (3 hours per month)  *\*Request Plan Management of Coordination budget.* |

## Having calculations assists the planner in justifying the request, especially where there is an LAC instead of a planner.

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| --- | --- | --- | --- | --- | --- | --- |
| Social & Community Participation | 2/7 days  Tuesday and Thursday | Plan Managed | $3,440 / $16,489 | CaRelief | Yes | Request budget to facilitate:  Five hours x three days (15)  Markets Sat/Sun (4 hours)  $1137/week  $59,124  \*increase in SCCP requested to prevent deconditioning of which Suzanne is high risk due to ongoing lockdowns and residence in an Aged Care facility. |

## Risks

Please identify any risks during the course of the current plan (e.g. health; safety in home/community; provision of supports; sustainability of informal supports; employment; exploitation; financial including ability to self-manage; decision making; home/accommodation; other).

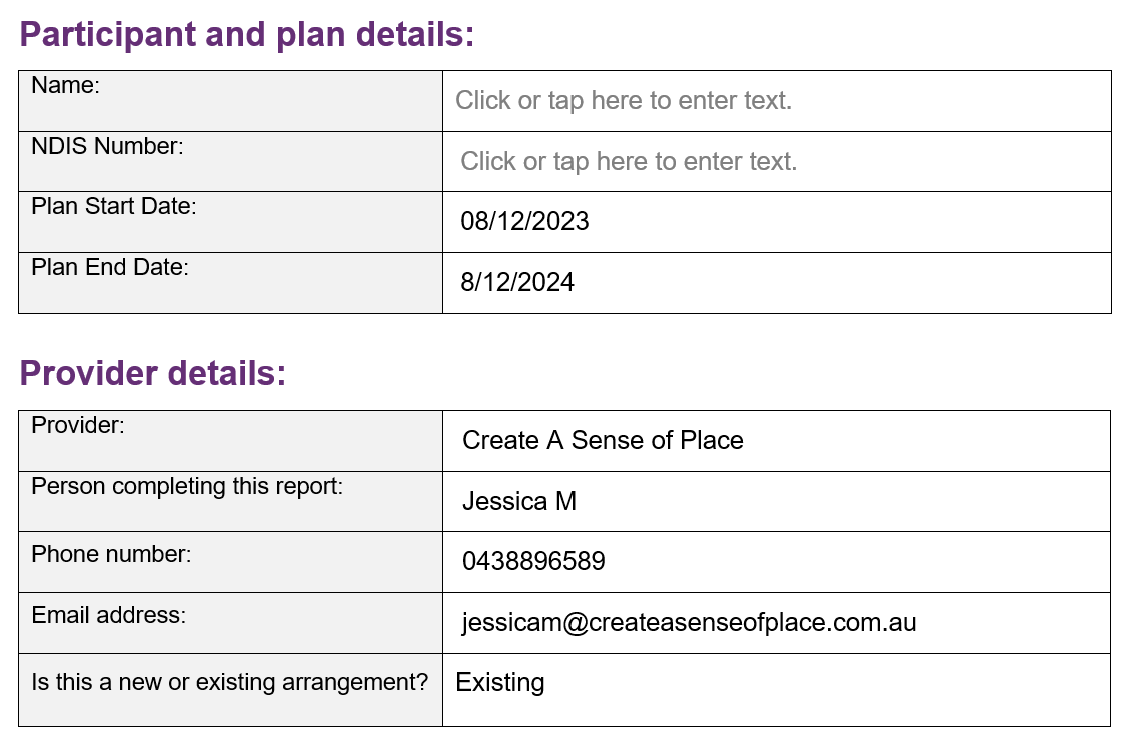
| Risk | Description/Comments |
| --- | --- |
| Sustainability of informal supports | *Use this risk to further justify when seeking CoS hours for children* |
| Health and wellbeing | *Without effective engagement by CoS, participant is at high risk of not commencing interventions or progressing toward goals due to informal supports not having capacity to manage the plan or connect with Service Providers* |
| Home/Accommodation | *Without substantial support from CoS participant is at risk of declining safety and independence at home and being unable to maintain community tenure/living independently. Guardian/decision maker will order participant to move into a facility if there are safety or health/wellbeing concerns.* |
| Provision of Supports | *Without effective stakeholder management by CoS participant is at risk of decreased goal achievement due to:*   * *Services overlapping in supports provided* * *Increased costs* * *Reduced collaboration and information sharing* * *Impaired clinical and therapeutic outcomes* |

|  |  |
| --- | --- |
| **Please provide justification for Support Coordination hours requested in new plan?** | Request for 12 month period:  96 (8 hours per month) hours Support Coordination to facilitate:   * Ongoing coordination of NDIS plan * Budget management * Service provision engagement * Supporting Suzanne to engage in necessary NDIS processes * Exploring Housing * Negotiating with SDA providers   Budget is required due to Suzanne’s lack of capacity to manage the above, and nil informal supports to assist her. If you require Level Three: Per the NDIS guideline for Specialist Support Coordination, Suzanne requires:  "an appropriately qualified and experienced practitioner to meet the individual needs of the participants circumstances. Necessitated by specific high complex needs or high level risks in a participants situation, to reduce complexity in the participant's support environment...negotiated solutions with multiple stakeholders and build capacity and resilience"  Request 30 hours of Specialist Support Coordination to:   * Engage in necessary SDA processes * Negotiate with SDA providers to source suitable SDA vacancy to meet Suzanne’s needs and fit her approved SDA budget * Liaise with SDA providers to source custom build accommodation if existing housing stock is not suitable for Suzanne * Manage transition from Aged Care accommodation to SDA housing * Engage with SIL provider to tenant match and develop roster of care suitable for Suzanne’s support needs |

## Supporting Evidence:

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| --- | --- |
| **Please list all additional supporting evidence (eg, therapy reports) provided in preparation for plan review.**  **Be Creative!** | 1. Supporting letter from Nurse Lisa Ball 2. Case conference notes 3. Participant statement 4. Carer impact statement 5. Progress reports 6. Home visit notes/observations |

**New Plan Implementation Report**

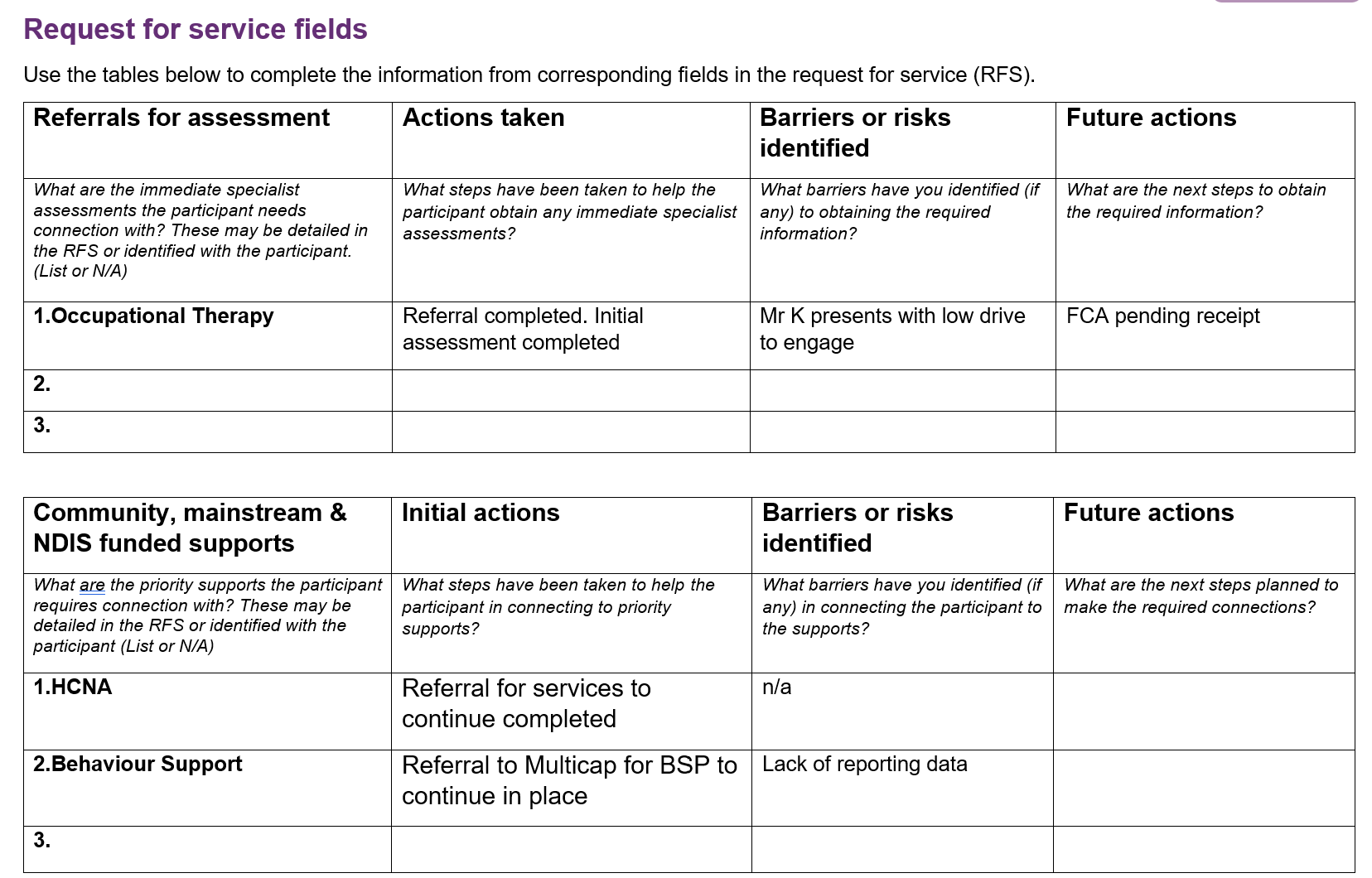


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A close-up of a questionnaire

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