H&H Care SA Pty Ltd	**Form06.** Care Planning Goals and Service Authorisation **Australian Government Support at Home Program**	
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Policy and procedure 6
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA turns assessed needs and client priorities into clear care instructions, meaningful goals and authorised services. It explains who agrees, approves, delivers and reviews each part of the plan, including changes coordinated with The Fig Trees.

Document control	Details
Policy number	HH SAH PLAN 006
Version and status	1.0 — Draft for Director approval
Prepared	24 October 2026
Policy owner	Director and Service Coordinator
Approved by	Huy Le, Director — signature: _____
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Managers, coordinators, nurses, workers and approved contractors involved in planning, delivery, review or invoicing

1 Purpose and scope

Every client must have current, accessible care instructions that reflect their assessed needs, strengths, goals, preferences and risks. Services must be consented to, clinically appropriate where relevant, within worker competence and authorised under the agreed funding and contracting arrangements. These are separate requirements; meeting one does not replace the others.

This policy applies to Support at Home services delivered on behalf of The Fig Trees and other separately approved registered providers. It supports the registered provider's care planning and care management obligations without transferring them to H&H Care by assumption. It does not replace the participant service agreement, specialist treatment plans, government assessment or brokerage contract.

2 Planning principles

- Plan with the client and support their own decisions. Include chosen supporters with a lawful basis and verify any substitute decision-making authority.
- Use strengths and meaningful daily goals, including maintaining comfort, independence or existing ability. Improvement must not be promised where it is unrealistic.
- Provide clear task instructions, risk controls and escalation arrangements; do not rely on a roster or a vague task list as the whole care plan.
- Use one coordinated current plan or a controlled set of linked documents. Resolve conflicting versions and share updates before affected tasks occur.

Responsibilities and plan development

3 Allocation of responsibility

Role	Required action
Client	Participates in the way they choose; identifies priorities and preferences; gives or refuses consent and can request review. Their rights are not conditional on achieving goals.
Registered provider	Confirms participant agreement, approved services and funding; coordinates care management and the overall plan through agreed arrangements; gives written service authorisation and approves relevant variations.
H&H Coordinator	Obtains assessments and current plans; develops or contributes to operational instructions within the agreement; checks consent and authorisation; controls versions and coordinates reviews.
Clinical Lead RN	Reviews nursing and clinical content; confirms professional instructions, monitoring, delegation and supervision; refers beyond scope and escalates clinical changes.
Workers and nurses	Read and follow current instructions; seek consent; support agreed goals; record delivery and observations; report refusals, discrepancies and changes promptly.
Director and finance	Director approves contractual scope and significant business decisions. Finance checks invoices against current written authorisation and actual service records.

4 Gather and reconcile information

Before drafting, obtain the relevant referral, assessments, home risk record, existing care plan, client preferences, consent and authority information, current clinical instructions and written service request. Record sources and dates. Ask the client what matters most and what they wish to do independently. Use an interpreter or communication aids where needed.

Compare assessed needs with approved services and available resources. Where there is a gap, document unmet needs, interim controls and referral to the registered provider. Do not rewrite a need out of the plan simply because funding is limited, or promise additional hours before approval. Resolve conflicting clinical instructions with the responsible clinician; a service authorisation is not a prescription.

5 Develop the coordinated plan

Agree with the registered provider who authors, approves and maintains the overall care plan. H&H Care may use a linked operational plan that translates the agreed services into worker instructions, provided it does not conflict with the overall plan. Record which documents are authoritative for each task and how the client and staff access the current versions.

Draft within the assessor’s competence. Use named accountable roles and practical directions. A staff member who prepares a plan does not automatically have authority to approve funding, consent to treatment or delegate nursing care.

Plan content and meaningful goals

6 Minimum care plan content

- Client identifiers, preferred name and communication, cultural and personal care preferences, relevant contacts and verified supporter or decision-maker role.
- Assessment dates, needs, strengths and goals; client involvement, consent method and any disagreement or declined support.
- Approved services and specific tasks: what assistance, how, when, where, visit frequency and duration, staff numbers and required competencies.
- Relevant allergies, clinical conditions, medication support role, equipment and linked specialist plans, with dates and instructions for locating them.
- Individual risk controls, safe transfer instructions, essential monitoring, deterioration signs and escalation contacts or thresholds set by the appropriate clinician.
- Arrangements for refusal, missed visits, emergencies, essential care continuity, after-hours support and changes in condition.
- Responsible professionals and service providers, review dates and triggers, authorisations, plan version and distribution record.

7 Agree and measure goals

Describe a goal in the client's language where possible. Record a starting point, desired outcome, support actions, who will help, a practical measure and review date. Measures may be client feedback, assistance needed, participation or comfort, rather than a numerical target. Goals must be feasible, culturally appropriate and agreed without pressure.

Example goal	Actions and review measure
I want to keep showering with privacy and as much independence as possible.	Support agreed safe steps under the assessed plan; provide only required assistance. Review client comfort, participation and level of assistance after four weeks.
I want to stay connected with my community.	Offer agreed outings or calls reflecting the client's interests. At review, ask whether the frequency and activity are useful and wanted.
I want to remain comfortable and avoid tiring care routines.	Follow the agreed clinical and personal care plan, offer rest and choices, and report symptoms. Review comfort and client preferences with the RN and care manager.

Examples are illustrative, not treatment instructions. Any exercise, swallowing, wound or medication goal must align with the relevant professional plan. Do not treat refusal, illness or changing priorities as client failure. Revise goals with the client rather than using them to withhold care.

8 Clinical plans and advance care preferences

Link clinical plans by title, author and date. Confirm required RN oversight and EN supervision. Do not copy instructions incompletely or let administrative edits alter clinical directions. Offer advance care planning discussions or referral where relevant and wanted; verify current documents and their applicability. A routine care plan or family request is not an advance care directive or authority to withhold emergency treatment.

Consent written authorisation and commencement

9 Confirm client agreement and consent

Explain the plan, proposed tasks, relevant risks, alternatives and service limits in an accessible way. Check understanding and record the client's agreement, requests for changes or refusal. Offer a copy in a suitable format. If someone signs on the client's behalf, verify authority for that decision. A signature is evidence of a discussion, not a substitute for informed consent or ongoing permission at each visit.

Where the client agrees verbally or through communication aids, document the method, date and staff member, subject to any applicable written agreement requirements. Do not fabricate a signature or imply agreement because the person did not object. Escalate disagreements that affect safe delivery and offer advocacy or supported decision-making.

10 Obtain service authorisation

H&H Care must obtain a written request or approval from the registered provider for funded services. Under The Fig Trees agreement, payment ordinarily applies to authorised and requested services. Record:

- Client, registered provider, approving person and reliable reference to the written request.
- Service type and approved tasks, location, staff numbers and relevant role or qualification.
- Start and end dates, visit frequency, hours or units, any maximum and review date.
- Agreed H&H rates, relevant time bands, travel, expenses and cancellation or overnight arrangements where applicable.
- Conditions, exclusions, reporting requirements and process for approving changes.

A referral, roster entry, goal, family request or H&H manager's approval does not by itself establish the registered provider's funding authorisation. A participant's consent does not permit billing for unapproved services. Verify the actual approving contact rather than relying on an unverified message.

11 Pre commencement check

The Coordinator confirms that client consent, service authorisation, current instructions, workforce competency, equipment, risk controls and required clinical arrangements are in place. Resolve discrepancies before the affected task starts. Confirm the first visit and give the allocated worker access to the current plan and essential contacts. Record worker acknowledgement.

Provide only a safe, specifically defined staged service while non-essential matters are completed. Missing clinical instructions or essential safety controls cannot be waived by a general approval. If safe commencement is impossible, notify the registered provider and arrange alternative essential care coverage through the agreed pathway.

Delivery variations and review

12 Follow the plan and record delivery

Workers check the current instructions before care, seek ongoing consent and document what was actually delivered, assistance provided, client response, observations and escalation. Support the client to do what they can safely do themselves. If the plan is unclear or the situation changes, pause the affected task and seek the Coordinator or RN's direction. Urgent changes must be communicated directly, not left only in case notes.

13 Manage variations and emergencies

Identify the proposed change and why it is needed. Reassess relevant needs and risks, discuss it with the client, seek clinical approval where appropriate and obtain written authorisation for ongoing changes to service scope, hours, staffing or charges. Update the plan and roster only after the required approvals are confirmed. Record the effective date and any conditions; do not backdate approval or conceal unapproved work.

For immediate danger, protect the client and obtain emergency assistance. Urgent protective action must not be delayed by billing questions. Notify the RN, Coordinator and registered provider promptly, document the reason and actions, and confirm a safe interim arrangement. Emergency action is not blanket authorisation for ongoing additional hours or an assurance of reimbursement.

If needs exceed approved funding or available competence, record the gap, discuss prioritisation and safe alternatives, and refer for care management or reassessment. Do not reduce essential tasks silently or ask workers to perform them unpaid. Respect refusals, document material consequences and escalate risks without coercion.

14 Review goals and the care plan

Ask the client whether the service meets their needs and preferences and whether goals remain meaningful. Compare progress with the agreed starting point and measure, using observations and relevant professional feedback. Record achieved, continuing, changed or discontinued goals, reasons and agreed actions.

H&H Care internal review controls are an early service check after the first visit or within five business days, an initial review within four weeks and a coordinated full review at least annually. Schedule more frequent reviews for higher needs, clinical plans, expiring authorisations or agreed provider requirements. These are internal minimum controls, not a statement of universal statutory intervals.

Review promptly after deterioration, falls, incidents, hospital discharge, medication or equipment changes, carer breakdown, complaints, client requests or changed goals. Do not wait for the scheduled date. Notify the registered provider of relevant changes and track referrals and approvals until resolved.

15 Version control records and oversight

Each plan has a version, author, approval and effective date, next review and links to current clinical instructions. Archive superseded versions, preserve the audit trail and remove them from active worker use. Record who received the update, including the client and registered provider, and confirm worker acknowledgement before the next affected task. Retain only necessary information under the privacy and records policies.

The Coordinator monitors expiring authorisations and outstanding reviews. As internal controls, management reviews exceptions monthly and audits a risk-based sample of plans, authorisations and matching invoices quarterly. Check that tasks match needs and consent, approved services match actual delivery, and changes reached workers. Assign corrective actions and verify effectiveness.

Care plan and goals template

PLAN F01 | Client participation and operational instructions. Expand fields and attach task-specific plans as necessary. This form alone is not a clinical order or funding approval.

Client name and identifier: _____
Registered provider and care manager: _____
Plan author and role: _____ Version: ____ Effective date: _____
Assessment sources and dates: _____
Language and decision support: _____
Client involvement and consent record: _____

What matters to the client

Strengths routines and preferences: _____

_____
Chosen supporters and verified authority where relevant: _____
Relevant risks and current clinical plans with dates: _____

Goal and support record

Client goal in their own words: _____
Starting point: _____
Desired outcome and measure: _____
Support actions and responsible role: _____
Review date: _____ Progress and client feedback: _____
Decision at review and next action: _____

Worker instructions for each approved task

Service and task: _____
When where and duration: _____
Assistance method and steps: _____
Client preferences and consent checks: _____
Staff numbers competency and supervision: _____
Equipment and risk controls: _____
What to observe and record: _____
When to stop or escalate and who to contact: _____
Clinical instruction reference where applicable: _____

Repeat the goal and task sections for additional goals and services. Attach current transfer, medication, mealtime or other clinical plans where required; do not replace them with vague summaries.

Emergency review and agreement

Emergency contacts and after-hours plan: _____
Essential care contingency and refusal response: _____
Review date and earlier triggers: _____
Client agreement or unresolved concerns: _____
RN clinical review where required: _____ Date: _____
Coordinator approval: _____ Date: _____

Copy provided to client and provider: _____
Workers informed and acknowledged: _____

Service authorisation and variation template

PLAN F02 | Complete for new services or an ongoing variation. Retain the registered provider's signed approval or verifiable written request with this form. H&H completion alone does not authorise funded services.

Client name and identifier: _____
Registered provider: _____
Authorised approving person and role: _____
Request date and reference: _____
New service / Variation / Renewal: _____
Reason and relevant assessment or clinical plan: _____

Authorised item	Details
Service and tasks	_____ _____
Location dates and frequency	_____ _____
Hours units and maximum	_____ _____
Staff numbers and role	_____
Rate and applicable time band	_____
Travel expenses and other conditions	_____ _____
Exclusions and clinical requirements	_____ _____
Review or expiry date	_____

Client informed and consent recorded: _____
Clinical review where required: _____
Registered provider approval method date and evidence: _____
_____
H&H acceptance and readiness checked by: _____ Date: _____
Effective date and time: _____
Plan and roster version updated: _____
Worker and client notifications completed: _____

Variation follow up

Interim controls and unresolved needs: _____
Action owner and due date: _____
First review outcome: _____
Invoice conditions confirmed: _____

Contract variations must also meet the brokerage agreement's formal variation requirements. This operational approval does not change contractual rates or terms unless validly agreed. Do not infer client contribution amounts from H&H's subcontract rate; refer those questions to the registered provider.

Implementation and references

16 Supporting records

Maintain PLAN F01 or an equivalent coordinated care plan; PLAN F02 or equivalent written authorisation; client consent and authority record; relevant assessments and specialist plans; goal review record; plan distribution and worker acknowledgement log; and authorisation expiry register. Records may be combined electronically if approvals, versions and audit history remain traceable.

17 Implementation checklist

- Agree with The Fig Trees who maintains the overall care plan and who may approve H&H service requests and changes.
- Appoint planning, clinical review and administrative roles and confirm financial delegations.
- Approve the templates, current-plan access method, version controls and expiry alerts.
- Confirm client information, interpreter support, clinical escalation and after-hours arrangements.
- Train staff to distinguish consent, clinical authority, professional competence and funding approval.
- Review existing clients for missing instructions or authorisations and address urgent gaps before affected services continue.

18 Related policies

Policies 1 to 5; scheduling and missed visits; case notes and records; clinical governance and delegation; medication and condition-specific care; incident reporting; safeguarding; complaints; workforce competency; emergency continuity; invoicing and document control.

19 References

Apply current requirements relevant to the registered provider's registration categories and services. This policy supports those obligations and does not establish that every registered-provider duty applies directly to H&H Care in its associated provider role.

- Aged Care Act 2024 and Aged Care Rules 2025, including the Statement of Rights and Aged Care Code of Conduct.
- Aged Care Quality and Safety Commission — Outcome 3.1 Assessment and planning. https://www.agedcarequality.gov.au/strengthened-quality-standards/care-and-services/assessment-and-planning
- Aged Care Quality and Safety Commission — Standard 3 The care and services. https://www.agedcarequality.gov.au/strengthened-quality-standards/care-and-services
- Department of Health, Disability and Ageing — Support at Home program manual, current version. https://www.health.gov.au/resources/publications/support-at-home-program-manual-a-guide-for-registered-providers
- Relevant professional standards and South Australian consent and advance care legislation; H&H Care and The Fig Trees agreement dated 10 March 2026 and approved variations.

Official guidance checked on 24 October 2026. Review this policy annually and following relevant legal, contract, service or safety changes.

Director approval: _____ Effective date: _____
Next review: _____

Version 1.0 — Initial draft prepared 24 October 2026. Approval and implementation remain to be completed.