Title	ACIA 013 - Communication between Service Providers and Therapist
Purpose	These guidelines are to assist: • Service provider organisation and individuals, participants, stakeholders and funders • Ensuring effective communication with therapist in the delivery of therapy programs by the support worker for a Participant at home
Background	There are various stages in introducing, developing and establishing a successful program for Participants with high, complex care needs that requires planning and collaboration with multiple stakeholders. These include: • Transition planning and development of the home therapy program • Initial transition to the Participant's home • Establishment of effective communication protocol between the service provider, therapists and case manager • Establishing the role of the support worker • Implementation of home therapy program/s • Maintaining therapy program/s • Review of therapy program/s Transition for Participants moving from a hospital/rehabilitation setting to a home environment is a complex process involving many different parties. To assist in the transition and achieve maximum outcomes in health and wellbeing, service providers must work closely with rehabilitation providers and other stakeholders as well as the Participants and their families. Planning for rehabilitation and therapy at home is an important part of the transition process and must be given careful consideration as the moving from a hospital/rehabilitation setting to home/community can be challenging and overwhelming for participants and their families. In the first weeks after discharge there is an adjustment period for the Participant (and their family) where therapy may require a gradual commencement to allow the Participant time to adjust to community living and to develop a routine that best suits their needs. As Participant involvement and service direction has increased it is imperative to involve the Participant in all aspects of the service delivery and the direction of their services to their ability. It is further acknowledged that dignity of risk is an important part of this choice and control.

Disclaimer	This guideline is provided to help guide best practice in the community service and support industry. This information does not in any way replace Commonwealth, State or Territory legislative and/or regulatory or contractual requirements. Users of this documents should seek appropriate expert advice where necessary in relation to their particular circumstances.
Desired Outcome	• To maintain a quality and safe standard of service delivery • To reduce confusion as to the roles and responsibilities of support workers and therapist in the delivery of therapy programs at the Participant's home
Definitions and Supporting Information	**Community Supports and/or Services** is defined as the provision of paid supports and services in a participant's home or community. It includes but is not limited to, the following activities of daily living: • clinical supports • community access • gardening and home maintenance • higher risk supports • housework or domestic assistance • nursing services • palliative care • personal care or support • respite care • social support • transport assistance **Support Worker** is an individual who assists or supervises a participant to perform tasks of daily living to support and maintain general wellbeing and enable meaningful involvement in social, family and community activities in the person's home and community. The Support Worker is a paid person who has access to education, support and advice from the **Service Provider** line manager or team leader. **Support Worker** has been commonly known as attendant care worker, disability worker, aged care worker, community worker, homecare worker, care worker or paid carer. **Service Providers** are organisation or a person who are funded for the delivery of supports and services to participants ***Participant*** means client, service user or consumer or person receiving service or support. **Carer** is a person that provides supports to the participant at no cost (generally family or friend).

	Support Worker Competency means a support worker who has been trained and assessed as competent by a skilled registered nurse ***or a person deemed competent by the provider*** or ***the treating therapist*** to safely and appropriately perform a specified task as a support worker ***Case Manager*** means person responsible for planning, coordination, referral and liaison regarding services and support for the Participants needs ***Therapist*** means person responsible for developing and implementing programs, strategies, routines, tasks and activities to achieve rehabilitation goals ***Rehabilitation Team*** means the team of clinical and rehabilitation specialists responsible for assessment, monitoring, implementing and review of clinical and therapeutic intervention
Guideline	The therapists' role during this transition phase is to provide the service provider with protocols and plans that detail therapy routines to be continued in the home by the support worker/s. Service providers are responsible for engaging and training support worker/s to be skilled and competent in maintaining therapy routines in the home. The Service Provider will work with therapists to ensure that the support worker/s are fully competent in the delivery of these services and clear about expectations in relation to recording and feedback processes. Service providers will include rehabilitation goals and routines as part of a Plan that includes recreational, educational and other personal goals. All parties involved in delivering care, services and rehabilitation to Participants in their home should recognise each other's roles and work together to ensure a coordinated approach for the benefit of the Participant and family It is important that communication between the service provider and the rehabilitation team remains streamlined and efficient and is shared with relevant stakeholders such as the case manager. The following points should be considered in the development and ongoing maintenance of a home therapy program to ensure the service provider provides appropriate input to the rehabilitation program that is implemented by the support worker/s and results in positive outcomes for the Participant

Considerations for ongoing maintenance and implementation of home therapy program	Responsibility
Ensure systems are in place for the treating team to speak directly to the service provider manager/coordinator	Service Provider
Document any changes to therapy routine or suggestions and share with therapist	Service Provider
Contact the service provider with any issues regarding support worker/s implementation of therapy program	Therapist
Liaise with the service provider to deliver training as required	Therapist