WEAVING A TAPESTRY

Working with geographic and cultural diversity

QHLFSS …. Case studies

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HOW DO WE KNOW WHAT WE SHOULD DO?

Mission

- Work in partnership with families and professionals
- Facilitate access and engagement to services which will promote health and well being for children
- Utilise a family centred philosophy based on the delivery of comprehensive, unbiased access to objective information

Vision

- To support families to optimize the quality of life and potential of children with a permanent hearing loss

Family – centred care

Respect and dignity

- We listen, with respect, to patient and family perspectives, choices and cultural beliefs.

Information sharing

- We strive to share complete and honest information in affirming ways.

Participation

- We encourage patients and families to participate in care and decision making.

Collaboration

- We work with patients and family members to design and enhance children's health services

CASE STUDY 1 CHLOE

- Bilateral double refer at Newborn Hearing Screen
- No high risk indicators
- Audiology at age 2 months – bilateral profound hearing loss
- Referral to EI provider – successfully established relationship and attendance
- Bilateral Cochlear implants

CASE STUDY 2 BRAYDEN

- Born overseas - unknown screening
- Bilateral HL
- Other impairments – vision
- Referral to multiple EI providers – successfully established relationship and attendance
- Unilateral Cochlear implant

CASE STUDY 3 AMBER

- Bilateral double refer at Newborn Hearing Screen
- No high risk indicators
- Referral to EI provider – difficult to establish stable relation ship with EI and regular attendance
- Bilateral Cochlear implants

WHAT WE DO …
FAMILY CENTRED CARE
BUILDING A PARTNERSHIP

Meet

Assess together

Provide and gather information

Who is the family? People and culture

What is their history?

What is their reaction to the diagnosis?

Where are their supports?

What are their strengths and resources

What are the key issues/concerns for the family?

What are the barriers to accessing services?

Who are the other professionals involved?

WHAT WE DO …
FAMILY CENTRED CARE
MAKE A PLAN …

Identify Goals with the family

Support – financial, housing, emotional, legal, medical..

Counselling – is this assistance needed? Emotional, legal, genetic, grief, ……..

Advocacy – access to services in remote areas, promoting parent beliefs and wishes ……

Liaison – links with services to enable access…

Case management – multiple issues, multiple service providers and the need for coordination…

Set priorities with the family

WHAT WE DO …
FAMILY CENTRED CARE
CLINICAL REVIEW - CHECK IN

- Review with the family on a regular basis – at each contact what has been achieved
- Check that the plan is still current - priorities can change
- Clinical review with your peers – celebrate success and support for help with road blocks
- Checking in with the family and discussing the plan and what has been achieved can be empowering and help them on the journey to self management.

FAMILY CENTRED CARE ….

Is not just about being “nice”

It requires system change to enable (family) partnership and involvement in decision making

Tweet from Mary Draper, Palliative Care Australia at ACHS Conference, Sydney Sept 25, 2012

THE CASE STUDIES AGAIN ….

CHLOE

- Complex family
- Regional area
- Protection issues
- Delayed speech despite ongoing EI involvement
- Developmental issues
- Barriers - physical and family capacity

BRAYDEN

- CALD family background
- Significant physical and health issues
- Significantly delayed speech development
- Inundation of service intervention once moved to Australia
- Initial social isolation
- Regional area

AMBER

- CALD – significant language barriers for parents
- Complex cultural issues – guarded
- Significant socio – economic issues – housing, finance
- Poor understanding of hearing loss lead to difficulty engaging with services and following through with appointments
- Metropolitan

AND THERE'S MORE.....SUPPORTS

CHLOE

- Extended family lives in area and is generally supportive
- Referral for Active Intervention – protection issues
- Advisory visiting teacher
- ECDP
- Disabilities Services
- QHLFSS
- Home help
- CI team – SP
- Transport assistance to attend ECDP
- Dept Child Safety
- EI provider

BRAYDEN

- Multiple medical specialities
- CI team
- Advisory visiting teacher
- ECDP
- Disabilities Services – initial involvement
- QHLFSS
- Australian Hearing
- CI team – SP + audiology
- ECDP
- Better Start funding
- EI provider

AMBER

- Multiple medical specialities
- CI team
- Settlement Support
- Multicultural Dev Worker
- ECDP
- Parent to Parent
- QHLFSS
- Australian Hearing
- CI team – SP + audiology + SW
- ECDP
- Better Start funding
- Community Health

SO WHAT'S THE PLAN?

… CHLOE

Support

- Resolve transport issues with family to facilitate attendance at appointments
- Support family through CI process

Counselling

- Assist family cope with and understand diagnosis
- Develop trusting relationship with family

Advocacy

- With Child Safety around risk issues and involvement of support services
- With medical professionals around attendance at appointments and juggling appointments

Liaison

- With AVT contact with family and establishing programs
- With EI services and arrange meetings to assess progress and address concerns
- With ECDP around enrolment and ongoing support
- With Child Safety around risk issues and involvement of support services
- With medical professionals around attendance at appointments
- With CI team re support in Brisbane and family's home area

Case management

WHAT ABOUT CASE MANAGEMENT? … CHLOE

- Arrange stakeholder and family meetings to bring about a more cohesive approach to service delivery
- To increase and facilitate family's involvement and understanding of services provided
- Prevention of duplication of service delivery
- Better understanding of roles of support services and service providers
- A better meeting of Chloe's needs and more effective communication between services
- Distribution of minutes and establishment of email group between service provides to enhance communication flow and clearer understanding of Chloe's needs and gaps to service provision

THE FUTURE OF THE PLAN?
… CHLOE

- Gradual reduction of time input from Facilitator as service providers become more independent in service delivery and addressing Chloe's needs. This occurred significantly once Chloe attended Prep and ECDP full time
- Organisation of Stakeholder and family meetings to address transition issues towards Grade One.
- Working towards ceasing our contact with family as child reaches commencement of Grade One

AN AFTERTHOUGHT …….
WHAT DOES IT MEAN IN TERMS OF WORKER TIME?

Month J

- **Family Contact (Phone and home visits):** 4
- **Service Provider contact:** 20 contacts either through phone or email. Some individual some group email**.**
- **Other:** Liaising with service providers about appointment times with Michelle are and then doing up Timetable of Service Provision for Family for Term 3 to enable Mum to remember when all Chloe's appointments.
- **Total: 11 Hours (This includes writing file notes)**
- **Month A:**
- **Family Contact (Phone and home visits):** 3
- **Service Provider contact:** 25 contacts either through phone or email. Some individual some group email**.**
- **Other:** Updating email list and referral to SLP services at EQ. Arranging next Stakeholders meeting.
- **Total: 17 Hours (This includes writing file notes and travel)**