Good Practice Guide to Consistent Assessment

August 2017
Contents

1. Overview.......................................................................................................................... 3
   1.1. Background.................................................................................................................. 3
   1.2. Purpose of the Good Practice Guide ................................................................. 3

2. Good practice approaches to achieve consistent assessment .................. 4
   2.1. Before Assessment................................................................................................... 4
       2.1.1. Receiving referral and screening at intake/triage ........................................ 4
       2.1.2. Scheduling an appointment ........................................................................... 5
       2.1.3. Preparing for assessment .............................................................................. 6
   2.2. During Assessment................................................................................................... 7
       2.2.1. Attending assessment location ....................................................................... 7
       2.2.2. Conducting assessment ................................................................................. 7
       2.2.3. Recording assessment information (using the NSAF) .................................. 9
       2.2.4. Completing the assessment summary ......................................................... 10
       2.2.5. Developing a support plan ............................................................................ 13
       2.2.6. Facilitating reablement (RAS) .................................................................... 13
       2.2.7. Delivering linking support to vulnerable clients (RAS) ............................... 14
       2.2.8. Assessment wrap-up ..................................................................................... 15
   2.3. After Assessment .................................................................................................... 16
       2.3.1. Finalising assessment information ................................................................ 16
       2.3.2. Completing delegation (ACATs) ................................................................ 16
       2.3.3. Supporting a successful match and refer process ...................................... 17
       2.3.4. Providing the client with assessment outcomes ........................................... 17
       2.3.5. Follow-up ....................................................................................................... 18

Appendix A – Assessment summary examples .................................................. 19
1. Overview

1.1. Background

Co-design

The Department ran four co-design workshops on My Aged Care during September and October 2016 in Brisbane, Sydney, Melbourne and Adelaide. An additional workshop was held in Melbourne with a specific focus on people with diverse needs. The workshops were attended by assessors, service providers, health professionals, client and consumer advocates, contact centre representatives as well as department and state government representatives from all states and territories.

Workshop participants provided more than 770 comments and pieces of feedback during the co-design workshops which informed the accelerated design stage.

Accelerated Design

Accelerated Design is a way to make rapid improvements to My Aged Care policy, process and systems. Feedback received from the co-design workshops was analysed, grouped by themes and developed into work streams. A series of work streams (sprints) were conducted with each sprint running for two weeks. Participants comprised department staff and aged care sector stakeholders including assessors, service providers, health professionals and client and state government representatives. Ten sprints ran from October to December 2016.

One of the policy sprints, ‘Consistent application of assessment’ addressed aspects of consistency and quality of assessment practice across the My Aged Care Regional Assessment Service (RAS) and Aged Care Assessment Teams (ACAT). Solutions were identified that would improve consistent assessment practice.

1.2. Purpose of the Good Practice Guide

One of the solutions identified was to develop a document that would outline and share good practice approaches already in place in the sector in order to achieve greater consistency in assessment. The Good Practice Guide to Consistent Assessment is just that – a guide to assist. It is recognised that at times assessors will move away from standard practice in response to a client’s individual circumstance or need; but that assessors will make good judgements that are client focused at all times.

The Good Practice Guide is a supplement to existing assessment guidelines and contracts. It is also intended to work hand-in-hand with the Quality Framework.
2. Good practice approaches to achieve consistent assessment

This section lists the key activities undertaken before, during and after an assessment. It details the main objectives assessors should aim to fulfil during the assessment process. Specific tips and techniques are provided on ways to achieve consistent assessment.

2.1. Before Assessment

This section addresses the following activities:

<table>
<thead>
<tr>
<th>Before Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1. Receiving referral and screening at intake/ triage</td>
</tr>
<tr>
<td>2.1.2. Scheduling an appointment</td>
</tr>
<tr>
<td>2.1.3. Preparing for assessment</td>
</tr>
</tbody>
</table>

2.1.1. Receiving referral and screening at intake/ triage

**Objective**

When those allocated a team leader role receive a referral they should view client information in order to gain a preliminary understanding of the client’s situation. Doing so helps to ensure that the client’s preferences and choices are supported during the assessment.

Reviewing a referral at the point of intake and triage helps to determine whether the referral is appropriate to be accepted by the organisation.

Matching the client with an assessor who has the appropriate level of expertise, cultural understanding and locational proximity helps to ensure the client is assessed in the most effective and timely manner, guided, where specified, by Key Performance Indicators and other performance benchmarks.

**Steps/activities**

- On receiving an assessment referral, team leaders should view any relevant information relating the client’s referral. Information can be sourced from the client record, including:
  - Previous screening/assessment details
  - Previous support plans
  - Previous approvals
  - Attachments e.g. hospital discharge summary
  - Notes
  - Interactions
  - Primary contact/support person for the client.
• Review information in the client record to:
  o Consider the client’s eligibility for aged care (CHSP and care types under the *Aged Care Act 1997*)
  o Check whether a representative for the client has been established (including whether an ‘Appointment of a Representative’ form is included in the referral)
  o Determine whether the referral has been made for the right assessment type and to the right outlet.
• If necessary, transfer referral to another assessment organisation. Add appropriate Notes relating to the transfer.
• Review the priority assigned by the referrer and change if it doesn’t align with the guidance on priority.
• Match the client to an assessor who can best meet the needs of the client. For example, an assessor:
  o of the same cultural background
  o who has knowledge of the local region
• Use Notes to document key steps or phone calls including date, time, assessor name, designation.
• For ACATs, consider timing of first clinical intervention.

2.1.2. Scheduling an appointment

**Objective**

When scheduling an appointment, speaking to the client (or their representative) to confirm and update information within the client record helps the assessment organisation and client prepare for the assessment.

By involving representatives, assessors can ensure that clients who may lack the capability to provide accurate and relevant information (e.g. clients with cognitive impairment) are accurately assessed.

**Steps/activities**

• Contact client (or representative) and:
  1. Identify who you are and the organisation you are from.
  2. Advise them of the organisation you have received the referral from and the role your organisation plays (e.g. Home Support/ Comprehensive Assessment).
  3. Provide information and set an expectation of what will happen at the assessment.
  5. Gather any additional information required including whether the client would like a support person present at the assessment (family member, carer, interpreter, etc.).
  6. Check to see if anyone else in the house may require an assessment, as appropriate.
7. Check to see if referrer and/or representatives also need to be contacted.
8. Make appointment.
10. Advise the client the name of the assessor who will be attending the assessment location (if possible).
   - Upload any additional client information to client record (e.g. WHS screen) and use Notes to record assessment booking details.
   - Organise interpreter (if required).

**Hint:** Clients with cognitive impairment or mental health issues may require the involvement of a representative. Where clients have lost the capacity to make decisions about personal, lifestyle and/or health-related matters, they will require an authorised representative to be established in My Aged Care. For more information on representation, visit [https://agedcare.health.gov.au/programs-services/my-aged-care/information-for-assessors](https://agedcare.health.gov.au/programs-services/my-aged-care/information-for-assessors)

### 2.1.3. Preparing for assessment

**Objective**

Preparing adequately for the assessment will help to ensure that assessors are well informed and are using existing information. This will reduce the need for the client to retell their story.

**Steps/activities**

- Allocate time in your schedule to review all information in the client record prior to attending the assessment.
- Contact referrer or GP (if required and with client consent).
- Confirm if the client is receiving existing services from whom and for how long.
- View the service finder to ensure you have up-to-date service information and availability.
- Find out what unfunded services are available in the client’s area or other options for community engagement.
- Organise access to any Supplementary Assessment Tools that may be required.
- Download client information (if using myAssessor app).
2.2. During Assessment

This section covers the following activities:

<table>
<thead>
<tr>
<th>During Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1. Attending assessment location</td>
</tr>
<tr>
<td>2.2.2. Conducting assessment</td>
</tr>
<tr>
<td>2.2.3. Recording assessment information (using the NSAF)</td>
</tr>
<tr>
<td>2.2.4. Completing the assessment summary</td>
</tr>
<tr>
<td>2.2.5. Developing a support plan</td>
</tr>
<tr>
<td>2.2.6. Facilitating reablement (RAS)</td>
</tr>
<tr>
<td>2.2.7. Delivering linking support to vulnerable clients (RAS)</td>
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<tr>
<td>2.2.8. Assessment wrap up</td>
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2.2.1. Attending assessment location

**Objective**

When first attending the assessment location, assessors should inform the client about the assessment process. This will help to ensure the client has the context to consent to the assessment. Assessors should also inform the client of potential outcomes of the assessment. Setting expectations appropriately in this manner will help assessors to engage clients more effectively during the assessment.

**Steps/activities**

- Be clear to the client who you are and your organisation/role as an assessor on behalf of My Aged Care.
- Explain the assessment process and provide the broader aged care context (e.g. the role of My Aged Care, Commonwealth Home Support Programme, Home Care Packages Program, residential care).
- Explain the consent that will be required e.g. for assessment, referrals.
- For ACATs, ensure client is medically stable to participate in assessment (if in hospital).

2.2.2. Conducting assessment

**Objective**

Conducting the assessment with a conversational and motivational approach will allow the assessor to develop rapport with the client. When clients are encouraged to tell the story, it will enhance the quality of the conversation and the information collected by the assessor.

Assessors should also observe client’s activities to gain insight beyond information that is conveyed just verbally by the client or the representative.
**Steps/activities**

Confirm the support the client has available to them
- Confirm client representatives and their consent.
- Consider informal supports first (e.g. can a family member/neighbour clean your windows).

Use a conversational approach when interacting with the client
- Use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes.
- Ensure your conversation is undertaken in a manner that is respectful, non-judgemental and non-confrontational.
- Know when and how to best use closed, open, direct and indirect questioning.
- Use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements.
- Use active listening skills.
- Make eye contact with the client to ensure client is engaged with the process (unless culturally inappropriate to do so e.g. Aboriginal and/or Torres Strait Islanders)
- Gauge the client’s level of engagement in the assessment. Look for signs of fatigue or discomfort, and adjust approach accordingly.

Use appropriate language when speaking with the client
- Use needs-focussed language, explaining what could be short-term vs. long-term options to meet their needs.
- Use language that is positive and not dismissive.
- Use language that focuses on the client’s abilities and how these could be further supported – a focus on independence.
- Reflect the conversation back to the client to ensure you have understood what was said/agreed.

Ensure a strengths-based approach to assessment
- Focus on elements of functional tasks that a client can complete, and discuss what specific assistance they would benefit from in order to complete the task.
- Discuss strategies a client can employ in order to more easily manage day-to-day tasks (e.g. using energy conservation techniques when completing housework).
- Explore client’s opportunity for reablement (e.g. can the client benefit from time-limited support to regain their functional capability?)

Collect further information through additional means
- Observe the client completing tasks in the house (‘show me’ assessment). Advise the client what was observed/seen during the task.
- Use validated tools to collect further information (e.g. Mini Nutritional Assessment).
2.2.3. Recording assessment information (using the NSAF)

**Objective**

Recording assessment information in a consistent and effective manner will help to ensure that the client’s situation is accurately reflected. Recording assessment information in this manner will also make it more easily readable and usable for people who need to access it in the future.

Service providers will benefit from well-recorded, consistent assessment information, as this will allow them to locate and understand the client’s service needs more easily.

**The audience of assessment information**

Throughout the assessment process, assessors must ensure that information is recorded in the most appropriate manner and for the right audience.

**Primary Author: Assessors**

Assessment information should be completed from the assessors’ perspective to ensure it:

- Lays the foundation for creating the support plan.
- Ensure duplication between the assessment and support plan is kept to a minimum.
- Provides sufficient evidence for delegate decision (Delegates should read the full Comprehensive Assessment to ensure all pertinent assessment information is considered).

**Primary Audience: Clients**

The assessment information should be:

- Transparent and reflective of what the client actually said.
- Easily understandable. This can be aided by the use of common phrases, minimising the use of acronyms and presenting clinical information in lay language.
- Free of oversimplification to ensure adequate information is presented.

**Key Audience: Service Providers**

Assessment information can help to inform a client’s provision of care.

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**Examples of ‘show me’ activities**

- Watching a client make a cup of tea or coffee, in order to observe physical mobility, cognition (can they appropriately make the cup of tea or coffee? Follow instructions?), nutrition, finances (e.g. observing items in cupboard or fridge)
- Using pictures/photos to start a conversation about social connection
- Asking the client to show you their current set up with rails, ramps and safety equipment, in order to observe their mobility and use of particular items/absence of these (e.g. does the person need specialist support with aids and equipment?)
Steps/activities

Focus on the client when recording assessment information
- Make sure all important assessment information is recorded before leaving the client’s home in order to prevent unnecessary follow-up queries.
- If using a computer at the client’s home, sit where the client can see your screen and ensure you are not focused on just the computer. Ensure you regularly make eye contact with the client.
- Minimise use of acronyms, only using the more common acronyms where necessary.
- Tell the client’s story – use client’s words where possible.

Completing the assessment
- Ensure the full client story is recorded throughout the assessment.
- Consider how best to record information so that viewers of assessment information do not think that a question was skipped/missed (e.g. use ‘Not Applicable’ where appropriate rather than leaving fields blank).
- Use Comments fields to identify where there is an inability to obtain information related to a certain profile.
- Minimise repetition in the assessment by utilising the areas of the NSAF that best suit the information.
- Use the myAssessor app (if appropriate).

2.2.4. Completing the assessment summary

Objective

Using a standard template to complete the assessment summary can help to ensure information is recorded in a consistent manner, across both RAS and ACATs. It is simple to adopt and helps make information easier to read and better support the delegation process. This will also benefit service providers by making it easier for them to access and interpret important assessment information in order to develop care plans.

The audience of the Assessment Summary

Primary Author: Assessors
Assessors may use the assessment summary to develop a succinct overview of assessment outcomes.

Primary Audience: Clients
Clients will receive this succinct, client-centred version of assessment information as part of their printed support plan.

Secondary Audience: Service Providers
Service providers benefit from the assessment summary as it presents an easy-to-read, focused snapshot of key information and client goals.
Steps/activities

- Use the template on the following page to guide the development of an assessment summary.
- Some examples are included at Appendix A, for your reference.

**Hint:** There are several principles that should be adhered to when completing the assessment summary. The assessment summary should be:

1. Written in a succinct manner (using the ISBAR approach – see following page), focusing on relevant/essential information.
2. Presented in a structured way that makes the information easy to interpret.
3. Grammatically correct and free from acronyms, abbreviations, jargon and unnecessary headings.
4. Relevant. Only include information that is relevant to the client’s current situation. This may mean updating previous information.
<table>
<thead>
<tr>
<th><strong>Assessment summary template using the ISBAR approach</strong></th>
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<tr>
<td><strong>Introduction</strong></td>
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### 2.2.5. Developing a support plan

**Objective**

Developing a support plan with the client will ensure it accurately reflects the client’s needs and goals. This will increase the likelihood that the client will work towards the goals they have identified. It will also help to paint a comprehensive picture of the client's situation which will in turn help providers to better understand the client’s needs and preferences.

**The audience of the Support Plan**

**Key Audience/Author: Clients**

The support plan should be based on the client’s own stated goals, concerns, and preferences.

**Facilitating Authors: Assessors**

Assessors must make sure the client’s story is articulated into a documented set of goals.

**Key User/Audience: Service Providers**

The support plan should:

- Provides a simple snapshot of the referral outcome to make it easier for service providers to access relevant information.
- Inform the development of a care plan.

**Steps/activities**

- Develop the support plan with the client and obtain their agreement (although it may be documented when back at the office).
- Establish client motivations, client goals/concerns and recommendations for all clients and record them from the client perspective.
- Document general recommendations (i.e. non-CHSP services, client actions).
- Remove use of acronyms and abbreviations.

### 2.2.6. Facilitating reablement (RAS)

**Objective**

Facilitating reablement can greatly benefit certain clients through short term, intensive service provision.

Reablement can assist clients who can regain their independence, the capacity to undertake daily activities and/or maintain social connections.
Steps/activities

- Consider if the client would benefit from short-term reablement support, particularly if the client has experienced some functional loss and expresses the desire to regain confidence and capacity to resume activities, including connecting with their community.
- Consider the client’s need for a mix of short term, episodic or ongoing services across service types (e.g. short term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the client’s needs.
- Maintain regular contact with the client and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised, and what ongoing support (if any) may be required for the client.
- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term clients as part of a reablement episode.

2.2.7. Delivering linking support to vulnerable clients (RAS)

Objective

Facilitating linking support can greatly benefit certain clients through short term, intensive service provision.

Linking support can assist those whose access to aged care services is impeded by their complex circumstances and areas of vulnerability.

Steps/activities

- Consider if linking support is likely to be required, particularly if the client presents with two or more complexities.
- Advocate to have services within and outside aged care organised for the client.
- Access relevant experts to address the client’s complexities (e.g. Assistance with Care and Housing providers, community GEM teams, mental health workers) and to assist with the co-ordination of the client’s care whilst receiving linking support.
- Discuss with service providers the client’s current situation and support plan moving forward.
- Maintain regular contact with the client, providers and those co-ordinating services during the period of linking support.
- In consultation, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the client.
2.2.8. Assessment wrap-up

Objective

At the end of the assessment, an assessor should inform the client of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the client to feel more assured and increase their satisfaction in the overall assessment experience.

Steps/activities

- Inform the client on the next steps, such as:
  - Who to contact and in what instance (i.e. if the client has chosen to be matched and referred to service, they will be contacted by service providers to discuss details of the service being requested; if the client has chosen to receive a referral code, they will need to take the code to the provider of their choice to access the service)
  - The actions they are responsible for (e.g. visiting providers, organising a check up with a GP/specialist)
  - For clients seeking access to the Home Care Packages Program, how the national queue works; and what action they should take once they have been allocated a package
- Leave behind a client information pack/form as written information on what will happen next.
- Provide contact details to the client on who they should contact in the future (e.g. the My Aged Care contact centre, the assessment organisation [name and contact details of the assessor], a service provider).
2.3. After Assessment

This section covers the following activities:

<table>
<thead>
<tr>
<th>After Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1. Finalising assessment information</td>
</tr>
<tr>
<td>2.3.2. Completing delegation (ACATs)</td>
</tr>
<tr>
<td>2.3.3. Supporting a successful match and refer process</td>
</tr>
<tr>
<td>2.3.4. Providing the client with assessment outcomes</td>
</tr>
<tr>
<td>2.3.5. Follow-up</td>
</tr>
</tbody>
</table>

2.3.1. Finalising assessment information

**Objective**

Finalising assessment information, including ensuring no information is missing, will help to ensure that the client story, including their needs, goals and preferences is conveyed accurately and actioned upon in the agreed manner.

**Steps/activities**

- Perform a quality check on the assessment information, expanding on information and assessment evidence where required.
- Ensure that there is consistent information across assessment and support plan documentation e.g. if there is a recommendation made for carer respite, ensure that there is clear information on the client/carer relationship, any difficulties or concerns that are experienced and the sustainability of the relationship.
- Identify triggers to refer on to specialist assessment e.g. allied health, OT assessment.
- Contact GP (if necessary and with client consent).

2.3.2. Completing delegation (ACATs)

**Objective**

Delegates should review all assessment information carefully to ensure their decision results in the approval of the most appropriate care types to address the client’s needs.

**Steps/activities**

- Gather further information from the assessor who conducted the assessment (if needed).
- Case conference (if appropriate).
2.3.3. Supporting a successful match and refer process

Objective

Checking information such as service availability during the match and refer process will help to ensure service referrals are actioned in a timely manner, and client choice and preferences are facilitated.

Steps/activities

- Check availability of service providers in the client’s region.
- If required (for example, for vulnerable clients) contact providers on behalf of clients when referring.
- Add additional Notes to ensure all pertinent information is available to service providers.
- Consider all referral options (broadcast, preference, referral code).
- Consider referrals to services not listed within My Aged Care.
- Advise the initial referral source of the outcome of assessment, delegation (if relevant) and referral.

2.3.4. Providing the client with assessment outcomes

Objective

Providing the client with adequate information relating to their assessment outcomes will ensure the client has a clear understanding of what will happen following the assessment, including who will contact them or who they will need to contact.

Steps/activities

- Provide the client with a copy of their:
  - Support plan.
  - Referral code letter (if appropriate, noting that home care package clients will receive a letter once they have been assigned a package).
  - Satisfaction survey (if applicable).
  - In addition, for clients who had a Comprehensive Assessment, a copy of the approval or non-approval letter.
2.3.5. Follow-up

**Objective**
Following up with clients who may require further assistance, such as with actioning referral codes, will help to ensure the client is receiving the services that address their needs. Following up may also assist vulnerable clients who experience more difficulty in accessing the services they require.

**Steps/activities**
- If appropriate, follow up with clients post-assessment who:
  - Were issued with a referral code.
  - Have referrals that have been rejected/not actioned.
  - Are working on short term reablement goal(s).
  - Are vulnerable, as determined by complexity indicators or need for linking support.
Appendix A – Assessment summary examples

Assessment Summary (RAS Assessment)

Mrs R. is a 71 year old woman who was referred for a Home Support Assessment by the Post Acute Care program. The assessment took place in her home on 17/01/2017, also present was her husband Mr R.

Mrs R has recently undergone a hip replacement, and has accessed four weeks of domestic assistance through the Post Acute Care Program. She feels she requires some further support as she recovers.

Mrs R lives with her husband and their dog Brutus. They have lived in the family home for the last 35 years. They are friendly with the neighbours. Together they have three children who all live in the western suburbs of Melbourne, and provide support to Mrs R when able. Mrs R. was a long time runner and fitness instructor, and she believes her need for the hip replacement was likely due to the years of running. Mrs R. has experienced pain in her hip for approximately 10 years, with it progressing to the point where it impacted quite significantly on her ability to manage most tasks.

Mrs R. reports she is struggling with not being able to be as active as she once was. She is keen to be able to return to walking Brutus; and would like to be able to return to managing the cleaning tasks within the home. Mrs R. is not driving at present due to the recent surgery, although she hopes to return to this once given the all clear by the surgeon. Mr R. is driving, and assists with all community access at present however has his own health issues that impact on his ability to help with house hold cleaning tasks. The couple state that between them, they are managing grocery shopping, medical appointments, and visiting family and friends. Mrs R is attending to most of the meal preparation, with some assistance from Mr R. as required. She prepared some meals before her surgery and froze them, enabling the couple to maintain their usual diet while Mrs R recovered. Their children also assist with providing some meals. The hospital undertook an Occupation Therapy (OT) assessment prior to discharge, and determined no further home modifications were required. Rails are present in the shower, toilet and at the rear entrance. The OT arranged for an adjustable chair to be provided to Mrs R. for six weeks following her discharge.

Mrs R is keen to return to her previous level of function and the following is recommended:

1. Physiotherapist referral for an exercise program to improve her walking so she can walk her dog again.
2. Domestic assistance for a period of 8 weeks to assist with the heavier cleaning tasks until Mrs R is fully recovered from her hip surgery.

Support Plan provided to Mrs R.
Assessor name, Home Support Assessor, Regional Assessment Service
Ph: 1234 5678
Assessment Summary (RAS Assessment)

I Mrs S is an 84 year old lady who lives with her husband. A Home Support Assessment was conducted on 14th February 2017 at the couple’s home. Mrs S referred herself for community support as both she and her husband are finding some things more difficult and are not sure what help is available to them. The couple have lived independently until now and are keen to remain at home. Also present at the assessment was Mr S.

S Mrs S has Rheumatoid Arthritis, Pain, ongoing lower back pain, and peripheral vascular disease.

B Mrs S identifies as a carer for her husband. He has mobility issues that impact on his day to day activities. Mrs S has always attended to the heavy cleaning tasks, cooking, shopping, and laundry tasks. The couple are active members of their local Probus club and enjoy attending outings and meetings. They have 2 daughters, who both live in Melbourne but visit regularly and are in touch via phone at least weekly. The couple do not access any formal community supports at this time. They have a good network of friends who offer support as needed, however Mrs S has expressed concerns that their circle of friends are also ageing, and so not able to provide as much support as previously.

A At assessment, both Mr and Mrs S engaged in the questions and assessment process. They both still drive, and reported no issues with accessing the community for medical and social needs. Mrs S attends to all meal prep and grocery shopping, and stated that she now does smaller shops several times a week to manage carrying the bags. Mrs S reported no appetite or weight changes, and stated they both eat 3 meals per day and snack. Mrs S ambulates without the use of any aides, and reports one fall in the last 6 months where she tripped over the hose in the garden. She was able to get herself up, and had a small bruise on her leg – no medical attention was required. Mrs S has contact every 6 months with the Continence Advisors at the local allied health team, and accesses the Continence Aids Payment Scheme for aids as required. Mrs S identifies as a carer for her husband due to his mobility limitations, and states she is now finding it more difficult to attend to all tasks around the home due to pain and flare ups of her rheumatoid arthritis. They have had support from their daughters with cleaning but their visits are ad hoc. Mrs S showed no signs of memory loss, and no concerns with cognition reported. All questions were answered appropriately.

R Mrs S has been recommended to access Domestic Assistance to assist with some heavy household tasks. Options for providers of Domestic Assistance discussed with Mrs S, and a referral code provided to Mrs S for her to choose a provider.

Support Plan provided to Mrs S.
Assessor name, Home Support Assessor, Regional Assessment Service
Ph: 1234 5678
Assessment Summary (RAS Assessment)

I Mrs Example is a 93 year old lady who self-referred for domestic assistance as her husband was receiving domestic assistance through Department of Veterans' Affairs (DVA) and has recently moved into residential care. This home support assessment was completed on 3 February 2017. Present at the assessment was Mrs Example and Katherine Smith (Assessment Officer).

S Since Mr Example has gone into residential care, Mrs Example has lost a significant amount of weight in the past few months and has become quiet frail. Her mobility has also been affected by her increased frailty, she is at times unsteady on her feet however she reports she manages with a 4 pronged walking stick.

B Mrs Example has lived alone in her own home since her husband was placed in residential care 2 months ago. She has two supportive sons who live nearby. Chris is the main contact person for Mrs Example and visits at least weekly and phones daily. Nick her other son manages Mrs Example's finances and has regular phone contact. Both sons assist with meals. Mrs Example also has a very supportive neighbour who takes her rubbish bins out, pops in daily and sometimes provides meals. Mrs Example sees her General Practitioner regularly and currently has regular appointments with a dietician for her recent weight loss. She visits her husband in residential care 3 times a week and talks to him daily on the phone. DVA are currently providing domestic assistance until 31 March 2017 to allow time to organise ongoing domestic assistance.

A Mrs Example was alert and orientated and actively participated in the assessment. Mrs Example has significant hearing impairment which made communication difficult at times, She used a note pad to communicate when required. She also wears hearing aids. Mrs Example is independent with showering and manages her own medications. She prepares some light meals but reports she does not like cooking. Mrs Example is keen to remain living in her own home, she reported she is claustrophobic and would therefore be unable to live in a residential environment. She likes to keep certain doors and windows open throughout the day. Mrs Example is quite independent but is anxious about finding domestic assistance so she can remain at home. She is keen to continue with the lighter cleaning chores as she reports she is quite particular and likes to keep busy.

R Mrs Example has been recommended for:
1. Domestic assistance to assist with heavier cleaning tasks, referral made to client's chosen provider.
2. Physiotherapy – discussed, Mrs Example will contact assessor if she wishes to pursue this in the near future
3. Delivered meals – discussed, Mrs Example will consider this and contact assessor if she wishes to pursue this in the future

Family Contact: Chris Example (son) Ph: 03 9000 1000 to be contacted to organise service
Mrs Example has been provided with a copy of the Support Plan
Assessor name, Assessment Officer, Regional Assessment Service.
Assessment Summary (Community ACAT Assessment)

I Mr Community Example is an 89 years old Serbian speaking gentleman. A comprehensive assessment was completed on 07.02.2017 at home. Community, wife Anna, daughter Ljubica and Serbian Interpreter were present. Community was referred to MyAgedCare for by Ljubica for advice on services and future planning. It is Community’s wish to continue living at home with Anna as his full-time carer.

S Relevant medical conditions include Cognitive changes, Ischaemic Heart Disease, Atrial Fibrillation, Osteoarthritis, Pain, Falls, Diabetes Mellitus Type Two (Insulin Dependent).

B Anna provides a full-time carer role attending to Community’s needs. Anna has her own significant health concerns. Community receives Royal District Nursing Service (RNDS) daily for supervision of blood sugar level testing, tablets and injection of insulin. Council Aged Services provide showering assistance three times a week and cleaning once a fortnight. Anna is heavily reliant on Ljubica for emotional and practical support, such as transport, reading letters and arranging bill payments. Community holds an Aged Care Approval for Residential Respite Low Care.

A On assessment, Community was pleasant and cooperative. He presented with cognitive impairment; deficits noted on praxis, memory recall and language. Family report a two year history of cognitive changes including repetitive questions, mixing up days of the week and difficulty recalling their names. Community was observed to mobilise 10 metres with a four wheeled walker under close supervision. Community completed bed transfers with bedstick and minimal assistance, chair transfers with supervision and raised seat height, and toilet transfers with bilateral rails and supervision. Community remains continent, and Anna assists with pad changes. Anna and Ljubica are concerned that if Anna’s health deteriorated she would not be able to care for Community at home. They are seeking case management, and would like to have residential approvals completed as a back-up plan. They do not wish to pursue further assessment of Community’s cognitive changes. It is evident that Community now has high level care needs. Community is agreeable to future planning.

R Community Example has been approved for Home Care Package Four, Residential Respite High Care and Residential Permanent Care. Community would benefit from Serbian speaking workers. Support Plan provided to Community and Dr General Practitioner.

Assessor name, Comprehensive Assessor, ACAT Team, Ph: 1234 5678
Assessment Summary (Hospital ACAT Assessment)

Mrs B, aged 87, participated in a comprehensive assessment on 17th January 2017 at Metropolitan Extended Care Centre (MECC) where she is a current inpatient. Also present were Mrs B’s daughters Ms P and Mrs N. Assessment information has also been obtained from Ward Staff and Clinical Patient File.

Mrs B was referred by the Ward Social Worker and is seeking access to the Transitional Care Program to support her goal to return home.

Mrs B was admitted to Metropolitan Acute Hospital on 24th December 2016 due to a delirium on the background of pneumonia. She was transferred to MECC on 27th December 2016 and has been receiving rehabilitation to prepare for her return home. Other health history includes Osteoarthritis and Mild Cognitive Impairment, diagnosed October 2016 MECC Memory Clinic.

Mrs B usually lives alone in her own home and reports to have been managing well with family support and formal services. Mrs B was previously attending to all meal preparation, light domestic tasks, medication management (Webster Pack) and made use of the Returned and Services League (RSL) bus to attend local RSL. Her 2 children visit 1-2 times a week and assist with community activities including shopping, banking/payment of bills and accompany to medical appointments. Mrs B was also in receipt of personal care and domestic support from her local Council and has Low Residential Respite Approval. Ms P and Mrs N were appointed Power of Attorney November 2016.

Mrs B’s is making a steady recovery but continues to experience ongoing fatigue and increased difficulty concentrating and retaining new information. She requires a higher level of support than previously with mobility, hygiene, medication management, domestic tasks and community access.

Mrs B is confirmed to have a number of functional and restorative goals which will support her return home and which can be met by The Transitional Care Program. Residential Care was also discussed at Assessment and it was agreed this may need to be considered if Mrs B is unable to achieve goals required to support her return home.

Approval has been provided for the Transitional Care Program and Residential Care.

Mrs B has requested all Services liaise with her daughter Ms P.

Copies sent to: Mrs B and her General Practitioner

Assessor name, Assessment Officer, Regional Assessment Service