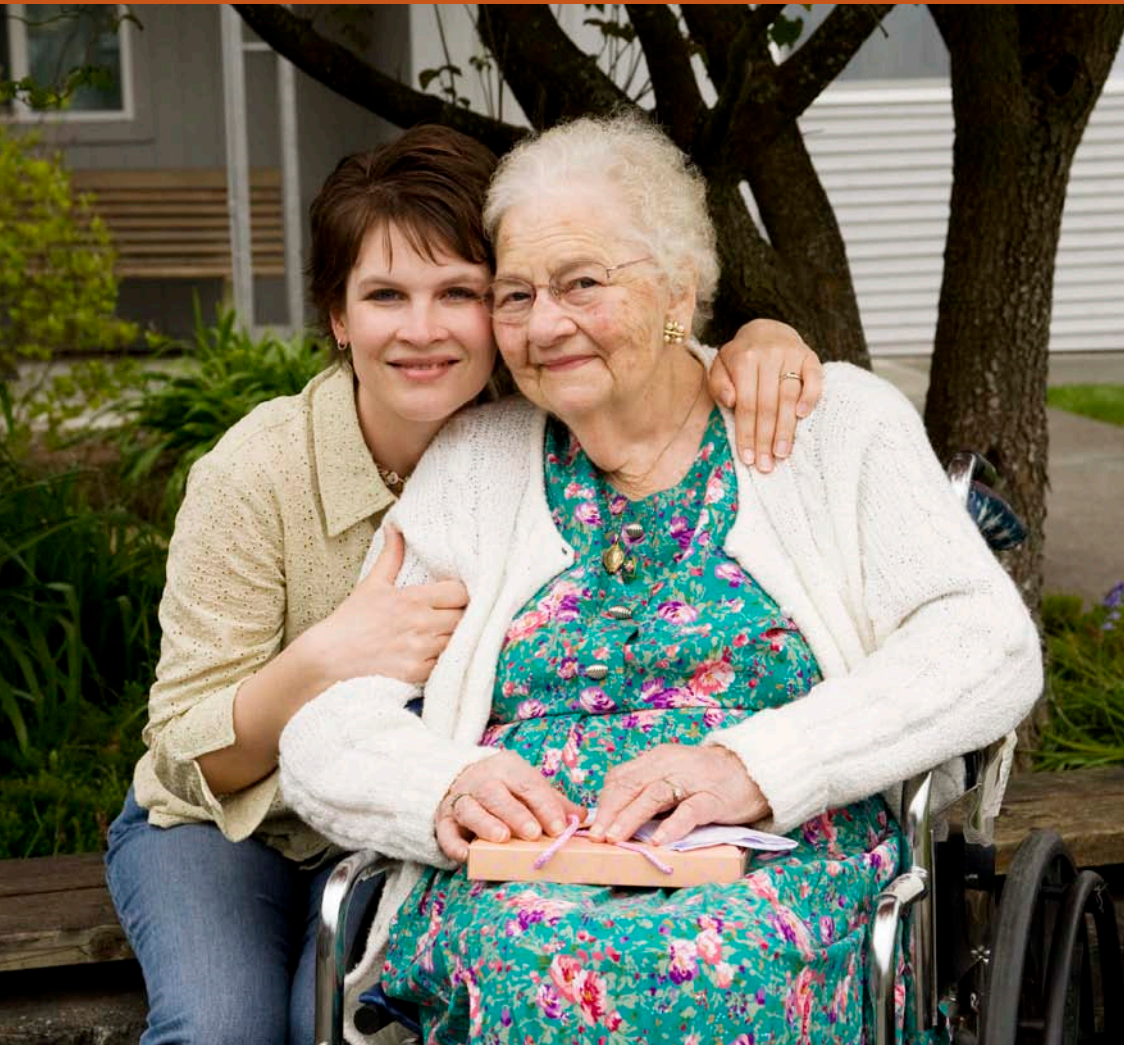


Strengthening assessment and care planning

A guide for HACCC assessment services in Victoria



Strengthening assessment and care planning

A guide for HACC assessment services in Victoria

Accessibility

If you would like to receive this publication in an accessible format, please phone (03) 9096 9977 using the National Relay Service 13 36 77 if required.

This document is also available in PDF format on the internet at:
<www.health.vic.gov.au/hacc>

Published by the Aged Care Branch
Victorian Government Department of Health
Melbourne, Victoria

Authorised by the State Government of Victoria, 50 Lonsdale Street, Melbourne.

© Copyright State of Victoria, Department of Health, 2011

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

This document may be downloaded from the Department of Health website at:
<<http://www.health.vic.gov.au/hacc>>.

Printed by Impact Digital, Unit 3-4, 306 Albert Steet, Brunswick 3056.

March 2011 (1102018)

Acknowledgements

This document was prepared by consultants, HDG Consulting Group, for the Victorian Department of Health.

Contributions to the development of this resource by the HACC Assessment/ASM Reference Group and the Project Working Group are gratefully acknowledged.

Membership included representatives from Department of Human Services, Department of Health, Department of Health and Ageing, ACASVic, Access Care, Carers Association Victoria, Municipal Association of Victoria, Aged and Community Care Victoria, Ethnic Communities Council of Victoria, Victorian Committee for Indigenous Aged Care & Disabilities, Royal District Nursing Service, City of Boroondara, City of Darebin, Bayside City Council, Warrnambool City Council, Central Gippsland Health Service, Moira HealthCare Alliance, Ballarat District Nursing Service, LGPro Assessment Officers Group, LGPro Aged and Disability Managers, Aborigines Advancement League, Banyule City Council, Mount Alexander Shire, Nillumbik Community Health Service, Fronditha Care, Caulfield Aged Care Assessment Service, City of Stonnington, Gippsland Lakes Community Health, Ballarat City, Central Gippsland Health Service Council, Surfcoast Shire.

Contributions from over approximately 80 HACC assessment staff who attended workshops and tested the resource are also gratefully acknowledged.

This project was supported with funding under the Home and Community Care program by the Commonwealth Government and Victorian Government.

Foreword

The HACC program in Victoria has a long history of supporting frail older people, people with disabilities and their carers to live independently at home.

In recent years the HACC program has been reorienting the way services are provided, in order to maintain or improve people's ability to do things for themselves and to help them to remain actively involved in their communities.

This approach aligns with similar reforms in health services with the improving care for older people initiative, in primary health and chronic disease self-management, in mental health and disability services. These reforms all revolve around early intervention, comprehensive assessment, improved self-management, goal-oriented care planning, social inclusion and community engagement.

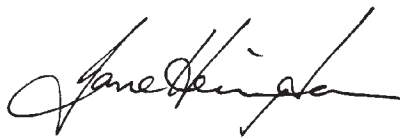
Fundamental to the success of all of these reforms is collaborative working relationships between service providers across the health and community care sector.

Two resources have been developed to assist HACC assessment services to implement the active service model.

- *Strengthening assessment and care planning: A guide for HACC assessment services in Victoria.* This practice guide was developed by the Victorian Department of Health and it describes the skills, techniques and knowledge base required to deliver Living at Home Assessments for people in the HACC target group. The guide has an accompanying workbook. This will assist HACC assessment service managers and staff to implement the guide.
- The *Induction resource for HACC assessment services* provides comprehensive information about the HACC program, the HACC assessor role and the broader service system. The Municipal Association of Victoria (MAV) developed this resource to support the induction and orientation of new HACC assessment staff working across all HACC assessment services.

It was encouraging to see the high level of interest and enthusiasm for each of these projects. The practice guide was developed with strong input from a range of program areas, peak bodies and a large number of frontline HACC assessment staff. These people contributed to working groups, reference groups, attended consultations and read multiple drafts.

The consultants and all those involved in developing the practice guide are to be congratulated for producing such a readable and information-rich resource. The guide will make a significant contribution to the development of assessment and care planning practice in the HACC program.



Jane Herington
Director Aged Care

Contents

PART A: Introduction and context

1	Introduction	1
2	Navigating the guide	3
3	Setting the scene	5
3.1	Service coordination	5
3.2	Influences on assessment practice	6
3.3	New directions in Home and Community Care	7
3.4	Diversity planning	9
3.5	The active service model	10
3.6	Developments in chronic disease management	11
3.7	Victorian state disability plan	12
3.8	Victorian mental health reform strategy	13
4	Living at Home Assessments	15
4.1	What is a Living at Home Assessment?	15
4.2	Who should get a Living at Home Assessment?	20
4.3	Applying an active service model	23
4.4	Assessment and planning pathways for younger people with a disability	24

PART B: Assessment in practice

5	Initial contact and initial needs identification	29
5.1	Eligibility	29
5.2	Intake	30
5.3	Paving the way to the front door and building rapport	32
6	Assessment techniques	35
6.1	Assessment skills	35
6.2	Assessment information sources	36
6.3	Observation	37
6.4	Types of questions	38
6.5	Active listening	39
6.6	Person-centred and family-centred practice	40
6.7	Identifying strengths and capacities	41
6.8	Motivation	42
6.9	Use of assessment tools	43
6.10	Using technology	44
6.11	Documentation	45

PART B: Domains

7	Holistic needs assessment	49
7.1	Understanding the people you support	49
7.2	Assessment domains	52

8	Health management	53
8.1	General health	53
8.2	Cognition	55
8.3	Dementia	58
8.4	Depression	61
8.5	Communication, vision and hearing	62
8.6	Continence	64
8.7	Nutrition and hydration	66
8.8	Chronic disease management	68
8.9	Medication management	71
8.10	Oral health	73
8.11	Palliative care and advance care planning	74
9	Psychological, social and emotional wellbeing	75
9.1	Psychological and emotional wellbeing	75
9.2	Family, friends and community	78
9.3	Families and carers	80
9.4	Alcohol	83
9.5	Family violence	84
9.6	Elder abuse	85
9.7	Financial and related considerations	86
10	Ability and capacity	89
10.1	Domestic activities of daily living	89
10.2	Personal activities of daily living	91
10.3	Mobility	93
10.4	Falls prevention	95
10.5	Physical activity	97
10.6	Emergency planning and home fire safety	99
10.7	Transport options	101
11	Diversity in practice	103
11.1	Diversity planning in the HACC program	103
11.2	Strengthening practice: Aboriginal people	104
11.3	Strengthening practice: people from culturally and linguistically diverse backgrounds	110
11.4	Strengthening practice: people with insecure housing	116
11.5	Strengthening practice: people affected by mental illness	119
11.6	Strengthening practice: younger people with a disability and their families	123
12	Service specific assessment	127
12.1	What is service specific assessment?	127
12.2	The active service model and HACC activities	129
13	Occupational health and safety	135
14	Fees assessment	141

PART C: Care planning

15	Goal-directed care planning	145
15.1	Goal development	145
15.2	Care planning	150
15.3	Priority of access for service delivery	157
15.4	Referral practice	158
15.5	Monitoring	159
15.6	Review	160
16	Partnerships and interdisciplinary practice	163
16.1	Interdisciplinary practice	163
16.2	Strengthening partnerships	165
16.3	Joint assessments	166
17	Care coordination for people with multi-agency involvement	169
17.1	Care coordination	169
17.2	Key worker	171
18	Reassessment and service exit	173
18.1	Reassessment	173
18.2	Service exit	173

Glossary	175
-----------------	------------

Acronyms	181
-----------------	------------

Table of figures

Figure 1: Service coordination framework	5
Figure 2: Influences on assessment and care planning practice	6
Figure 3: HACC assessment principles	8
Figure 4: Core components of HACC active service model	18
Figure 5: Assessment and planning assistance: mapping assessment and planning services across HACC and Disability Services	25
Figure 6: Information seeking	31
Figure 7: The 5-R model designed to motivate behaviour change	42
Figure 8: Clusters of assessment domains	52
Figure 9: List of HACC Aboriginal agencies	108
Figure 10: Care plan components in a Living at Home Assessment	151
Figure 11: Care plan process requirements	153
Figure 12: Example of a care coordination plan for a young adult with a disability	155
Figure 13: Example of a care coordination plan for an Aboriginal person	156
Figure 14: Example of a care coordination plan review	161

PART A

Introduction and context

1 Introduction

Introduction

The Home and Community Care (HACC) program in Victoria provides funding to approximately 500 agencies and supported over 265,000 older people and people with a disability in 2008-09.

HACC provides a range of basic support services to frail older people and younger people with a disability and their carers, who wish to continue living at home and need some support in managing daily tasks.

People receiving HACC services have diverse backgrounds and needs. Assessment and care planning is the foundation for individualised high-quality interventions, support and assisting people to navigate through HACC and the broader service system.

HACC Living at Home Assessments and the active service model (ASM) use a strength-based partnership approach to develop individual solutions to optimise health and wellbeing. Recognising diversity and using culturally acceptable practice is essential.

Aim

The aim of this guide is to:

- develop consistency of practice by describing the policy, concepts and thinking behind Living at Home Assessments
- describe assessment and care planning skills and techniques which will assist assessors in moving to a person-centred, ASM approach
- provide information and resources to support HACC assessors in their day-to-day practice.

Every HACC assessor has their own assessment style and background. A shared understanding of HACC assessment and care planning practice – within the context of the HACC Assessment Framework, ASM and recognition of diversity – will help to achieve consistent, high-quality HACC assessment and care planning practice in Victoria.

Who it is for

The guide is intended for use by HACC assessment services, including intake workers, assessment staff, team leaders and managers. It will continue to be updated over time. It will assist other HACC organisations to learn about Living at Home Assessments, and practices such as goal-directed care planning which are important for implementing an ASM approach.

Not a procedure manual

This is not a procedure manual. It does not provide step-by-step instructions or operational procedures. Each HACC assessment service will need to review and adjust policies and procedures to reflect the concepts and practices outlined.

Other key resources

The *Victorian HACC program manual* (2003), and amendments/updates and the *Framework for assessment in the HACC program in Victoria* (2007) should be read in conjunction with this guide, as these documents provide the full policy context and guidelines for service delivery in the HACC program.

The *Strengthening assessment and care planning workbook* is a companion document to the practice guide. <http://www.health.vic.gov.au/hacc>

The *Induction resource for HACC assessment services* is a resource for new HACC assessment staff. It is published by the Municipal Association of Victoria on their website <http://www.mav.asn.au>.

2 Navigating the guide

The guide is set out in three parts.

Shaded sections are used throughout to indicate key messages.

PART A:

Introduction and context

- 1 Introduction
- 2 Navigating the guide
- 3 Setting the scene
- 4 Living at Home Assessments

PART B:

Assessment in practice

- 5 Initial contact and initial needs identification
- 6 Assessment techniques
- 7 Holistic needs assessment:
Assessment domains
- 8 Health management
- 9 Psychological, social and emotional wellbeing
- 10 Ability and capacity
- 11 Diversity in practice
- 12 Service specific assessment
- 13 Occupational health and safety
- 14 Fees assessment

PART C:

Care planning

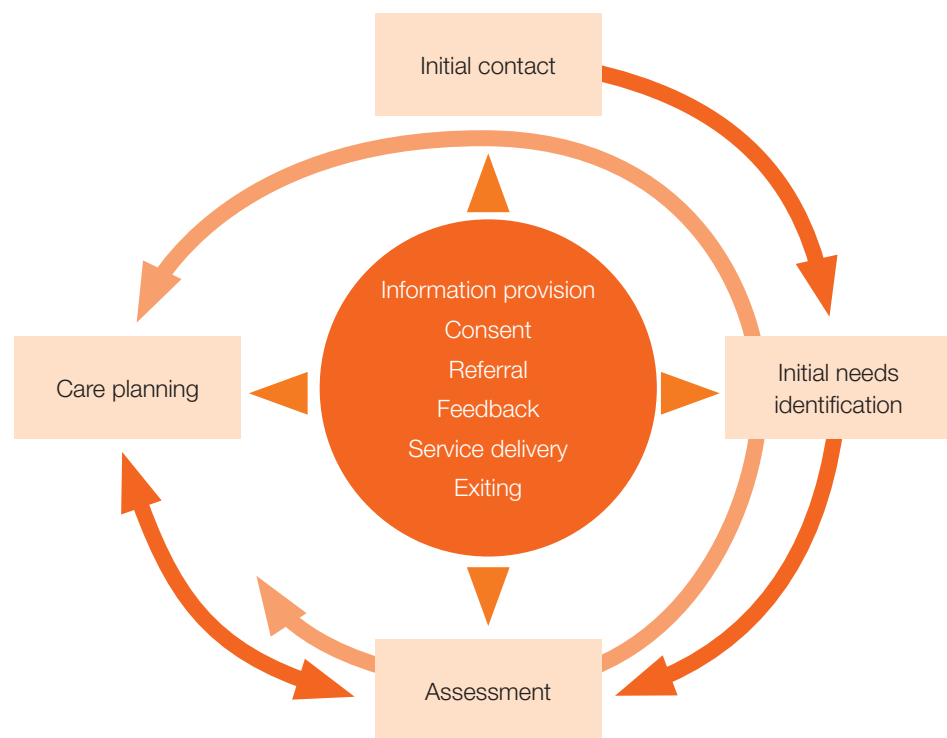
- 15 Goal-directed care planning
- 16 Partnerships and interdisciplinary practice
- 17 Care coordination for people with multi-agency involvement
- 18 Reassessment and service exit

3 Setting the scene

3.1 Service coordination

All HACC-funded organisations are required to work within the service coordination policy described in the *Better access to services framework* (Department of Human Services, 2001). The *Victorian Service Coordination Practice Manual 2009* provides clear practices, processes and protocols to support service coordination on a statewide basis. This means that all HACC organisations must recognise the full range of needs and refer people to relevant organisations wherever these needs are outside their own service capacity, using the Service Coordination Tool Templates (SCTT). See the Primary Care Partnerships (PCP) website for access to the full range of resources to support service coordination implementation: <http://www.health.vic.gov.au/pcps/coordination/index.htm>

Figure 1: Service coordination framework



3.2 Influences on assessment practice

There are multiple influences on the way HACC assessment and care planning practice is conceptualised (Figure 2). Research informs the broad policy context which, in turn, informs the HACC program policy, associated frameworks and guidelines. These then influence day-to-day assessment practice.

Recently, emerging research and policy has resulted in new directions for the HACC program in Victoria. There are two main drivers for this: expected increase in demand and, more importantly, greater knowledge about the factors positively influencing 'wellness' for people of all ages.

Figure 2: Influences on assessment and care planning practice



3.3 New directions in Home and Community Care

New directions New directions in the HACC program focus on improved planning for diversity, strengthened assessment and care planning processes, and service delivery underpinned by an ASM approach.

These initiatives are located in the broad policy context set out in *A Fairer Victoria* (2005), which emphasised early intervention and prevention in all services and for older people, helping them to ‘stay involved in everyday activities to maintain or rebuild their confidence and stay active and healthy’.¹

These new directions align with strategic planning in other sectors such as disability services, chronic disease management and mental health. Policy development in these sectors focuses on:

- early intervention
- linking people into community-based interventions and supports
- goal-directed care planning
- improving emotional wellbeing
- social connectedness.

All these initiatives are based on the philosophy that the person is at the centre, with services and systems working in a coordinated and integrated way to support them.

Increased demand for HACC services

These new directions are partly driven by the expected growth in demand for HACC services, due to:

- the increasing number of older people, especially those aged over 85 years
- life expectancy increases of people who are born with or who develop disabilities and functional impairments
- policies that support people to remain in their own homes for as long as possible.

To meet these demands, the HACC program must identify ways to continuously improve our approach to service delivery.

HACC Assessment Framework

The *Framework for assessment in the HACC program in Victoria* (Department of Human Services, 2007) sets out the program policy for assessment as a HACC-funded activity. It details the requirements for delivering a Living at Home Assessment, which includes home-based holistic assessment of need and service specific assessments as key components. The goal of the Framework is to support and build good practice in conducting Living at Home Assessments. This requires designated HACC assessment services to build alliances with other key assessment providers, to ensure a coordinated and streamlined approach to assessment and care. The framework is available at <http://www.health.vic.gov.au/hacc/assessment.htm>

Assessment principles

The principles outlined in the framework reflect the approach to a Living at Home Assessment as a HACC-funded activity. They are relevant to all organisations in their approach to assessment, care planning and service delivery in the HACC program.

¹ Victorian Government Department of Premier and Cabinet 2005, *A Fairer Victoria: Creating opportunity and addressing disadvantage*, State Government of Victoria, Melbourne.

Figure 3: HACC assessment principles²

Principle	Description
Person-centred	<ul style="list-style-type: none"> • Clients are treated with respect and dignity. • Clients receive a timely response: the right assessment, in the right place, at the right time. • Assessment approach is empowering and builds relationships over time. • Approach is client driven, culturally sensitive, flexible and is solutions-based. • Communication during the assessment process is in the client's preferred language, utilising a language service or bilingual assessment staff. • Clients are well informed of their role and rights in the assessment process, most importantly, their right to determine their own needs and be actively involved in decision making. • Respect for client's right to privacy should be maintained by all staff involved in collecting and storing client information. • Where there is a family member or carer present, assessment focuses on the care relationship, rather than the individual in isolation.
Carer-focused	<ul style="list-style-type: none"> • Families and carers are treated with respect and dignity. • Families and carers receive a timely response: the right assessment, in the right place, at the right time. • Family or carer assessment is empowering and builds relationships with carers over time. • Approach is individualised, flexible and culturally sensitive. • Families or carers are well informed of their role and rights in the assessment process for the care recipient and their right to an assessment of their own needs. Most important is their right to be involved in the assessment and decision-making process, where appropriate. • Respect for family or carer's right to privacy with respect to the collection and storage of carer information.
Promote independence	<ul style="list-style-type: none"> • Assessments build on strengths and abilities to improve the client's quality of life and social participation, as well as functional independence. • Clients and family members or carers are assisted to continue living independently at home through improved capacity, minimising the need for assistance from formal services for as long as possible. • The assessment approach advocates and provides information about local prevention/ health promotion initiatives and social and recreational activities.
A partnership approach	<ul style="list-style-type: none"> • Partnerships, alliances and inter-agency protocols ensure that the assessment process is coordinated around client and family or carer need, drawing on specific expertise as required. • Alliances are developed between HACC assessment services and other relevant organisations within a defined geographic area, preferably the PCP catchment. • Alliances build trust between organisations, which results in reduced duplication and more timely completion and coordination of assessment, care planning and service delivery.
Care planning and service delivery	<ul style="list-style-type: none"> • A Living at Home Assessment leads to a care plan which includes service specific care plans and a referral action plan, and which is individualised and goal oriented. • Care planning takes into account support for the care relationship.
System-focused	<ul style="list-style-type: none"> • Assessment and care planning processes take account of demands on the organisation's resources, as well as demands on the community care system as a whole. This leads to appropriate targeting of resources and consistent decisions about eligibility, resource allocation and priority of access. • Assessment processes manage client and family expectations, assisting them to transition to higher levels of care (such as packaged care or residential care), when the required service response can no longer be met from the HACC Program.

² Victorian Government Department of Human Services 2007, Framework for assessment in the Home and Community Care Program in Victoria, Aged Care Branch, Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne. <http://www.health.vic.gov.au/hacc>

3.4 Diversity planning

Background The *Victorian Charter of Human Rights and Responsibilities* (2008) is the Victorian Government's commitment that all Victorians are treated with equality, fairness and respect. It is within this context that recent developments in improving planning for diversity and access to HACC services are framed.

HACC diversity planning is a quality improvement initiative which builds on the HACC Cultural Planning Strategy. It encompasses the diversity of the Victorian community and acknowledges that barriers to accessing services are experienced by many marginalised or disadvantaged groups and individuals.

Concept Diversity planning ensures that there is appropriate planning for the needs of all people, whatever their age, gender and sexual identity, physical and cognitive ability, emotional, spiritual, religious and cultural background and beliefs, ethnicity, Aboriginality, refugee status, language and socio-economic circumstances and needs.

Diversity planning encourages recognition and response to the commonality between people, as well as to differences within groups. It requires skilled workers who can reflect on their practice and assumptions, and change their practice accordingly. It requires appropriate tools and resources to enable service providers to respond to the diversity of their catchment's target population.

Special needs groups Within the broad target population, there are a number of special needs groups that may experience particular difficulties in gaining access to HACC services. These groups are identified in the *HACC program manual* as being:

- people from Aboriginal and Torres Strait Islander backgrounds
- people from CALD backgrounds
- people with dementia
- people living in rural and remote areas
- people experiencing financial disadvantage (including people who are homeless or at risk of homelessness).

Diversity planning seeks to ensure that we adopt a diversity lens when planning, developing and providing services to HACC eligible people, particularly those in the special needs groups.

Resources Diversity planning will be incorporated into program planning and the HACC quality framework, including the triennial HACC quality audit.

(See Part B, Section 11: Diversity in practice)

3.5 The active service model

What is it?

The Active Service Model (ASM) is a quality improvement initiative which explicitly focuses on promoting capacity building and restorative care in service delivery. HACC 'clients' in this context include both service recipients and their family or carers.

The core components of the ASM are:

- capacity building, restorative care and social inclusion to maintain or promote a person's capacity to live as independently and autonomously as possible
- a holistic person-centred approach to care, promoting wellness and active participation in goal setting and decisions about care
- timely and flexible services that respond to the person's goals and maximise their independence
- collaborative relationships between providers, for the benefit of people using services.

In principle, this approach applies to all people accessing HACC services and to all HACC service types. The service response will differ according to individual needs and goals. It takes as its starting point that ageing or disability is not in itself a determinant of functional, social or psychological decline, leading to an inevitable need for service.

It is important to note that capacity building in this context does not only relate to physical function, but includes social and psychological wellbeing.

Principles

Five principles underpin an ASM approach:

Principle 1: People want to remain autonomous

Principle 2: People have potential to improve their capacity

Principle 3: People's needs should be viewed in a holistic way

Principle 4: HACC services should be organised around the person and family or carer; the person should not be slotted into existing services

Principle 5: A person's needs are best met where there are strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers.

Resources

- *ASM PREPARE* (Department of Health, 2010) is a resource tool for use by HACC-funded agencies to assist in implementation of the active service model.
- *Victorian HACC active service model discussion paper* (Department of Health, 2008)
- *Victorian HACC active service model implementation plan 2009-2011* (Department of Health, 2010)
http://www.health.vic.gov.au/hacc/projects/asm_project.htm

3.6 Developments in chronic disease management

Chronic disease The burden of chronic disease is increasing rapidly. In Victoria, approximately 70 per cent of the total burden of disease is attributable to chronic diseases that ‘cluster’ around common behavioural, environmental and biomedical risk factors – cardiovascular disease, cancers, diabetes, chronic respiratory disease and musculoskeletal disease.

The co-existence of multiple chronic diseases is common in the HACC target group. For example, 80 per cent of the older HACC population have three or more chronic conditions. The presence of multiple chronic diseases is associated with a decline in quality of life, mobility and functional ability, increases in hospitalisations, psychological distress and mortality.

Integrated chronic disease management (ICDM) Care for people with chronic disease usually involves multiple health care providers, across multiple settings. To this end, integrated chronic disease management (ICDM) is defined as the provision of person-centred care, in which services work together with the person (and their family or carer) to ensure coordination, consistency and continuity of care over time and through the different stages of their condition.

The direction for state funded primary care in Victoria is toward delivering wellness and person-centered care, providing people with chronic disease with well-planned, integrated care in a community setting that supports their capacity to self-manage. This is reflected in initiatives such as Early Intervention in Chronic Disease.

All state-funded primary health organisations that provide care to people with chronic disease are required to manage a change process, to embed evidence-based integrated chronic disease management into service systems and practice. Service system improvements are underpinned by the Improving Chronic Care (Wagner) Model. Organisations are also required to participate actively in PCPs to achieve a more integrated service system.

Principles Guiding principles that underpin ICDM work include:

- providing person-centred care, including support for carers and/or families of people with chronic disease
- recognising that consumers are active partners in the management of their chronic disease
- increasing choice and control
- providing the right care in the right place at the right time
- proactively promoting health and encouraging protective health behaviours
- building a whole-of-service-system response (engaging GPs as part of a multidisciplinary coordinated approach).

Resources

- Chronic disease management
<http://www.health.vic.gov.au/communityhealth/cdm/index.htm>

3.7 Victorian state disability plan

Disability Act

The *Disability Act 2006* is the legislative basis for a whole-of-government approach to supporting people with a disability to exercise control over their lives and participate in the community. The Act provides a framework for clear and consistent processes for access to disability services, planning that is directed by the person with a disability and the provision of flexible, high-quality disability supports.

The Act recognises the need to address potential increased disadvantage which may be experienced by people with a disability as a result of their gender, language, culture, background or location.

Victorian state disability plan

The *Victorian state disability plan 2002-2012 (VSDP)* outlines the policy directions for disability services in Victoria. It reaffirms the rights of people with a disability to live and take part in community life as citizens of Victoria.

One priority strategy is to reorient disability supports to be more flexible, to work with people as partners, and respond to individual needs. The introduction of a self-directed approach is part of this strategy and aims to provide supports based on the choices that people make about their lives.

Principles

- Equality: people with a disability are citizens who have the right to be respected and have equal opportunities to participate in the social, economic, cultural, political and spiritual life of society.
- Dignity and self-determination (choice): respect and value the knowledge, abilities and experiences that people with a disability possess, supporting them to make choices about their lives, and enabling each person to live the life they want to live.
- Diversity: recognise and value individual difference.
- Non-discrimination: all people have the right to live their lives free from discrimination.

Self-directed approach

A self-directed approach is consistent with the international trend towards focusing on the person's aspirations, lifestyle choices and goals. Self-directed approaches include:

- planning that is directed by the person or is family-centred for children, to the greatest extent possible
- supports that are flexible and tailored to individual needs
- individually attached and portable funding that allows people to choose and change service providers
- a focus on community participation and informal supports.

Resources

- http://www.dhs.vic.gov.au/disability/state_disability_plan
 - http://www.dhs.vic.gov.au/disability/supports_for_people
 - http://www.dhs.vic.gov.au/disability/publications-library/planning_policy
 - http://www.dhs.vic.gov.au/disability/publications-library/access_policy
-

3.8 Victorian mental health reform strategy

Policy

Because mental health matters: Victorian mental health reform strategy 2009-2019, is the Victorian Government's agenda for change and improvement in the way mental health is addressed. It foreshadows a shift towards more holistic community-based prevention, treatment and support, involving a spectrum of universal interventions, specialist clinical mental health approaches and rehabilitation and social support services.

Because mental health matters is based on four core elements:

- prevention
 - early intervention
 - recovery
 - social inclusion.
-

The proposed reforms will make a difference to Victorians by:

- helping people with mental health problems earlier, thereby avoiding harmful individual and social impacts
 - providing easier access to the most effective treatments, be it in a public mental health service or elsewhere, for a greater range of people
 - offering longer-term, holistic support to sustain people in the community, drawing on all relevant health and community services
 - fostering an inclusive and respectful culture of service delivery that gives people the support they need to achieve individual recovery goals.
-

Networked service system

The strategy envisages a highly networked service system that can function without barriers and focus attention on achieving commonly agreed health and social outcomes for people and communities.

The strategy takes a whole-of-government approach, recognising that mental health cannot be solely the concern of the specialist mental health service system. It covers a broad spectrum of mental health concerns and promotes partnerships with consumers, families or carers, and general health and community services for the provision of prevention and care.

Resources

<http://www.health.vic.gov.au/mentalhealth/reformstrategy/index.htm>

4 Living at Home Assessments

4.1 What is a Living at Home Assessment?

Purpose

The **purpose** of a Living at Home Assessment is to gain a broad understanding of the type and range of a person and their family or carer's needs for community-based services, in order to build people's capacity to remain living as independently as possible.

This involves careful care planning, matching the person's needs to the most appropriate service response either from informal sources, community resources or groups and/or subsidised services funded through the HACC program or broader health and community services.

A Living at Home Assessment is a funded HACC activity delivered by designated HACC assessment services. The HACC Assessment Framework replaces Section 7.3 of the *Victorian HACC program manual (2003)* and describes the policy framework for Living at Home Assessments.

A Living at Home Assessment is a person-centred assessment of the person and their family or carer's needs, which leads to a care plan and individualised service responses. The assessment and care planning process sits within the service coordination framework and takes an ASM approach to:

- building on the person's and carer's autonomy, by offering choices and focusing on individual strengths and interests
- encouraging people to do more for themselves, by regaining skills and capacities wherever possible
- strengthening social, community and family connections.

Assessment is a process of relationship building which occurs over time as a person's needs change, become more evident or they become more receptive to intervention. In this sense, assessment is usually not a one-off event, but an ongoing process of building trust and understanding. An ASM approach is a facilitative process which actively encourages people to define their own needs, goals and the manner in which services can assist to meet those needs.

Components

The key components of a Living at Home Assessment are:

- ➔ **Initial contact and initial needs identification**
- ➔ **An holistic needs assessment** which focuses on:
 - identifying strengths and areas of need for assistance
 - using a capacity-building and restorative approach
 - assessment of individual, family or carer needs, goals and aspirations.
- ➔ **Service specific assessments** for services provided by the assessing organisation (if required), including occupational health and safety and HACC fees assessment.
- ➔ **Care planning** using a goal setting approach and including:
 - a referral action plan for referrals to other agencies
 - service specific care plans for services provided by the assessing organisation, including an occupational health and safety care plan
 - information provision on health promotion and social activities.
- ➔ **Care coordination** for people receiving services from multiple agencies.

Each key component is described in the next section in this guide.

Difference

How is a Living at Home Assessment different to assessment and care management?

A Living at Home Assessment has the same components as previous requirements for assessment and care management. Holistic assessment, referrals to services beyond those provided by the assessing agency, service specific assessment and care planning are still the core components. Care management has been replaced by the term care coordination, which is the term more commonly used in Department of Health service coordination policy documents.

The new policy has significant continuity with the previous one. The key difference is the implementation of the ASM. The ASM is a new direction for the HACC program as a whole and represents a new philosophical approach to assessment and care planning practice and service delivery.

The assessor should focus on the person's presenting needs, without having their view of these needs coloured by services provided by the assessor's own organisation.

The term 'Living at Home Assessment' was introduced in 2007 to clearly mark this new direction and to elevate the importance of the assessment and care planning activity in its own right, not just as the gateway to accessing HACC services.

Practice

This guide aims to achieve a common understanding of the practice change required to carry out a Living at Home Assessment.

Core components of the ASM are listed in the table below and provide concrete examples of the types of practices and outcomes that reflect this approach. Incorporating these components into your assessment and care planning practice will mean that you are doing a Living at Home Assessment.

Some assessors will already include some of these components in their current practice. However, it is unlikely that many HACC assessment services or many individual assessors will currently incorporate all of the components listed below.

This guide and *ASM PREPARE* will help you as an assessor, and your organisation, to understand the strengths and weaknesses in current practice and develop an action plan to implement Living at Home Assessments. Over the next two years, a more consistent understanding and practice of this new direction will result.

The broader service system

Moving towards an ASM requires a clear understanding of the HACC role within the broader service system. HACC services are limited to providing basic maintenance support. To get the best outcomes for people, HACC assessment services need to have systems in place to ensure that assessors are well informed and kept up-to-date with the range of service options available outside HACC. The *Induction resource for HACC assessment services* has a comprehensive list of statewide service and programs. This is a good starting point for new assessors.

Figure 4: Core components of HACC active service model



Figure 4: Core components of HACC active service model (continued)

Intervention or service delivery:	
Flexible and responsive	<ul style="list-style-type: none"> • one size does not fit all – diversity of options • the person has confidence that a HACC service can be provided when needed • person-centred and person-driven, rather than agency-driven • dynamic, problem-solving and creative solutions
Holistic and coordinated	<ul style="list-style-type: none"> • a range of services to meet the person's and family or carer's needs • avoids 'silo' thinking and practice
Capacity building	<ul style="list-style-type: none"> • an enabling approach of doing 'with' not 'for' • recognition that some people may still need services that do 'for' for some tasks • driven by client's goals and aspirations • exercises incorporated into everyday activities where appropriate • promotion of links and referral to capacity building and social connection opportunities based on the person's interests
Intervention time	<ul style="list-style-type: none"> • timely, episodic and short-term approach to interventions is considered where appropriate • time-limited intervention leads to agreed, measurable outcomes, based on person-centred goals and care plan
Health promoting	<ul style="list-style-type: none"> • includes opportunities for physical activity • links and referral to nutrition and chronic disease programs • improves access to health promotion information and education • maintains and improves social connectedness
Continuum of care	<ul style="list-style-type: none"> • early intervention and prevention • service provision responds to needs across the care continuum • engages people with the community care, sub-acute and primary health service system in a timely manner, based on needs
Access to skilled and knowledgeable staff	<ul style="list-style-type: none"> • continuous professional development and training for staff • access to appropriate expertise when needed • access to interdisciplinary support and a team approach • use of case conferencing and professional development strategies
Partnerships	<ul style="list-style-type: none"> • strong partnerships between agencies, including referrers • well-established and documented procedures, protocols, practices and systems between agencies.

Victorian HACC active service model discussion paper (Department of Human Services, 2008)

4.2 Who should get a Living at Home Assessment?

Tailored assessment response

The HACC program provides a broad reach of service to a large and diverse population. The majority of HACC users receive low levels of service and only a smaller group of people receive medium to high levels of service.

For this reason, the assessment experience in HACC needs to be tailored to fit individual needs and circumstances. People should not be over assessed, or repeatedly assessed for the same things by different agencies. Ensure that people get the right type of assessment at the right time.

A key function of the intake and initial needs identification process is to determine the most appropriate assessment response. Spending time making these decisions will create efficiencies and free up resources to meet demand. (See the *Learning activities and continual improvement workbook* section on lean thinking). Key principles to guide assessment practice include:

- people with basic, one-off or short-term needs are not over assessed
- people are assessed by assessors with the appropriate skills and knowledge
- assessment builds on existing information and does not repeat or duplicate it.

Everyone receives initial needs identification

HACC assessment services receive referrals in two main ways: telephone calls directly from the person or family member or carer seeking assistance, or referrals from other service providers. Either way, people seeking HACC services should be screened through an initial needs identification process to determine:

- eligibility for HACC: is the person in the HACC target group?
- the reason for the referral
- what other needs the person might have, other than those they present with
- what services the person is currently receiving and what other assessment and care planning processes have already occurred.

The role of intake and initial needs identification is to determine this information, either via a telephone conversation with the person, via information contained in the SCTT referral, or a combination of both.

Providing the right assessment response

The decision about whether a client needs a Living at Home Assessment or a service specific assessment only, will usually be made at intake. Follow-up conversations between the person requiring the service and the assessor before the home visit will confirm which approach appears to be most appropriate. You can always change your approach during the home visit if required.

**Who should
get a Living
at Home
Assessment?**

Most referrals will prompt a Living at Home Assessment. Described below are the two most common circumstances where Living at Home Assessments are provided.

Situation 1. The intake and initial needs identification process identifies that the person is in the HACC target group, has **not** recently had a holistic needs assessment from another organisation, and potentially has a long-term need for a HACC service. In this situation a Living at Home Assessment should be provided.

A HACC assessor will visit the person in their home and carry out a holistic assessment, service specific assessments as required (plus OHS and fees assessments) and care planning. This process should **build on** allied health assessments that have occurred and/or other care plans that the person may have (for example: disability services, mental health).

Situation 2. The intake and initial needs identification process identifies that another agency **has** recently carried out an holistic assessment with the person. In this situation, the holistic component of the Living at Home Assessment **should not be repeated**.

Typically this occurs when people are referred by another HACC assessment service, or Linkages, HARP, EICDM, Disability Services or ACAS. Discharge information from an acute hospital or sub-acute setting is valuable, but may be limited in terms of a broad understanding of the person's situation in their home environment.

In this situation, a HACC assessor visits the person at home to carry out service specific assessment and care planning. Assessors build on information from the previous holistic assessment and need to be aware of those existing issues, goals and care plan strategies. This information can be obtained:

- from written referral information (and attachments)
- by asking for more written information (such as requesting a summary of the assessment and care plan)
- by talking to the worker who undertook the holistic assessment (with consent) and documenting the information in the person's file
- by talking to the person.

In this way, prior to the home visit, the assessor will have gathered and documented relevant information in the person's file about their broader issues, such as underlying health care problems, cognition, daily living skills and abilities, family, carer and psycho-social issues.

The assessment home visit will therefore focus on providing a service specific assessment and care plan. Other issues to be addressed may arise during the visit – circumstances may have changed or there may have been gaps in the information provided prior to the visit.

Through this process, an assessor may complete a Living at Home Assessment without collecting all the information directly from the person.

Who should get a service specific assessment only?

There are situations where the person will only need a service specific assessment. This generally occurs when the person has not recently had a holistic assessment and, based on your professional judgement, does not appear to need one at this point in time. The typical circumstances where only a service specific assessment would occur include:

- when a person is referred post-hospital or, due to other reasons, has a short-term need (up to six weeks) for services while they are 'getting back on their feet'
- when a person is requesting an intermittent home maintenance task, such as gutter cleaning, but does not require other supports.

In each case, if further unmet needs are uncovered during the home visit or later on through the monitoring of their service provision, the person should be provided with a full Living at Home Assessment.

(See Section 12: Service Specific Assessment)

Other outcomes of the initial needs identification process

The person may be eligible for HACC services, but because of their specific nature needs and circumstances, they should be assessed by another service provider. In this case, contact the appropriate organisation (for example, ACAS, disability services or a mental health service) and discuss the most appropriate assessment response, such as joint assessment. (See Part C, Section 16)

If the person is found to be ineligible for HACC services, redirect them to a more appropriate service provider to meet their needs and/or provide relevant information about how to access private sector supports or services.

4.3 Applying an active service model

- Getting started** The ASM is a continuous quality improvement initiative, so change will be incremental. Experience to date shows that it is easier to implement an ASM approach with new clients who do not have set expectations about HACC services. Existing clients should not be excluded if they are interested and willing to engage in a more active, capacity-building approach.
- ASM PREPARE** All HACC organisations are required to develop an implementation plan. *ASM PREPARE* (Department of Health, 2010) has been designed to assist agencies to identify their strengths and weaknesses, organisational and practice issues required to move to an ASM approach. The implementation plan will focus on strategies and actions to implement Living at Home Assessments as a key priority.
- Partnering** Partnering with key agencies in your local area is a vital part of implementing an ASM. Partnerships build trust, improve understandings of each other's work and provide the foundation for implementing collaborative work practices.
- Work in local assessment alliances** The purpose of assessment alliances is to provide a forum for sharing, supporting and building expertise in assessment and ASM implementation across a region. Every HACC assessment service should be a member of a HACC assessment alliance.
- Belonging to an assessment alliance means that managers and assessors are connected with what is happening in other services and in the broader service system.

- Know your role boundaries** Implementing an ASM approach does not mean that HACC assessors are expected to know everything about all types of disabilities and conditions of ageing. HACC assessors are generalist assessors and need to:
- have a good knowledge of services
 - know the limits of their clinical knowledge and use their professional judgement to monitor the assessment process
 - know when to refer to another service or program, or get advice through a secondary consultation.

Moving to an ASM approach does not mean that assessors take on the responsibility for coordinating all aspects of the assessment, care planning and care coordination process for every person.

For people with complex health care needs and circumstances, your organisation may be one of many involved in their care. Your role may be limited to providing a HACC service response, because another organisation is taking the lead in assessment, care planning and care coordination.

Being confident of your own role and having good communication and good working relationships with service providers in your area is the key to maintaining the boundaries of your role as a HACC assessor.

(See Part C: Care planning, care coordination and key worker roles)

4.4 Assessment and planning pathways for younger people with a disability

Understanding Disability Services planning policy

Disability Services provides and funds disability services organisations to provide planning and support for people with a disability.

Disability Services Division has recently released the *Disability Services planning policy* (Department of Human Services, 2009) on assisting people to plan broadly for their aspirations, goals and needs. Assistance with planning includes identifying community-based services and disability supports that can help meet the person's goals.

HACC-funded assessments and similar processes funded through disability services for people with ongoing needs are shown below. In most circumstances, younger people with a disability with ongoing needs would receive assistance with planning, which is similar to a Living at Home Assessment. People receiving planning assistance from a disability service would therefore only receive a service specific assessment and service specific plan from a HACC assessment service.

Build on existing plans

A Living at Home Assessment and care planning process needs to build on the planning that the person with a disability and their family or carer may have already completed with a disability service. Do not repeat this planning process or provide a Living at Home Assessment.

If the person and their family or carer have not received prior assistance with planning:

- clarify if the person is eligible for disability services
- determine if the person or family or carer would like to receive formal assistance with planning from an organisation that delivers services and supports for people with a disability
- refer the person to the Department of Human Services' Regional Disability Intake and Response Service for planning assistance.

When should a younger person with a disability receive a Living at Home Assessment?

If the person is **not** seeking assistance with planning, your HACC assessment service should provide a Living at Home Assessment. The person may still need referral to organisations that deliver services and supports for people with a disability or other specialist services for more specific assessment and support (such as specialist accommodation, employment, training, childhood intervention services and transition support).

The following Figure maps HACC-funded assessments and similar processes funded through Disability Services for people with different levels of need.

People receiving this assistance from a community service organisation that delivers services and supports to people with a disability would therefore only receive a service specific assessment and care plan from an agency providing HACC services.

Figure 5: Assessment and planning assistance: mapping assessment and planning services across HACC and Disability Services

Level of need	HACC Living at Home Assessment	Disability Services Assistance with planning for people with a disability and their families*
Short-term needs only	Service specific assessment and care plan (unless Living at Home Assessment is indicated)	Includes information, advice and referrals to help the person and their family or carer identify goals and needs, and engage appropriate supports
Ongoing needs	<p>Living at Home Assessment</p> <p>Assessment:</p> <ul style="list-style-type: none"> • holistic needs assessment • service specific assessment for services provided by the assessing organisation <p>Care planning:</p> <ul style="list-style-type: none"> • care plan • service specific plans • referral action plan • information and advice <p>Outcome:</p> <p>Care plans/service specific plans are developed and a copy left with the person</p>	<p>Planning can include assistance to enable a person to identify goals and needs, support to build a person's informal networks, link them into community, build the skills and capacity of the person and their network</p> <p>This is provided by any provider funded by Department of Human Services to deliver planning and/or case management support for people with a disability as one of their core functions</p> <p>Plans are prepared in a format that is meaningful to the person</p> <p>Outcome:</p> <p>Self-directed plan owned by the person</p>

*Source: *Disability Services Planning Policy* (Disability Services Division, 2009)

PART B

Assessment in practice

5 Initial contact and initial needs identification

5.1 Eligibility

Overview of target group

The HACC target group encompasses older people and people of all ages with a moderate, severe or profound disability, and their carers. Each group has particular support needs which must be acknowledged and responded to by HACC organisations.

Services funded by the HACC program are only provided to people within the target group, after the person is assessed and their level of need prioritised. Eligibility does not confer entitlement to service provision.

The HACC program targets those in greatest need, or with the greatest capacity to benefit. Services are provided where they would not otherwise be available through self provision, family or carer support or another government program, including disability services. (See *Victorian HACC program manual*, Section 2.6)

This means that when prioritising, other resources available to prospective and existing clients need to be taken into account.

Carers

In the context of the HACC program, those who have a personal relationship with the older person or person with a disability are considered to be carers and are included in the HACC target group. People who have a formally organised care relationship, such as unpaid volunteers or paid workers, are not part of the HACC target group.

Carers can be family members or friends and often provide a major part of care for older people and younger people with a disability. Including carers as a specific target group of the HACC program acknowledges their need for support, services, recognition and assistance.

Beyond supporting carers directly in all assessment and care planning processes, the needs and preferences of clients and their carers need to be considered together. The department's policy framework, *Recognising and supporting care relationships* provides a context for supporting and sustaining the care relationship. The HACC program operates within this framework.

It is important to understand that carer needs can change, depending on health, ageing, family or carer circumstances or sudden emergencies. Service providers should allow, as far as possible, flexibility in service delivery arrangements to meet the fluctuating needs of people, especially in times of crisis or emergency.

5.2 Intake

Initial contact	Initial contact is the person's first contact with your organisation and in some instances, the service system as a whole. It usually includes the provision of accurate, comprehensive service information and facilitated access to initial needs identification.
Initial needs identification	<p>Initial needs identification is a broad screening process to uncover underlying and presenting issues. Information from the initial needs identification will inform the way that the assessment process is likely to proceed. Spending time on initial needs identification will ensure that people receive the most appropriate assessment response. These include a Living at Home Assessment, service specific assessment, a joint assessment with another organisation, or referral, such as an ACAS assessment.</p> <p>Initial needs identification may start with the intake worker and continue with the HACC assessor, who may have further conversations with the person and/or the referrer before the assessment home visit.</p>

What other assessments have already occurred?	<p>Intake workers need to seek as much information as possible about existing supports and assessment, or planning processes provided by other organisations. Reassure the person that providing this information will not mean they will be automatically refused access to HACC services. Access is based on priority of access guidelines and current demand for services.</p> <p>Knowledge of a person's supports means that existing processes can be built on. Agencies can work together with the person and their family or other carers to get the best outcomes. Building trust between all the parties involved is an important first step.</p>
--	--

Skills and techniques	<p>During initial contact and initial needs identification, the person will seek information and gain an impression about the organisation. Tone of voice, style, approach, language, time taken to explain the process, listening to concerns and offering choices will inform their perception.</p> <p>From an Aboriginal and CALD perspective, the initial contact and initial needs identification experience is critical to building trust and rapport and hence, the future success of assessment and service provision.</p> <p>The worker will seek preliminary information about the person and provide key messages, for example:</p> <ul style="list-style-type: none">• We (the service) will visit you to talk about your situation and discuss some options. Together we will devise a plan to help you stay as healthy and independent as possible.• We may be able to arrange a support person to be present for you, such as a person from an Aboriginal organisation or CALD organisation, with your consent.• An interpreter can be arranged for you.• When we visit you, we will ask you some questions to work out what you would like to change or achieve.• Our visit to your home is confidential and free of charge.• During the home visit, we can discuss your expectations of the service.
------------------------------	--

Strategies

- Use the SCTT Summary and Referral Information form to check which other services may be involved.
 - Identify whether a professional interpreter from a language service is required (for initial contact, consent, assessment, medication discussion or complaints).
 - Ask the person about other services they have spoken to or used in the last 12 months.
 - Ask the person for their consent to speak to other providers and family members or carers.
 - Ask the person for their consent to check with the GP for relevant information.
-

Figure 6: Information seeking

What the person wants to know	What the organisation wants to know
<ul style="list-style-type: none">• Can you help?• What type of help can be provided?• When will it start?• How much will it cost?• Who will you share my information with?• What is an assessment?• What will happen next?	<ul style="list-style-type: none">• Is the person eligible?• Have they used HACC in the past?• What are the current issues that led to the contact or referral? Why are they seeking support? What has changed?• Has the person had other assessments completed?• Is the person receiving services from another organisation?• If so, will the person consent to sharing their information, to assist with the assessment and avoid duplication?• Does the person have concerns about the assessment process?• Has screening and initial needs information been collected and risk factors identified?

Resources

- All HACC-funded organisations implement service coordination as described in the *Better access to services framework* (June 2001). The operational elements of service coordination are initial contact, initial needs identification, assessment and care planning. For a full description, refer to the *Victorian service coordination practice manual 2009*
<http://www.health.vic.gov.au/pcps/coordination/ppps.htm>
 - SCTT 2009 user guide
http://www.health.vic.gov.au/pcps/downloads/sctt_user_guide09.pdf
-

5.3 Paving the way to the front door and building rapport

Preparation

An effective assessment begins long before the assessor enters the home. Before the home visit, the assessor may prepare by:

- reviewing intake information, to understand what has changed and why the person may require HACC services
- checking the SCTT consumer information form for the name of the recommended contact
- contacting the person to gain consent to speak with relevant others (such as family, carers, friends, GP, other service providers)
- reading case notes, referrals, assessments or care plans from other organisations
- asking if the person identifies as Aboriginal, and if so, offering to arrange for a HACC Aboriginal worker to be present, to ensure the process is culturally appropriate
- asking if the person has a CALD background, and if so, if they would like a worker from a relevant organisation, or informal advocate, family member or carer, neighbour or friend, to be present
- checking the person's English language proficiency for assessment purposes and if an interpreter (in person or by telephone) is needed for effective communication
- enquiring if other family members or carers will be present and the person is comfortable with that arrangement
- updating their knowledge about particular health conditions
- asking a younger person with a disability if they use assisted communication techniques or sign language.

Before entering a person's home:

- consider the person's willingness for you to visit their home, their language and culture, memory and comprehension
- be aware of cultural practices you will need to observe
- consider the person's concerns and what is important to them
- consider what their thoughts might be about the assessment process, their main concerns and the desired outcome
- check OHS matters relevant to the assessment visit, such as known risk factors. (See Part B, Section 13)

Case snapshot³

The husband of an elderly Greek woman had passed away. She was referred to HACC for assistance in coping without her husband. During screening and needs identification, it was evident that all she wanted at that point in time was short term assistance getting to the bank to rearrange her financial affairs. As she was resistant to any further assistance, a full assessment was not appropriate at that time. A staff member took her to the bank on two occasions and arranged to speak with her again in three weeks.

3 Fictitious case study

Communication and rapport

An assessor's role is to make the person feel as comfortable and safe as possible. For example, for Aboriginal people, this means making sure the place of assessment is comfortable and appropriate to them.

The person may be feeling vulnerable and depressed about their current situation, or have strong expectations (for example, they deserve services as they have paid taxes all their lives). They may be suffering a chronic condition that has been developing slowly and are now at a point where the condition is impacting on their capacity to manage activities of daily living.

Rapport is a relationship of mutual understanding, trust and agreement between people. It is about reducing differences and building on similarities. Assessment requires empathic listening and sensitivity to the person, carer and relevant others.

Starting off

To help put the person at ease:

- smile and introduce yourself (use your name badge or card)
- address the person respectfully and ask permission to enter
- clarify why you are there
- explain the assessment process, using discussion and observations to explore their circumstances, concerns or goals
- ensure you have the person's consent to proceed and inform them that the assessment can cease at any time they wish
- observe if the person seems tired, distressed or distracted
- find a common interest, for example, if the garden looks neat and tidy, comment on how lovely it is, ask if they are a keen gardener, who does it and so forth (be careful commenting about their house)
- ask permission to ask questions rather than launching straight into the assessment (you are in their home and asking permission is basic courtesy)
- explain that your questions will be about their health and wellbeing and the assistance they may need, so that you can work together to solve problems.

Managing expectations

It is important to manage expectations about assessment and service provision at an early stage. During the visit, discuss what to expect from the process and what is realistically possible in terms of service provision. Key points to make:

- what you cannot do
- the length of involvement depends on their needs – services may be short term, are reviewed on a regular basis and will cease if no longer required
- service exit is a positive result of achieving identified goals.

The expectation that a service may be short term due to the person improving their capacities should be established at intake and again during the assessment and care planning process. Managing people's expectations right from the beginning is a key element to successfully managing the exit process

The person may even find that they do not need a HACC service at all, because their issues can be resolved in other ways.

6 Assessment techniques

6.1 Assessment skills

Assessment Assessment needs to occur within a supportive, non-judgemental environment. This means leaving personal values and preconceived assumptions aside, having an open mind and respecting the person's values, health beliefs, lifestyle and preferences. Assessment practice requires professional expertise, experience in aged care and disability and an appreciation of cultural diversity.

An assessor's role is to collect information from multiple sources, analyse and synthesise information and work with the person to identify goals and develop a care plan. This includes sharing information (with the person's consent) with other service providers. Assessment is not a one-off event. It may require multiple visits and is an ongoing process of building a relationship with the individual and family member or carer, beginning at the first point of contact and continuing through to service delivery, review and reassessment.

Assessments should involve the person, carers, extended family and support person as active participants in the process – assessment is done 'with' not 'to' a person. Information is obtained, exchanged and jointly considered in a culture of collaborative problem solving and partnership. The assessor's skills and knowledge are an expert resource which should help the person make informed choices to achieve their own goals. The assessment process is flexible and modified to respond to each individual person. Assessment is not 'one size fits all.'

Assessment is an independent and impartial analytical process which brings together:

- the professional knowledge and expertise of the assessor
- the person's skills and expertise in defining their own needs and identifying their goals and aspirations
- knowledge about the person's needs and information provided by the carer, family members and other service providers.

Assessment outcomes inform care planning, in turn influencing resource allocation decisions. Resource allocation includes considering:

- the person and their family or carer's background and needs
- resources the person and family members or carers can provide
- opportunities for reducing risks and improving individual capacity and independence
- service availability and existing demands on the organisation's resources
- demand within the broader community care service system.

(See Part C: Care planning)

This approach leads to service interventions that meet people's own goals and aspirations, appropriate targeting of resources and consistent decision making about eligibility, resource allocation and priority of access.

6.2 Assessment information sources

Collecting assessment information

There are many ways to gather information about the person being assessed: self reporting, informant reporting (carer, family member, service provider, school), direct observation, reading existing health records (with the person's consent) and using assessment tools. Each of these approaches can add information to the 'assessment picture' and improve its validity.

Self-reports

Self-report involves direct communication with the person. When assessing a person's physical function by self report, it is important to recognise the distinction between their capacity (what they are capable of doing – ask questions that start with 'how do you ...') and their performance (what they actually do – ask questions that begin with 'do you ...'), which may more accurately reflect levels and frequency of activity. Some factors may reduce the accuracy of self-reported information. If the person's capacity to provide accurate information is in doubt, corroboration from other sources should be sought. Examples include:

- acute illness, impaired cognition or depression (may manifest in replies such as 'I don't know')
 - impaired communication or hearing
 - limited English proficiency
 - unwillingness to admit difficulties in front of family members or others, or denying needs
 - making problems sound worse than they are (to receive a service)
 - fear of 'the government' becoming involved
 - a desire to access their preferred service
 - religion or culture impacting on health beliefs
 - fear of significant lifestyle change.
-

Informant reports

Information from other key sources may be informal (family members, carers and neighbours), or formal (GPs, service providers, teachers). It is often assumed that carer reports will be more accurate than those provided by people themselves. However, informant reports, particularly of physical function, can be less accurate than self reports because:

- they might be based on observed or expected performance, which can consistently underestimate capacity
 - there might be secondary gain in reporting greater activity limitation (such as to gain sympathy or access to additional resources)
 - they can be biased in favour of what the informant wants to happen, rather than what the person wants to happen
 - they attempt to protect the person's dignity.
-

Health records

Existing health records, such as referral summaries, medical records or previous assessment reports, can be accessed with the person's consent.

6.3 Observation

Use your eyes

Direct observation is likely to provide a more accurate measurement of functional capacity than either self or informant reports. Observation includes asking the person to show you how they go about tasks and how they perform key activities.

Observation is a key factor in practising a needs-based approach to assessment. More than merely looking at a person, it is the collection of visual information to identify important indicators of a person's physical and emotional wellbeing and environment. For example, noticing family photos or photos of grandchildren in the house may be used to prompt discussion about social connectedness; religious icons may indicate religious beliefs.

Use interaction, observation and measurement to collect information.
Use all your senses (eyes, ears and nose) to assist assessment.

Body language

Observe the person's body language – are they alert, interested and focused on what you are saying? Note what they appear to get most animated about when speaking – this may give you an indication of their priorities and goals. (See the observations suggestions under each domain.)

Be aware of fatigue. Note the person's concentration, body position, breathing and yawning. If the person tires easily (due to frailty, illness or a specific disability), you may need to complete the assessment over multiple visits.

Two case snapshots⁴

An assessor was talking with a person with motor neurone disease. The person started yawning and their body language indicated they were tiring. The assessor asked the person if they would like to continue the assessment at another time. On speaking with the person's partner, the assessor established that tiredness was usual and linked to the motor neurone disease, which informed the rest of the assessment process and the care plan.

An assessor watched as a person made a cup of tea. There were opportunities to observe their:

- physical health (mobility to and from kitchen; upper body strength in lifting kettle)
- cognition (sequence of events to make the tea; ability to find the required items).
- nutrition (observe food items in cupboards and refrigerator).

4 Fictitious case study

6.4 Types of questions

Building rapport To ensure people are empowered through the process, assessment requires sensitivity in how questions are asked. All questions should be asked in the context of engaging with the person and building rapport. Successful interviewing includes asking questions in a conversational manner, rather than reading questions from a list or form.

Conversation and open questions Conversation and the use of open-ended questions are critical to eliciting important information.

Open-ended questions encourage conversation. If you want a person to open up, use questions that start with who, what, where, why, when, and how, such as:

- Please tell me about...?
- How have you been managing at home until now?
- What has changed in the last couple of months that has made that more difficult?
- How would you like to address that problem?
- What ideas do you have about that?

Closed questions Closed questions seek specific facts and can be used to validate information. They are often answered with a yes or no. They can also be used to direct the conversation. For example:

- Do you have family close by?
- Would you be interested in that?

Probing questions Probing questions are an open-ended technique used to follow up or narrow the response. Probing questions ask 'why' and help to get to the heart of the matter. For example:

- Why has this changed?
- You said that you were unable to do the vacuuming, why is that?
- Tell me more about how you manage to get to your medical appointments and participate in social activities?
- You mentioned you look after your grandchildren – how do you go affording food for them?
- You mentioned earlier that you enjoyed cooking. Can you tell me how well you manage this now? How often do you cook?
- You mentioned that you would like to get out more and perhaps find a group to join – what ideas do you have?

Follow-up questions Follow-up questions are important for capacity building.

- Does your GP know about this?
- Has anyone tried to help you with this?
- Is it important that you get back to doing this again?

6.5 Active listening

Active listening How well an assessor listens has a major impact on the assessment and their relationship with the person. Listening requires adequate time to understand the person's values, concerns, stories, needs and usual problem-solving approaches. Active listening is where there is a conscious effort to hear not only the spoken words, but to understand the unspoken words and total message.

Active listening requires careful attention to the other person and acknowledgment and reflection of the message. Acknowledgement can be something as simple as a nod of the head or a 'mm' to indicate you are listening. Body language and gestures can also be used to acknowledge listening. Reflection can summarise both the spoken words and the feeling or unspoken message. For active listening:

- avoid being distracted by environmental factors
- don't interrupt, as it frustrates the speaker and limits understanding
- observe the speaker's body language
- show that you are listening and use body language and gestures to convey your attention
- nod occasionally, smile and use positive facial expressions
- ensure your posture is open and inviting, use small verbal comments to encourage the speaker
- reflect the person's comments and provide feedback.

Feedback Feedback encourages the person to continue speaking. Personal filters, assumptions and beliefs can distort what is heard, so reflection and clarification is used.

- Reflect on what has been said by paraphrasing: 'What I understand is...' and 'So what you are saying...'
- Ask questions to clarify certain points: 'What do you mean when you say...' or 'Is this what you mean?'
- Summarise the speaker's comments periodically: 'So, if you can bear with me I'll just go over that briefly....Is that correct?'

Health literacy Health literacy⁵ refers to the 'capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.' It refers to the fact that people need multiple skills to interpret and understand health related information: reading, writing, interpreting images, basic numeracy, listening skills and so forth. These influence understanding and risk perception and inform decision making and action. Health literacy is considered worse for those aged over 85, or with chronic disease.

HACC assessors need to be aware of health literacy barriers, avoid jargon and use strategies such as active listening, repetition and encouraging questions, to highlight the most important information and enhance the person's understanding.

⁵ *Lost in Translation: practical strategies to improve client understanding*. Powerpoint presentation, RBWH ACAT, unpublished 2010

6.6 Person-centred and family-centred practice

Concept

Person-centred practice is a HACC assessment principle. Person-centred or family-centred practice is respect for a person's or family's right and desire to make their own decisions. The approach focuses on self-determination and empowerment. For Aboriginal people, older people from CALD backgrounds, or younger people with a disability, family members may play a pivotal role in care relationships and in making decisions.

Research has shown that person and family-centred practice can make a positive difference to outcomes and satisfaction and can improve the worker's sense of professional worth. It engages, encourages and supports the person and their family or carers, where relevant, to take an active part in assessment, goal setting, care planning and implementation decisions and processes.

Person and family-centred practice includes:

- a commitment to seek to understand the desires and wishes of the person (and family members or carers, where relevant)
- a conscious resolve to be 'of service', by supporting and helping the person to identify and address their issues or concerns
- openness to being guided by the person – to seek, engage and respect the guidance and preferences of the person
- understanding the process as person-driven regarding decisions about support needs and service delivery
- flexibility, creativity and openness to what might be possible, including innovation, experimentation and unconventional solutions
- a willingness to persist to achieve goals.

Person and family-centred practice enables assessors to trust their professional judgement and take a flexible approach to needs identification (including which SCTT profiles may be appropriate to document needs), assessment, goal setting and care planning.

Indicators

How will you know if you are implementing person-centred practice?

- You can build rapport within a conversation about where the person is at and are not led by a tool or checklist.
- The person's values, social and cultural identity is respected.
- The person has autonomy and choice to express their needs.
- The person is supported to identify realistic, achievable goals, make their own decisions and work towards achieving them.
- Unrealistic expectations and risks are clarified early in the relationship.
- The approach is flexible, dynamic and individually tailored.

6.7 Identifying strengths and capacities

Strengths-based approach A strengths-based and solution-focused approach requires the assessor to identify the person's strengths, talents, capabilities and resources.

Understanding the person's history and life story can help to develop rapport and identify motivational goals. Identifying strengths can help to challenge stereotypes about ageism, or a person's capacity to live as independently and autonomously as possible.

Maintain a focus on strengths throughout all phases of assessment. Once identified, the assessor can encourage the person to develop and use these strengths to work on particular goals and tasks in their care plan.

Strengths, interests and capacity

Assessment should commence with the person's interests and attributes, rather than their deficits.

Questions to elicit strengths, interests and capacity are an essential part of assessment. The information should be elicited through a conversational dialogue with the person, rather a list of questions.

Abilities, interests and desires

- Tell me about yourself – and about you as a person.
- What are your interests? What do you enjoy?
- What gives you a sense of accomplishment, confidence or makes you proud?
- When you get out, what do you like to do?
- Who are the people that are especially important to you? Tell me about these relationships.
- What community connections do you have – who is part of your community? What community activities are important to you?
- What do you want to achieve? What is getting in the way of this happening? (Elicit why strengths are not used, for example religious or cultural belief or restriction.)
- What ideas do you have to overcome these hurdles?

Daily routines

- Tell me about your daily routine and what makes a good day for you.
- What are the things you do, each day or each week, because you really want to – not because you have to?
- Can you describe how you do specific tasks and their components (for example, can push a shopping trolley and select items from a shelf but cannot lift heavy bags; can push the vacuum but cannot bend down to plug it in; can shower but cannot step over the bath edge into the shower).
- What kind of exercise do you get each day?

6.8 Motivation

Motivational interviewing

Motivational interviewing is a communication technique that aims to help people explore and better understand their behaviour. It is based on the belief that a person's motivation to change will increase if they are able to express and understand the benefits and costs involved. Key enablers are a collaborative relationship between the person and worker, agreement to tackle the problem together, and an understanding that conflict is unhelpful.

Principles

- Express empathy by using reflective listening.
- Consider the ways in which the person's values, circumstances and current capacity or behaviour conflict with their wishes.
- Sidestep resistance by responding with empathy and understanding, rather than confrontation.
- Support self-efficacy by building the person's confidence that change is possible.

Strategies

Encourage the person to:

- clarify their goals by asking what is important to them
- think about their behavior, so they can see the conflict or discrepancy
- look at how their behaviour impacts on others
- generate a solution and set realistic goals for making changes
- identify what they may find difficult about changing and offer help and support
- build confidence.

(See Part C, Section 15)

Figure 7: The 5-R model⁶ for motivating behaviour change

Relevance	Encourage the person to state why behaviour change is relevant to them, such as risk of disease, health concerns, family or social situation.
Risks	Ask the person to identify potential negative consequences of their behaviour and highlight those that seem most relevant.
Rewards	Ask the person to identify potential benefits of changing their behaviour (such as improved health, to feel better about yourself, to set a good example, or to remain independent).
Roadblocks	Ask the person to identify barriers to change. Identify strategies (problem solving) that could address barriers.
Repetition	Repeat the motivational intervention as often as possible, to reinforce the motivation for change.

6 Adapted from www.cvhpinstitute.org/aafp/motiv.html

6.9 Use of assessment tools

'Good assessment thinking and practice is not static or limited to use of a single assessment tool. Assessment workers from all fields use their professional judgement as to which assessment tools to use in a particular situation.'⁷

Using assessment tools

Professional assessment practice is not governed by assessment tools. It is governed by the sum of our duty of care, professional knowledge, skills, practices and the way practitioners have been trained to think.

There is no single assessment tool prescribed by the Department of Health for a Living at Home Assessment. Various tools may be suitable, depending on the person and the presenting circumstances. Be guided by your organisation's policies and by professional judgement in deciding which assessment tool or tools are appropriate in each case.

The selection should depend on the assessor's judgement and skill level in using specific tools. Validated tools provide baselines for future assessments and can help to identify the indications for particular interventions. In using tools, assessors should consider:

- whether the tools are validated, reliable, and culturally sensitive (be aware that tools developed for use in remote areas of Australia are not necessarily appropriate for use in Victoria)
- that tools should not be revised without awareness of the impact on their usefulness and validity
- training required to use the tool, including interpreting and acting on the findings appropriately
- the order and use of tools (difficult questions at the beginning may not be well received)
- that they will need to be comfortable in dealing with responses arising from the use of tools.

Sometimes a referral to a clinical specialist is necessary for particular assessments (such as mental capacity). A useful summary of the evidence base and domains for a range of specific tools in use for older people in inpatient settings can be found at *Best care for older people everywhere: The toolkit*, Department of Health 2010 <http://www.health.vic.gov.au/older/toolkit>

SCTT screening tools

The Service Coordination Tool Templates (SCTT) is a suite of templates developed to facilitate and support service coordination practice by recording and sharing consumer information. The SCTT profiles are designed for screening purposes. They are not assessment tools, as they do not elicit in-depth information, but highlight areas where assessment is needed. Good assessment practice then 'digs more deeply' to explore those areas in more detail.

⁷ Adapted from UK Department of Health 2001, *National Service Framework for Older People*, Department of Health, London.

6.10 Using technology

Using technology while assessing Using technology such as lap-top computers during assessment can be compatible with person-centred assessment. However, where the technology may act as a barrier to building rapport and good communication, it should not be used. Use your professional judgement about when technology is appropriate.

It is not advisable to use computers in an assessment interview, until assessment proficiency is attained. To make computer use less obtrusive and more acceptable to the person being assessed:

- explain why the computer is being used
 - sit side-by-side and position the computer so the person can see the screen if they wish to
 - ensure computer use does not overly distract from eye contact or awareness of body language.
-

6.11 Documentation

The Information Privacy Act 2000 and the Health Records Act 2001

The privacy principles contained in the Victorian privacy laws are the minimum standards for handling personal and health information. Personal information constitutes identifying personal information, and health information constitutes identifying information about a person's health or disability.

Refer to the *Victorian service coordination practice manual 2009* for information on consent to share information with other service providers.

Freedom of Information Act 1982

The Victorian *Freedom of Information Act 1982* gives people the right to:

- access documents about their personal affairs and the activities of government agencies
- request that incorrect or misleading information held by an organisation about them be amended or removed.

Client files may, in some cases, be subject to a freedom of information request. Staff should understand that if an individual (or family or carer) seeks access to their information, in most cases, all records pertaining to them are made available. It is important for support staff to bear this in mind whenever they are creating a record.

HACC documentation requirements

The documentation requirements for HACC assessment are:

- documentation of an assessment report or summary
- documentation of a care plan (as well as service plans and an OHS care plan if required (See Section C 15.2 for details)
- MDS data collection, including the Functional Status data items
- use of the SCTT tool for referral purposes.

Assessment and care planning information may be documented on the relevant SCTT tools, with expanded information included in the notes sections and/or attached as case notes, or as an assessment report.

HACC assessors are not required to complete all the SCTT tool profiles for every client. (See Section 7 Holistic assessment)

Organisations usually have their own templates for documenting individual service plans.

Case notes

Case notes are an important aspect of assessment practice. Each agency should have case note policies and procedures. They have two primary functions:

- Accountability – case notes and reports describe assessment findings and the rationale behind key decisions and care plans. They summarise service responses and the success or failure of past interventions to inform future decisions.
- Communication – case notes and reports ensure continuity between staff and provide an archival record of all contact and events related to the person.

Case notes should be legible, dated and signed by the author. Later alterations to case notes should be explanatory, and signed and dated.

Considerations Assessment case notes should be written with the reader in mind.

- Have you organised your thoughts logically?
- Is what you are trying to convey clear and concise?
- Have you avoided florid descriptions or excessive use of adjectives?
- Do you make your point? Is the rationale for assessment recommendations clear?
- Have you recorded facts only, avoiding personal judgements?
- Are any opinions clearly labelled as such – is it clear what evidence led to that opinion, for example?
- Would another assessor be able to read your notes and proceed?
- Would you be comfortable if the client read these notes?

Resources

- *HACC program manual* (and amendments/updates)
 - See the Department of Human Services information privacy policy for more information, at <http://www.dhs.vic.gov.au/privacy-statement>. An organisation that has a service agreement with the Department of Human Services is also obliged to comply with this policy.
 - *Victorian Health Records Act* <http://www.health.vic.gov.au/healthrecords/>
-

PART B

Domains

7 Holistic needs assessment

7.1 Understanding the people you support

What is holistic assessment?

Holistic assessment follows on from the initial needs identification process. Issues triggered by screening questions will inform the way the holistic assessment proceeds.

The holistic assessment process allows you to talk about a wide range of domains in a person's life, establishing a deeper understanding of their needs and issues before developing a care plan.

For domains where the person may need the support or intervention of a specific HACC service (provided by the assessing organisation), the holistic assessment process will overlap with, or move into the realm of, a service specific assessment.

Some of the questions and considerations in key domains such as nutrition, domestic care activities and personal care will overlap with a service specific assessment for these HACC services. See Section 12 for further guidance on service specific assessment and an ASM approach.

Understanding common health conditions

If assessors have a basic understanding of common health conditions, and how these impact on lifestyle and quality of life, this will help to move through the holistic assessment process more easily.

You should be able to recognise typical symptoms of common health conditions and know when a referral to a medical or allied health service might be required. Be aware of the limits of your clinical knowledge – when to stop the assessment and refer to another program for specialist assessment. Supervision, team meetings, case conferences and peer review sessions can be used to develop this understanding.

Most importantly, continually ask why something is stopping a person from doing what they want to do, develop appropriate interventions and take a restorative approach.

Older people

Older people, aged over 65, make up 64 per cent of the HACC target group.

Observed changes in the areas listed below may provide early warning signs of increasing frailty and the need for support. These may or may not be associated with the onset of a health condition or illness. Good assessment will explore why these changes are happening and not just accept them as an inevitable part of ageing:

- declining functional status
 - impaired balance and mobility
 - reduced physical activity levels and endurance
 - change in family/carer support or carer stress
 - recent bereavement
 - social isolation
 - driving capacity
-

-
- difficulty maintaining continence
 - unintended weight change
 - falls, including an increased number and frequency of falls
 - difficulties due to polypharmacy and psychoactive medications
 - impaired vision or hearing
 - irregular sleep patterns
 - frequent or increased pain
 - altered mental health status, including indication of depression or dementia.

These indicators are not isolated to ageing and may be just as relevant to younger people with a disability.

People with a disability

Younger people with a disability

Younger people using HACC services may have an intellectual, physical, sensory, acquired brain injury (ABI) or neurological disability and often several of these together. While younger people with a disability are part of the general HACC target population, they are distinct from the older client population in many ways. There is great diversity within the younger client group. For the purposes of assessment and care planning skills and expertise, younger people with a disability fall into three quite different groups, based on age and family circumstances.

0–10 age group

These are the early years where parents, grandparents and other extended family members play a major role supporting very young children. Services to families may be provided through different levels of government. Key programs include:

- early childhood intervention services (up to age 6)
- family support services
- HACC services
- disability services
- education services, including maternal and child health.

Be aware of local supports for this age group. Specialists are sometimes needed to clarify whether children have a developmental delay, rather than a permanent and ongoing disability.

The most common HACC service provided to this group is respite, followed by volunteer social support. Families under stress are keen to know what community care workers can provide. Clarify this with your manager before finalising the care plan.

Disability Services are generally available to people in the target group from age six, depending on the circumstances see *Disability Access Policy*. www.dhs.vic.gov.au/disability/publications_library/access_policy

11–20 age group

As in the early years, extended family members play a major role supporting the family. Most common HACC supports are respite, volunteer social support and personal care. There are relatively few people under 20, compared to the overall HACC target group, but they generally have high and complex needs.

Many people in this group are clients of both HACC and Disability Services, indicating the complexity of their care needs and the likely involvement of multiple agencies in supporting them and their families or carers.

Local councils provide youth services aimed at young people with disabilities. The Department of Human Services provides services such as behaviour support, case management, respite and carer support.

A Living at Home Assessment must take into account the needs of various family members and carers. Consider separate assessment for parents or carers who also have high-level needs. Expert assessments should be accessed for specific issues such as challenging behaviours, which need to be addressed before a HACC service is put in place. You may encounter families who express anger or frustration at having to negotiate with a service system that may struggle to meet ongoing needs for assistance.

21-64 age group

Approximately 20 per cent of HACC clients are in this age group and many are shared clients with disability services. Most live with their families, so assessment and care planning is likely to involve the person within the context of their family and social network. A wide range of HACC services are used by this diverse group.

Some people in this age group will have acquired a disability later in life, or may have early onset of ageing.

Disability organisations provide a range of support for adults with a disability that aim to promote their independence and participation in the community.

Families and carers

Recognising and supporting care relationships (Department of Human Services, 2006) acknowledges, respects and supports the dynamic interconnections between people in care relationships.

Carers provide unpaid care and support to family members and are part of the HACC target group. Thirty-four per cent of people using HACC services have a carer.⁸ A key principle of HACC assessment is a focus on carers.

Carers may receive HACC assessment and care planning to address their needs and support their care role. Assessment and care planning may occur either together with the person and their family or carer, or individually with the carer as a client in their own right.

Acknowledge and respond to the diversity of care relationships and the different circumstances in which they exist. Typical challenges faced by families or carers include physical and emotional tiredness, financial strain and isolation, and access to general support and respite care.

8 http://www.health.vic.gov.au/hacc/hacc_victoria/facts.htm

7.2 Assessment domains

Domains⁹

- A domain is a broad area of health and wellbeing, such as mental health or physical functioning.
- The extent to which each domain is assessed will vary according to the person and their needs.
- As domains may be interdependent, improvements in one domain may lead to improvements in others.
- Some domains will not be assessed at all due to fatigue, time constraints or a focus on those that are most important.
- Assessment is not a one-off event. Additional domains may be assessed over time as trust increases, or as circumstances require.

What domains should I assess?

Holistic needs assessment begins with domains relevant to the person's presenting situation. Beyond this, explore domains with a focus on the person's capacity for functional improvement, family or carer needs, sustainability of the caring relationship, extent of social connections to the community and quality of life issues.

HACC MDS requires completion of the Functional Status data items. The requirement to rate clients against these data items means that assessors will always gather sufficient information to rate the person's capacity in these areas. A deeper assessment is only required if relevant to the presenting circumstances.

Professional judgement should be used to decide which domains provide the greatest opportunity for capacity building. Use a sequence that relates to the person's presenting needs and issues. In practice, you are likely to combine many of the domains in one conversation. It is important to remember that no one can be an expert in everything, so in many domains you will need to access further expertise to fully explore the issue. See the resources listed in each domain.

Figure 8: Clusters of assessment domains

Health management	Psychological, social and emotional wellbeing	Ability and capacity building
<ul style="list-style-type: none"> • general health • cognition • dementia • depression • communication, vision and hearing • continence • nutrition and hydration • chronic disease management • medication management • oral health • palliative care and advance care planning 	<ul style="list-style-type: none"> • psychological and emotional wellbeing • family, friends and community • families and carers • alcohol • family violence • elder abuse • financial and related considerations 	<ul style="list-style-type: none"> • domestic activities of daily living • personal activities of daily living • mobility • falls prevention • physical activity • emergency planning and home fire safety • transport options

⁹ Information included in the following domains has been adapted from multiple sources including the Australian Government Department of Health and Ageing, Aged Care Assessment Teams website at www.health.gov.au/internet/main/publishing.nsf/content/ageing-acat-acap-training.htm

8 Health management

8.1 General health

Introduction

Knowledge of a person's general health and medical background is essential to understand their presenting issues and ensure a restorative approach. Enquire about a person's general health issues and consider action to improve their overall health and wellbeing. The aim is not to make a medical diagnosis, but to gather information on health conditions and discuss the impact this has on performing daily tasks and social activities. This informs interventions and care planning.

Start with a conversation about what is going on for the person (the presenting problem) and what lies behind it. Considerations include:

- medical history including current problems, past medical conditions, operations, fractures, diagnosed diseases or illnesses (such as diabetes or head injuries), history of depression and so on
- hospital stays, including reasons for admission
- pain that affects function
- lifestyle risks (smoking, alcohol intake, poor diet)
- whether the person has a regular GP and is a current or recent user of health services
- general observations (for example, physical appearance, shortness of breath)
- health beliefs (impact of religion and culture)
- concerns expressed by the person.

How to recognise poor health

Poor health is an abnormal state for the person, which may be indicated by them saying or gesturing that they do not feel well, symptoms such as coughing, shivering, or unusual skin appearance, or visible changes in appearance or behaviour. For example, poor health may be indicated if a person appears to have pain or discomfort, behaves in a different manner or appears quiet, distressed, sad or tired.

Health conditions – what to look for

Common health conditions in older people include:

- chronic conditions and associated pain, such as arthritis
- reduced oral health
- reduced vision and hearing
- nutritional risk
- incontinence
- cognitive and psychological issues
- mobility issues and falls.

Understanding diversity and the prevalence of different health conditions in specific cultural groups will assist in recognising health issues. What people know and understand about their health conditions should be elicited and is also a good indication of how they understand and use professional information and services.

Positive questions

- Tell me about yourself – how would you rate your health generally?
- What aspects of your health are you proud of?
- What gives you most concern?
- Are there things you used to do that you can't do now?
- Is there anything you need help with?
- How much moderate physical activity exercise do you have each day (one hour of moderate exercise per day)?
- How do you manage a healthy diet (two serves of fruit and five serves of vegetables each day)?
- Have you had a fall in the last six months, or are you afraid of falling?
- How do you manage to control your weight (waist below 80cm for women and 100cm for men)?
- Have you had a general health assessment in the past two years?

Their answers will inform your assessment and analysis.

A person's changing or unstable health may be observed by an assessor or community care worker. It may indicate the need for referral to a GP for further health assessment, or to an Aboriginal health worker for a more specific assessment.

Strategies

- Consider referring to a GP if the person has not had a check up in the last two years.
- Explore further, using the assessment domains below.

Resources

- *Best care for older people everywhere: The toolkit*, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>
-

8.2 Cognition

Introduction

Cognitive and physical issues can interact, making overall assessment and management complex. Cognitive issues may be perceived by older people, their families and professionals as a result of ageing, not as health problems that may respond to treatment.

Various cultures view cognitive impairment differently, for example with shame or as madness. For Aboriginal people, sensitivity is a priority when asking about memory and wellbeing – if a person feels that the assessor thinks they are not mentally stable, it will create a barrier.

Cognitive impairment can result in family conflict and tension about who has decision-making responsibility for a person.

Mental capacity

There may be doubts that a person has mental capacity to make decisions about risks, lifestyle, health or financial matters.

What is mental capacity? To have mental capacity is to have the ability to reason things out, understand, retain, believe, evaluate and weigh relevant information. See <http://www.publicadvocate.vic.gov.au/>

Tips on assessing capacity

You need to seek an assessment of a person's mental capacity when:

- there is a demonstrated reason to do so. For example, the person is making a decision that is out of character and may cause harm or mistreatment
 - all other attempts to solve the problem have failed
 - there are important legal consequences or the conduct of the person is causing, or is likely to cause, significant harm to the person or someone else.
-

Apply the principles

If you think the person may need a referral for a capacity assessment, begin by applying the following six capacity assessment principles. See http://www.lawlink.nsw.gov.au/lawlink/diversityservices/LL_DiversitySrvces.nsf/pages/diversity_services_capacity_toolkit

1. Always presume a person has capacity

The most basic principle is to presume that a person has the capacity to make all decisions for themselves.

2. Capacity is decision specific

Apply the presumption of capacity for every decision the person makes. This is because a person may be able to make some, but not all, decisions for themselves.

3. Don't assume a person lacks capacity based on appearances

Do not assume a person lacks capacity because of their age, appearance, disability, behaviour or other condition or characteristic.

4. Assess a person's decision-making ability, not the decision they make

a person cannot be assessed as lacking capacity simply because they make a decision you think is unwise, reckless or wrong.

5. Respect a person's privacy

Respect a person's right to privacy when you are assessing their capacity.

6. Substitute decision making is a last resort

If all efforts to support a person through the decision-making process fail, you can decide the person doesn't have capacity to make that decision. Only then can a substitute decision-maker make that decision for the person.

Positive questions

For signs of cognitive capacity:

- ask about orientation: day, time, place, reason for visit
- be aware during the initial contact telephone call of general comprehension and short-term memory (check back with the person what has been discussed and agreed)
- during the assessment, ask questions about what was previously discussed or covered.

Observations

A cognitive assessment may be applicable for some people. Discuss with family or carers or GP if a referral for further assessment is required. Document objective information as a baseline strategy – to help determine the need for a cognitive assessment, observe:

- appearance and dress (meticulous, sloppy, eccentric)
- manner (formal, suspicious, aggressive, meek, irritable)
- behaviour (talkative, reticent, restless, fumbling)
- general hygiene (skin, grooming, teeth, hair, finger nails, odour)
- voice and speech – quantity, rate and type (slow to respond, pedantic, slurred, spontaneous)
- perceptions (hallucinations, delusions)
- consciousness (alert, attention span)
- orientation (day, time, place, person, fluctuations)
- concentration and attention (distractibility)
- intellectual capacity (information, comprehension)
- awareness of need for help and effect on others
- recall, short or long-term memory
- behaviours that affect function.

Depression can mask or mimic cognitive impairment. Delirium can cause dementia-like symptoms, such as fluctuating confusion.

Strategies

- Individual, family or carer concerns about undiagnosed changes in a person's cognition may indicate the need for referral for a GP review and further cognition testing. Refer to a Cognitive, Dementia and Memory Service (CDAMS) clinic, the Aged Care Assessment Service, private geriatrician or neurologist.
- The results of this testing may prompt a referral to the Office of the Public Advocate for a guardianship application.

Resources

- *Best care for older people everywhere: The toolkit*, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>
 - Capacity Toolkit NSW Lawlink
http://www.lawlink.nsw.gov.au/lawlink/diversityservices/LL_DiversitySrvces.nsf/pages/diversity_services_capacity_toolkit
-

8.3 Dementia

Introduction

Dementia is a clinical syndrome with widespread loss of cognitive function, including:

- memory loss
- language impairment (having difficulty finding words, especially names and nouns)
- disorientation (not knowing the time or place)
- change in personality (becoming irritable, anxious or withdrawn, loss of skills and impaired judgement)
- self-neglect
- behaviour that is out of character (for example, sexual disinhibition or aggression).

A person with dementia may find it harder to do previously familiar tasks, such as writing, reading, showering and using numbers.

Dementia progresses and function declines over time.

Types of dementia

Alzheimer's disease is among the most common types of dementia, and its cause is unknown. Although Alzheimer's disease is not a normal part of ageing, it is more common in older people and may affect one in four people over the age of 85 years.¹⁰

- Alzheimer's disease includes memory loss and difficulties with language in its early stages, gradually becoming more severe over several years.
 - Vascular dementia, due to strokes or insufficient blood flow to the brain, has a varied clinical picture, depending on which parts of the brain are most affected.
 - Dementia with Lewy bodies, with symptoms similar to Parkinson's disease, hallucinations and falls.
 - Other forms of dementia have different patterns.
-

Delirium

Delirium can often be misdiagnosed as dementia. Delirium is a sudden deterioration in mental functioning. It can represent a serious underlying medical condition that may be life threatening if left untreated.

In an older person, delirium can be precipitated by factors including infection, disease, metabolic disorder, pain, dehydration, constipation, urinary retention, drug effects and interactions.

¹⁰ Australian Government Department of Health and Ageing 2008, *Introduction to Aged Care Assessment Program*, PowerPoint Presentation.

Sudden change in the person's usual behaviour may indicate delirium. It is crucial to know the person's usual behaviour patterns to identify these changes.

Delirium is a short-term, acute episode and should be ruled out before decisions are made about a person's usual functioning capacity.¹¹

The American Psychiatric Association lists three common diagnostic criteria for all forms of delirium:¹²

- disturbed consciousness (reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention
- a change in cognition (such as memory deficit, disorientation, language disturbance) or a perceptual disturbance that is not better accounted for by a pre-existing, established or evolving dementia
- disturbance develops over a short time (usually hours to days) and tends to fluctuate during the day.

Delirium can be superimposed on dementia, significantly worsening a client's state. Do not assume a client with dementia does not also have a delirium, if their condition has worsened over a very short period of time. There are significant resources on dementia available for health professionals, clients and their families or carers.

Questions and observations

- How is your memory?
- Do you use a calendar to remember appointments? Do you use other aids, such as a webster pack or dosette for medications?
- If there are concerns about dementia, check with the family member or carer and consider carer stress and impact.
- It may be necessary to speak to the family or carer separately if the client is upset by the discussion.
- Dementia may be a sensitive issue for Aboriginal people.
- Dementia may be a sensitive issue for people from CALD backgrounds. People with dementia may revert to their first language.
- Help the person maintain their sense of self and include them in decision-making.
- Use gentle but persistent questions and encouragement to engage the person in tasks and assessment.

11 AHMAC Care of Older Australian Working Group 2004, *Best practice approaches to minimise functional decline in the older person across the acute, sub-acute and residential aged care settings*.

12 American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

Strategies

Sometimes a person will have been diagnosed with dementia; at other times an assessment to determine a diagnosis will be required. If you are unsure what action to take, ring ACAS, CDAMS or Alzheimer's Australia for advice.

Depending on the person's diagnosis and circumstances, it may be appropriate to:

- refer the person to their GP for a dementia screen. A dementia screen excludes reversible causes for impaired cognition and includes a CT scan of the head, urine and blood tests
- refer the person to the Cognitive, Dementia and Memory Service (CDAMS)
- refer the person to the Aged Care Assessment Service (ACAS), most of which have access to a geriatrician
- refer the person to a private geriatrician or neurologist
- refer the family or carer for counselling and information (National Dementia Helpline or Alzheimer's Australia)
- refer the person to an Aboriginal spiritual and emotional wellbeing worker
- use resources from Alzheimer's Australia (fact sheets, counselling services, training)
- refer the person to the Support for Carers of People with Dementia Program
- ring the Dementia Behaviour Management Advisory Service (DBMAS). This service provides appropriate clinical interventions to help aged care staff and families or carers improve their care of people with dementia, where the behaviour of the person with dementia impacts on their care.

Resources

- *Best care for older people everywhere: The toolkit*, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>
 - Alzheimer's Australia, <http://www.alzheimers.org.au/>
 - National Dementia Helpline 1800 100 500
 - Cognitive, Dementia and Memory Service (CDAMS),
<http://www.health.vic.gov.au/subacute/cdams.htm>
 - Department of Health, Aged Care publications,
<http://www.health.vic.gov.au/agedcare/>
 - Dementia Behaviour Management Advisory Service (DBMAS).
Contact 24 hours a day on 1800 699 799.
-

8.4 Depression

Introduction

Depression is more than a low, sad mood. It is a serious illness. Some people experience depression intensely, for long periods of time and often without a known reason. Depression is one of the most common mental health problems. One in five people experience depression at some stage of their lives, including older people. Depression is not a normal part of the ageing process.¹³

Depression in older people is common and may occur with the onset of a physical illness or personal loss, however depression is not inevitable as people age. Diagnosis of depression in an older person is based on consideration of their feelings, thoughts, behaviours and physical symptoms. An older person may be feeling irritable, angry or aggressive, or experiencing feelings of hopelessness or emptiness, loss of self-esteem, or make negative comments about the worth of living over a period of weeks.

Dementia can mask depression. Early detection by a health professional may stop depression becoming severe. Effective treatments are available.

Observations

Depression in an older person may become evident in behaviours such as neglect of self care, withdrawal, lack of motivation and uncharacteristic behaviour. Physical symptoms may include constant tiredness, unexplained headaches or backache, changes in digestive or bowel habits, or significant weight loss or gain.

Strategies

- Consider using the SCTT Psychosocial profile, which includes the Kessler Psychological Distress Scale (K10) screening self-assessment tool. It is a validated measure of psychological distress for people who can self report. Training in its use and interpretation of results is recommended.
 - Refer to a counsellor or psychologist.
 - Consult with a specialist mental health service.
 - Refer to a GP for a team care plan arrangement that includes counselling with a mental health professional.
-

Resources

- beyondblue: the national depression initiative, at <http://www.beyondblue.org.au/index.aspx?>
 - Mental Health Advice Line 1300 280 747
 - *Best care for older people everywhere: The toolkit*, Department of Health 2010 <http://www.health.vic.gov.au/older/toolkit>
-

¹³ Zubenki, G.S., Zubenki, W.N., McPherson, S., Spoor, E., Marin, D.B., Farlow, M.R., Smith, G.E., Geda, Y.E., Cummings, J.L., Petersen, R.C., & Sunderland, T. (2003). A collaborative study of the emergence and clinical features of the major depressive syndrome of Alzheimer's Disease. *The American Journal of Psychiatry*, 160, 857-866.

8.5 Communication, vision and hearing

Introduction

Consideration of the person's communication, vision and hearing is part of an overall assessment. If communication, vision or hearing is impaired, this will influence the design of interventions and restorative strategies. The SCTT Health Conditions profile questions can be used as a lead-in to the conversation.

Vision loss has many causes. Some of the more common eye conditions include glaucoma, cataracts, age-related macular degeneration (AMD) and diabetic retinopathy. Hearing loss affects people of all ages, but the problem is more common among the elderly.

Communication

- Check for difficulties in communication with others, such as cognition, language, literacy (English, language other than English), speech and sensory issues.
 - Check preferred language of choice.
 - Check if the person uses assisted communication devices or sign language (AUSLAN).
 - Check for understanding, by asking the person to give feedback or repeat what you have said.
-

Questions and observations about vision

- Check that people with glasses are wearing them.
 - Check if the person can see items.
 - May I ask you about your vision?
 - Do you have difficulty with vision, even with glasses?
 - Do you have difficulties carrying out your daily activities due to poor vision?
 - How long is it since you had your eyes tested or new glasses?
 - Does your vision impact on your confidence to get around and do your day-to-day tasks?
 - How good is the lighting in your home – particularly the bathroom and kitchen? Are the light globes all working and bright enough?
 - Do you need books or instructions in large print?
 - Does your eyesight limit things you do or would like to?
-

Questions and observations about hearing

- Check that hearing aids have batteries, are fitted and switched on.
 - Do you have trouble hearing what people are saying to you in normal or group conversations?
 - Do you have trouble understanding what people are saying and what they mean?
 - How do you go hearing people on the telephone?
 - How long is it since you had your hearing tested/new aid?
 - What different aids or equipment have you tried?
 - Does your hearing limit things you would like to do?
-

Strategies

- Attract the person's attention by speaking or gesturing.
 - Greet the person by name, repeat your own name and keep your face in view.
 - Speak clearly and slowly if the person has a hearing impairment, keep sentences short, and use predictable words.
 - Reduce background noise such as TV, radio or other people speaking.
 - Ensure people can access annual checks for hearing and vision.
-

Resources

Vision:

- Victorian Eyecare Service provides eye care services for people who have a Pensioner Concession Card or Health Care Card. It is provided by the Victorian College of Optometry in metropolitan regions and by individual private practice optometrists in rural regions. For more information: Tel 03 9349 7400 or <http://www.health.vic.gov.au/agedcare/services/ves.htm>
- <http://www.visionaustralia.org.au/>
- The Centre for Eye Research Australia Vision Screening Test. The Low Vision Kit contains information, charts and various other materials and can be obtained from: Centre for Eye Research Australia, email: lowvisiononline-info@unimelb.edu.au, mail to: 32 Gisborne Street, East Melbourne, 3002, Victoria, Australia. Tel: +61 3 9929 8375 <http://www.lowvisiononline.unimelb.edu.au/Screening/testing.htm>

Hearing:

- <http://www.health.gov.au/hear>
- Free hearing tests at University of Melbourne Audiology Clinic Ph: 9035 5333, and some community health services.
- Better Hearing Institute quick hearing check, based on the Revised American Academy of Otolaryngology- Head & Neck Surgery (AAO-HNS) five-minute hearing test. Source: Koike, J., Hurst, M.K., and Wetmore, S. J. Correlation between the American Academy of Otolaryngology - Head and Neck Surgery five-minute hearing test and standard audiological data, *Otolaryngology – Head and Neck Surgery*, Vol. 111 (5), pp. 625-632. See http://www.betterhearing.org/hearing_loss/quickHearingCheck.cfm
- The Whisper Test at <http://www.webster.edu/~davittdc/ear/whisper/whisper.htm>

Communication:

- AUSLAN <http://www.auslan.org.au/>
- For information about when use of an interpreter is required, see the *Language services policy* at <http://www.dhs.vic.gov.au/multicultural/html/langservpolicy.htm>
- Translating and Interpreting Service Ph: 13 14 50 and ask to be connected to the relevant regional number.
- If a person is deaf, has a hearing impairment, or complex communication needs, telephone the National Relay Service on 13 36 77, or the Speech to Speech Relay Service on 1300 555 727 and ask to be connected to the relevant regional number.

General:

- Better Health Channel <http://www.betterhealth.vic.gov.au/>
-

8.6 Continence

Introduction

Continence is the ability to exercise voluntary control over the bladder and bowel. There are many causes of urinary and faecal incontinence. Poorly managed incontinence has a negative impact on a person's ability to perform activities of daily living. Continence issues can often be prevented with appropriate screening, assessment, prevention and management strategies. Incontinence is **not** and should not be an expected outcome of older age. Common reasons for urinary incontinence include:

- a weak pelvic floor, leading to leakage of urine when a person sneezes, laughs, strains, lifts or plays sport
- a sudden strong urge to urinate, which may be due to conditions such as stroke, enlarged prostate gland, Parkinson's disease, constipation or the outcome of a long history of poor bladder habits
- poor bladder emptying leading to overflow
- inability to reach or use the toilet
- problems with the nerves that control the bladder
- urinary tract infection
- some medications
- delirium.

Common reasons for faecal incontinence include weakness of anal sphincter muscles, severe diarrhoea, constipation and impaction, disorders of the nervous system such as spina bifida or dementia, or disorders of the lower bowel such as haemorrhoids.

Incontinence is a significant contributing factor to the admission of older people to residential aged care.

Questions and observations

Be aware that continence is a sensitive issue to most people, even though you may discuss it with people every day.

- Do you mind if I ask you some personal questions?
- Do you have trouble getting to the toilet on time?
- How often do you have to go to the toilet during the night?
- Do your bowels or bladder cause embarrassment, pain, concern?
- Do your bowels or bladder affect your self image?
- Are you worried about going out, as you may need a toilet?
- Do you leak urine before you get to the toilet?
- Do you suffer from constipation or diarrhoea?
- Observation of odour or stains.

Strategies

Refer to a GP, nursing service or continence clinic for further assessment.

During a continence assessment, a person will be asked questions about their diet, weight, medical history, medication and general health and a physical examination or tests may be performed.

Management plans for incontinence may include physiotherapy for improved pelvic floor muscles, bladder control or mobility, dietetics, prompted or timed toileting and use of continence aids or a catheter.

Resources

- Continence clinics can be accessed through the National Continence Helpline: 1800 33 00 66
 - Department of Health and Ageing continence checklist at <http://www.bladderbowel.gov.au/>
 - Continence Foundation of Australia Vic (03) 9816 8266
<http://www.continence.org.au/>
 - RDNS Continence Nurses 1300 33 44 55
<http://www.rdns.com.au/corporate/Pages/default.aspx>
 - *Best care for older people everywhere: The toolkit*, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>
-

Project snapshot

The purpose of the Royal District Nursing Service (RDNS) and Banyule City Council Caring for Continence project was to implement active service model principles to address incontinence issues experienced by HACC clients.

Interventions included education and information, aids and individual exercise programs. Following the interventions, most clients showed improved continence and reported significant improvements across all life activity areas.

See http://www.health.vic.gov.au/hacc/projects/asm_pilot.htm

8.7 Nutrition and hydration

Introduction

Good nutrition is integral to maintaining good health, muscle and bone strength and therefore the ability to be physically active. Poor nutrition is one of the major reasons why people become frail and dependent. People at risk of falls may need a review of their calcium and vitamin D intake. Reasons for poor nutrition may include:

- inappropriate or inadequate food intake
- poor appetite, reduced smell and taste
- social isolation, financial issues, dependence or disability (unable to shop)
- feeding problems (chewing, swallowing, dentures)
- acute conditions, chronic disease, multiple medication
- depression, anxiety
- advanced age
- cognitive impairment
- medication side-effects, such as loss of appetite or nausea.

Positive questions

The SCTT Health Behaviours profile has a nutritional risk screen.

- Have a general conversation about food, asking about favourite foods and when they last had them, what they normally eat and how they manage to get the food they need.
 - Malnutrition and being underweight are considered bigger issues for frail older people than being overweight.
 - Obvious underweight or frailty or unintentional weight loss: Have you gained or lost weight recently? How long have you been at your current weight? Have any of your friends or family commented on your weight recently?
 - Reduced appetite, food or fluid intake: Has your appetite changed recently? If so, what is the reason for this?
 - Mouth, teeth or swallowing problems: Do you have problems with your mouth, teeth or swallowing, such as chewing your food (including meat), pain or sore teeth when you eat, or trouble swallowing food or medications? Have you noticed loss of taste?
 - Special diet: Do you have a special diet (consider cultural or religious practices such as fasting)? Are there foods you are allergic to or cannot eat? Has a special diet ever been suggested for you?
 - How do you manage your shopping and meals? Does the person split delivered meals over the day and not get adequate nutrition?
 - Has the person decreased their fluid intake because of continence issues?
 - What strategies for your weight have you tried in the past? Are you interested in considering options or trying new strategies as part of an overall approach to maintaining or improving your weight, health and independence?
-

-
- Observations**
- Ask to see the kitchen and be aware of the state of the benches (clean/dirty/unused), whether there is food in the fridge and cupboards, watch how they make a cup of tea or similar, but be subtle and sensitive about this.
 - Look inside the refrigerator if appropriate.
 - Identify barriers or concerns they have about eating or drinking, as well as what they would like to change.

-
- Strategies**
- Refer to a GP for issues like unexpected recent weight loss or swallowing problems.
 - Refer to a dietician if the person is underweight or has unexpected weight loss/gain or changes to food intake; refer for specialist assessment of risk factors, diabetes or special needs.
 - Consider skills development training by people with a disability, advocacy groups and community service organisations that deliver supports and services for people with a disability.
 - Refer to a speech pathologist for swallowing issues.
 - *Well for Life: improving physical activity and nutrition*, see www.health.vic.gov.au/agedcare/publications/wellforlife_nutrition.htm
 - Refer to HACC food services for delivered meals or other assistance
 - See Section 12: Service specific assessment.

Hydration

Introduction The most vital substance for a healthy mind and body is water. Older people have been identified as particularly susceptible to dehydration, because of age-related changes. Sense of thirst also appears to be reduced, even in the healthy older person. It is important for people to drink regularly, even though they may not feel thirsty. Some people reduce their fluid intake because they have continence issues.

Dehydration makes a person tired, cranky, and stiff-jointed. Being dehydrated can bring on headaches, nausea, aches, cramps and other, more serious physical ailments. Dehydration can make it more difficult for people to be patient with each other. Severe dehydration can cause seizures, coma or even death.

Observation In an older person, mild dehydration can be indicated by thirst, dry lips, dry mouth, flushed skin, fatigue, irritability and headache. Urine can be darker in colour and urine output decreases.

-
- Positive questions**
- Have you had fluids or water today?
 - How many glasses of water would you normally have in a day?

-
- Resources**
- *Well for Life: Improving physical activity and nutrition* resources at http://www.health.vic.gov.au/agedcare/publications/wellforlife_nutrition.htm
 - Continence Victoria help sheet 'Fluids and the older person' at <http://www.continencevictoria.org.au/>
 - Nutrition Australia food variety checklist <http://www.nutritionaustralia.org/national/resource/food-variety>
 - *Best care for older people everywhere: The toolkit*, Department of Health 2010 <http://www.health.vic.gov.au/older/toolkit>

8.8 Chronic disease management

Introduction

By definition, chronic diseases are long lasting and rarely cured. However, there is a growing body of evidence to suggest that people can achieve improved health by better managing the chronic disease. This involves individuals knowing and understanding their condition (including treatment options), monitoring and managing the symptoms and signs of illness, adhering to treatment regimes, modifying risk factors for disease, engaging in activities that protect and promote health and managing the impacts of illness on functioning, emotions and interpersonal relationships.

Even late in life, chronic disease management can have health benefits for the individual, such as longer life, increased or maintained levels of functional ability, disease prevention and an improved sense of wellbeing.

An important component of chronic disease management is self-management support. 'Self-management' is what the person with a chronic disease does to manage their own illness. Self-management support is what health care practitioners provide to support a person to build their confidence and ability to effectively self-manage. Self-management includes:¹⁴

- managing illness-related demands, such as medications and other therapies, monitoring and managing signs and symptoms
- avoiding risk factors for secondary disease development, disease progression or exacerbation, such as alcohol misuse, obesity, high blood pressure or high cholesterol
- engaging in health promoting behaviours, such as adhering to dietary recommendations and engaging in regular physical activity
- engaging with health care services, such as seeking assistance when required, attending appointments and communicating information or concerns
- managing the activities of daily life (personal, social, functional) in a way that accommodates their illness.

These activities and responsibilities often require individuals to develop or strengthen their knowledge, skills, resources, personal efficacy and motivation. Thus self-management support involves goal setting and problem solving, assists to address barriers to self-management, respects choice and individual circumstances, and is an ongoing collaborative process between the health care practitioner and the person with a chronic disease.

14 www.health.vic.gov.au/communityhealth/downloads/icdm_self_management_support_primary_care.pdf

Considerations The following should be considered, particularly when the assessor is the first service provider involved with the person. If the person has been referred by a health service, assessment should not duplicate information that may have already been collected:

- medical history
- the person's understanding of their health conditions and how to manage symptoms (including acute symptoms such as chest pain)
- regular GP involvement
- medication management and polypharmacy
- engagement in decisions about care and treatment
- services involved, including support (allied health services, self-management programs)
- identifying self-management techniques
- who is the lead agency/key worker/care coordinator?

Identify strengths

If the person is not currently receiving self-management support from a health service or GP, identify the following:

- understand the person's health beliefs and perceptions
- check if the person has a self-management plan, which includes managing acute episodes and pain
- identify the person's problem-solving skills, decision-making capacity and resources
- identify their level of confidence and capacity to engage in specific activities that will improve their health and care.

Positive questions

- What do you understand about your condition and how to manage the condition?
 - What does your chronic condition mean for your day-to-day life?
 - Tell me about things that are concerning you at the moment about your condition?
 - People with chronic conditions may have trouble coping with the changes and difficulties in managing their condition. How are you feeling about taking care of your health?
 - What services have you attended /are you attending that have helped you manage your condition?
 - What support do you have to improve your health? What kind of support do you think you need to address any concerns?
 - Do you know about local support groups?
-

Observations

As the person explains their condition to you, it is important to identify their level of health literacy and understanding of written material. Note emotional reactions such as anxiety, grief, depression, or anger as the person discusses their condition. This may indicate how they are coping and whether they have accepted their condition. Observe the person's level of motivation, interest and willingness to engage in specific activities that will improve their health and care.

If a referral is needed to a health service, passing on information gleaned through observation will be helpful for other health professionals.

If multiple services are involved, check for coordination, communication and a care coordination plan.

Strategies

- Ask about the person's desire to improve their health.
- Help people understand that services can support them in managing their condition.
- If the person has a chronic condition/s, gaps in knowledge about their condition and managing their condition, has no or limited GP contact, consider referral to a health service.
- Consider and talk about referral to other services as required (consider health services and education programs such as allied health services, nursing, health coaching, counseling, specialist services or GP if not already involved).
- Consider peer-led support groups or online networks to share experiences and provide support.
- Provide information in the person's preferred format / language.
- If health services are involved, participate in a coordinated approach to care planning.
- Note that family members or carers can be particularly vulnerable to chronic conditions and may require their own assessment.

Resources

- Victorian Government information at <http://www.health.vic.gov.au/communityhealth/cdm/> and www.health.vic.gov.au/harp-cdm/
 - Arthritis Australia has information sheets in different languages <http://www.arthritisaustralia.com.au/index.php/>
 - Diabetes Australia <http://www.diabetesaustralia.com.au/>
 - Parkinson's Association TV program and information sheets <http://www.parkinsonsvic.org.au/>
 - Community health centre chronic disease self-management information <http://www.health.vic.gov.au/communityhealth/cdm/resources.htm>
-

8.9 Medication management

Introduction

Australia's National Medication Policy advocates a partnership approach that recognises governments, health care providers, consumers and others as having a shared responsibility.

Effective use of medicines can have a positive impact on health and can improve quality of life. It has been shown that inappropriate or incorrect use of medicines can have an adverse affect on health.

Consistent with this approach, the *Guiding principles for medication management in the community June 2006* recognise that partnerships are important when support is being provided to people at home. People should be encouraged to maintain their independence for as long as possible, including managing their own medicines in a safe and effective way. It is recommended that all HACCC assessors, managers and practitioners involved in medication management read this best practice guide.

Considerations

The effect of drugs on older people is a significant variable to consider when completing an assessment:

- poor medication management can lead to hospital admission
 - medication may impact on, or relate to, other functional domains such as falls, confusion or incontinence, loss of appetite
 - mental and/or physical impairment can make it difficult for people to self-administer medication
 - polypharmacy is indicated if the person is taking five or more different medications
 - ethnopharmacology and race-based genetic differences amongst CALD populations.
-

Positive questions and observations

- Ask if medications are prescribed. Does the person know what the medication is prescribed for: Do you know what medication you are taking and why?
 - Ask if the medication is self-administered, supervised or given by another person.
 - Ask about natural therapies and traditional or cultural treatments.
 - Check if the person has concerns with their medication or side effects.
 - Check if the person has had a recent medication review by the GP or pharmacist.
-

Strategies

- People with dexterity/vision issues may be assisted to manage own medications with aids developed by OT and pharmacist.
- If you have concerns about a person's medication management or polypharmacy, consider a referral to a GP or district nurse for further investigation and a Medication Risk Screen (MRS) or a Home Medication Review.
- When assistance with medication management is needed, referral to a HACC nursing service can determine if appropriate assistance can be provided by a nurse or community care worker. Where assistance is provided by a community care worker, the department's document *Assistance with medication by HACC community care workers* (2009) must be followed.
- The Q-max scheme for Aboriginal people enables free prescriptions for Aboriginal people from their GP. Aboriginal people need to identify as Aboriginal to their GP.
- Pharmacists have access to free interpreters via the Telephone Information Service.

Resources

- *Guiding principles for medication management in the community*, June 2006. Multiple free copies of this document are available by ringing (02) 6289 7753.
 - *Assistance with medication by HACC community care workers*, Victorian Department of Health September 2009 <http://www.health.vic.gov.au/hacc/>
 - GP medication review http://www.health.gov.au/internet/main/publishing.nsf/Content/medication_management_reviews.htm
-

8.10 Oral health

Introduction

Oral health plays an important role in health and wellbeing and therefore quality of life.

- Pain and difficulty with eating can lead to poor levels of nutrition.
 - Poor oral appearance, bad breath and dental incapacity can lead to social isolation.
 - Oral disease is implicated in peptic ulcers, respiratory and cardiovascular illness.
 - Dental decay is the most costly diet-related disease in Australia ahead of coronary disease, hypertension and diabetes.
-

Positive questions

- Have you seen a dentist in the last three years?
 - Mouth, teeth or swallowing problems: Do you have problems with your mouth, teeth, gums or tongue? Do you have problems when eating, such as swallowing or chewing your food (including meat), pain or sore teeth when you eat or trouble swallowing food or medications?
 - Have you noticed loss of taste?
 - Can you still manage cleaning your teeth/dentures?
 - Do your gums bleed when you eat or brush your teeth?
-

Observations

- Do they have missing teeth or poorly fitting dentures?
 - Is there soreness or cracks in the corner of the mouth?
-

Strategies

- Referral to a community dental clinic.
 - Referral to Royal Dental Hospital of Melbourne-Domiciliary Unit: for people who are completely home-bound (free service for Health Care Card and Pension Card holders who are home-bound).
 - Fact sheets (see below).
 - *Resource guide for CALD communities* (see below)
-

Resources

- Dentistry in Victoria www.health.vic.gov.au/dentistry/clients/index.htm
 - Location of community dental clinics www.health.vic.gov.au/dentistry/locations.htm
 - Royal Dental Hospital of Melbourne – Domiciliary Unit www.dhsv.org.au/public-dental-services/services-for-homebound-patients/
 - Fact sheets <http://www.dhsv.org.au/dental-advice/general-dental-advice/older-adults-and-carers/>
 - Culturally and linguistically diverse communities resource kit <http://www.dhsv.org.au/oral-health-resources/guides-and-resources/#Mouth>
-

8.11 Palliative care and advance care planning

Introduction

Palliative care is the specialised care of people who have life-threatening illnesses. The term 'life-threatening' describes an illness that is expected to result in a person's death. The aim of palliative care is to provide the best possible quality of life for the person, their family and carers. Palliative care:

- regards dying as a normal process
 - is not intended to speed up or postpone death
 - provides pain and symptom relief, spiritual and psychosocial support from diagnosis to end of life and bereavement
 - anticipates and addresses problems to minimise the impact of illness
 - offers a support system to help people live as actively as possible until death
 - offers a support system to help the family or carers cope during the person's illness and bereavement
 - uses a team approach.
-

Palliative care is provided in many settings – private homes, residential services, hospitals and palliative care facilities. Decisions about where to provide palliative care are based on the needs and wishes of the person who has a life-threatening illness.

HACC assessors may be required to assess or review service provision to people who are palliative, for example to:

- participate in care planning
 - assist where appropriate in providing support staff
 - address the training needs of support staff who will be providing HACC services
 - respond to cultural, linguistic or spiritual needs of the person
 - refer support staff to appropriate services if they need support to manage grief or change.
-

Advance care planning¹⁵

Advance care planning refers to 'the process by which patients, together with their families and health care practitioners, consider their values and goals and articulate their preferences for future care.'¹⁶ It requires respect for the person and their autonomy.

Making decisions about future medical treatment is called advance care planning. An advance care plan is a written or verbal record of a person's choices about their future medical care.

Resources

- Palliative care <http://www.health.vic.gov.au/palliativecare/what.htm>
-

¹⁵ Advance care planning <http://www.respectingpatientchoices.org.au/> or <http://www.sswahs.nsw.gov.au/SSWAHS/myWishes/default.html>

¹⁶ Tulsky, 2005, p.360 download from www.respectingpatientchoices.org.au

9 Psychological, social and emotional wellbeing

9.1 Psychological and emotional wellbeing

Definition

VicHealth: 'Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.'¹⁷

Introduction

Psychological and emotional wellbeing is an important part of overall health. It is also a sensitive topic for many people.

Aboriginal people conceptualise good mental health as part of social, spiritual, emotional and physical wellbeing. Fostering cultural identity and connection to land, family and community is critical to this and underpins the need for a holistic, culturally-based response that recognises the centrality of culture to wellbeing and promotes self-determination. Unless managed sensitively, questions pertaining to a person's memory or wellbeing may create a barrier.

For people from a CALD background, it may be important to elicit attitudes and values about disability, ageing and dementia. Some people may have experienced torture, trauma or war and this will impact on their psychological and emotional wellbeing.

Family and carers can be particularly vulnerable to mental health problems such as anxiety and depression.

Elements of emotional wellbeing

Resilience and coping: Resilience is the capacity to recover from and adapt to life events. Effective coping skills give people better control over their lives and add to their achievement of emotional wellbeing. The use of coping mechanisms contributes to resilience and has a protective effect when dealing with ill-health or age-related changes.

Being productive and making a contribution: Research shows that the way older people think about quality of life and mental or emotional health is not much different from the way younger people think. People usually need to feel like a useful member of society. Contributing to family and community can be important to emotional wellbeing.

Social relationships and connections: Having meaningful relationships with family, friends, peers and the wider community is a key factor in achieving and maintaining quality of life. The perceived *quality* of contacts is important. Meaningful social connections and having people to do things with and talk about things with helps people cope with worries and motivates them to get up and about. People with a disability are at risk of social isolation at any age.

Basic needs and comfort: Fulfilment of basic physical needs contributes to psychological and emotional wellbeing, for example being warm, having a sense of privacy, security and safety and a comfortable, well-lit environment.

Sensory enrichment: Sensory stimulation is an important aspect of overall emotional wellbeing. It can convey emotional support, affection and respect.

Grief and bereavement

Stressful life events and the loss of a partner, family, friends or pet can adversely affect a person's emotional wellbeing and contribute to loss of function, for example giving up driving. Organisations have a duty of care to both staff and service users to have systems in place to anticipate, accommodate and support the grieving process.

Grief is a process that helps us adjust and cope with loss. Everyone has a different, individual experience with grief. However, there are some common feelings that people may share, including denial, anger, resentment, sadness, loss and acceptance.

Grief reactions vary widely within and between cultures. Bereavement services may be inappropriate to some cultures and individuals. The ways in which death is viewed and the rituals that accompany it vary within and between cultural groups. In the Aboriginal community, grief and loss is a significant factor as people die at a younger age and attending funerals is considered a high priority for all community members.

Positive questions

Commence by identifying strengths and capacities. (see Section 6.7)

People may find questions about psychological and emotional wellbeing intrusive. When completing an assessment with an Aboriginal person, sensitivity needs to be a priority when asking questions about memory and wellbeing. Consider their identity, impacts of the Stolen Generation, connection to land, their role and responsibilities in the community.

- During the past four weeks, was someone available to you if you needed and wanted help? (See screening question on SCTT psychological profile)
 - Tell me about your background and where you came from.
 - Have you experienced dislocation from country, community or family?
 - How have you been feeling within yourself lately? Is anything bothering you?
 - Do you have responsibilities for looking after others, such as grandchildren?
 - Do you get to do the things you like to do?
 - Is there something that you used to do in the past that you miss and you would like to do again?
 - Do you have any concerns about your safety or security?
-

Observations

- Look for expressed and observed emotions – appropriate, depressed, anxious, irritable, blunted, perplexed?
- Does the person have psychiatric or mood concerns that affect capacity to function?
- Is there risk of abuse and neglect (elder abuse, substance abuse, self-neglect)?
- Are they motivated? Motivation is often affected when someone is depressed.

Strategies

- Consider using the SCTT psychosocial profile, which includes the Kessler Psychological Distress Scale (K10) for self-assessment. It is a validated scale to yield a global measure of psychological distress for people who have the capacity to self report. Training in its use and interpretation of results is recommended.
- Liaise with GP. The presence of mental illness does not necessitate a referral to mental health services. Non-specialist services will continue to assist older people with a mental illness, until such time as the person's behaviour or illness will be more effectively managed by a specialist service.
- Consult with specialist mental health services
<http://www.health.vic.gov.au/mentalhealth/services/index.htm>

Resources

- *Well for Life: Improving emotional wellbeing for older people at home (draft resource)* 2010 available at <http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm> The resource includes help sheets for:
 - promoting independence and autonomy
 - social relationships and connections
 - purposeful activities
 - physical activity and emotional wellbeing
 - food and emotional wellbeing
 - using sensory stimulation
 - sexuality and emotional wellbeing
 - resilience and coping skills
 - spirituality and wellbeing
 - grief and bereavement.
 - Mental Health Advice Line 1300 280 747
 - Better Health Channel http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness?open
 - *Promotion, prevention and early intervention for mental health* [http://www.health.gov.au/internet/main/publishing.nsf/Content/A32F66862E8894ABCA25723E00175229/\\$File/prommon.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A32F66862E8894ABCA25723E00175229/$File/prommon.pdf)
 - *The influences on mental health* [http://www.health.gov.au/internet/main/publishing.nsf/Content/A32F66862E8894ABCA25723E00175229/\\$File/pro2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A32F66862E8894ABCA25723E00175229/$File/pro2.pdf)
-

9.2 Family, friends and community

Introduction

Having social connections and meaningful relationships with family, friends, peers and the wider community helps achieve and maintain quality of life.

People who are recently bereaved, or have difficulty getting out of the house because of decreased mobility, and those who have ceased driving are at risk of losing their community connections and becoming socially isolated.

This can be a particular issue for people in unstable housing, public housing or supported accommodation.

Social isolation can be caused by, but also impact on, physical and mental health. Challenges to maintain or create social relationships and connections may include:

- public transport: disability, affordability, frailty or vision impairment may restrict use
- financial restraints: limited money to spend on activities
- attitude: reluctance, lack of motivation, being afraid, entrenched isolation, past conflict
- communication: if hearing or speech is impaired or a language other than English is spoken
- health conditions: incontinence, impaired vision, pain, depression and other mental health issues
- assumptions by others: time, resources, health issues, special needs or community resources.

Considerations

Consider and discuss relationships between people and their social environment and community, including:

- key relationships and current levels of interaction and support
 - the person's and family or carer's perceptions
 - family issues (composition, dynamics, coping, interaction)
 - family members living interstate or overseas
 - indicators of neglect or abuse
 - legal issues such as power of attorney
 - current service providers
 - connections, such as community, neighbourhood, cultural, religious and access to transport
 - the importance of, for example, cultural connections to Aboriginal and CALD organisations
 - advocacy.
-

Positive questions

- Tell me about your family and community.
- Do you have someone you can talk to?
- Who do you speak to most frequently?
- How do you go getting out and about in the community?
- Do you meet up with your friends and family regularly?
- Do you belong to clubs or groups in the community?
- Did you in the past? Might you again if there was something that interested you?
- Do you know your neighbours?
- How often do you use the telephone to contact your friends, or how often do they contact you?
- What is the next social event that you are looking forward to?

Strategies

Strategies for supporting social relationships and connections include to:

- explore a person's interests, strengths and abilities to encourage involvement in meaningful social relationships
- explore opportunities for enjoyable social activities at community facilities and events (such as library, local clubs, fete)
- identify if assistance is available to help a person to attend a community group, for example asking a family member, friend or volunteer to provide support
- consider transport options (See Section 10.7)
- consider a referral to a Planned Activity Group or for volunteer coordination
- actively link with Aboriginal agencies face-to-face to connect with community
- use the expertise of staff in ethno-specific or multicultural organisations to develop strategies and support connections for people from CALD backgrounds.

Refer a person with a disability to an advocacy organisation for assistance and support, to ensure their rights are respected and upheld, and to support self-advocacy (see below).

Resources

- Association of Neighbourhood Houses and Learning Centres
<http://www.anhlc.asn.au/>
- University of the Third Age <http://www3.griffith.edu.au/03/u3a/>
- Telelink Victoria <http://home.vicnet.net.au/~telelink/>
- Service seeker for ethno-specific agencies <http://www.serviceseeker.com.au/>
- Divine: A community for and by people with a disability
<http://www.divine.vic.gov.au/>
- Disability information and support
http://www.dhs.vic.gov.au/__data/assets/pdf_file/0018/152721/dis_contact.pdf
- Disability Advocacy and Resource Unit <http://www.daru.org.au/>
- Youth Disability Advocacy Service <http://www.ydas.org/>
- Disability Advocacy Program
http://www.officefordisability.vic.gov.au/disability_advocacy_program.htm

9.3 Families and carers

Introduction

Care provided by family and friends occurs in the context of an existing relationship. Recognising and supporting care relationships (Department of Human Services, 2006) recognises, respects and supports the dynamic interconnections between people in care relationships.

Families or carers are critical to enabling people with care needs to remain at home. Carer's own health and wellbeing needs, as well support for their carer role, should be addressed through assessment and care planning.

Carers may have multiple caring responsibilities – partner, parents, children and grandchildren. Many older Aboriginal people are the primary carers for their grandchildren. This is also the case in some other cultures.

Caring can have a negative impact on the health and wellbeing of the carer. Wellbeing decreases as the number of hours of caring increases. Carers experience a higher rates of mental health problems than the general population, in particular anxiety and depression. Carers are twice as likely to have poor physical health compared to the general population and have a higher incidence of chronic disease.¹⁸ Carers can be reluctant to seek assistance for their own health needs.

Carers may benefit from an assessment in their own right.

Carer focus

Living at Home Assessments must be person and carer-focused. This means to:

- give attention to the needs of both the carer and the person receiving care
- avoid giving one party preference or privilege at the expense of the other or the relationship
- acknowledge and respond to the different circumstances and contexts in which care relationships exist
- recognise the diversity of care relationships
- help to negotiate outcomes to meet the needs of both parties.

Considerations

Consider:

- the history of the relationship and changes in the relationship due to the care role, including cultural considerations and the role of family members in decision making
 - needs within and beyond the care relationship
 - how the carer understands the person's condition, goals and options
 - care support arrangements (tasks required, level of support, nature of support, suitability of physical environment, access to transport, financial support, decision making, vulnerability, risks).
-

¹⁸ Cummins et al. 2007 at http://www.deakin.edu.au/research/acqol/index_wellbeing/index.htm.
See also Gill et al. 2007 at <http://www.health.sa.gov.au/pros/portals/0/Carers%20Report%202007.pdf>.

-
- coping capacity: carer roles and responsibilities, how well the carer is coping, how well the person is coping, strengths and needs, stability of the situation, emotional and spiritual needs, stress management, physical needs (for example: sleep), leisure activities, support networks
 - carer goals regarding future care
 - role of significant others.
-

Positive questions

- Describe your family routine.
 - How do you manage looking after [care recipient]?
 - What do you find most difficult or tiring? Are you sleeping OK?
 - Who helps you in your care role?
 - Do you get help from other organisations? If so, how does this work for you?
 - Do you manage to get time for yourself?
 - Do you stay in touch with family and friends?
-

Strategies

- Offer a separate interview or telephone conversation if you think the carer does not feel comfortable talking in front of the person they care for.
- Do a joint assessment where one staff member talks privately with the carer/ family member.
- Be aware of how the person is feeling and do not increase their anxiety.
- Check if the carer or support person is linked with respite options and carer support groups.
- Identify if a separate carer assessment is needed.

People have different styles and approaches to solving their problems. It may help to:

- understand how the person usually solves problems and work with that
 - provide information or what is needed for the person to problem solve and make choices
 - talk about different ways to solve a problem if the person's usual way is not effective.
-

Resources

- A Victorian charter supporting people in care relationships <http://www.health.vic.gov.au/agedcare/policy/carers.htm>
- Victorian Support for Carers Program (SCP) http://www.health.vic.gov.au/agedcare/publications/support_carers.htm
- *Recognising and supporting care relationships*, Department of Human Services, 2006 http://www.dhs.vic.gov.au/pdpc/downloads/framework_ap.pdf
- National respite for carers program <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-carers-nrcp.htm>
- Carers Victoria <http://www.carersvic.org.au/>
- *Guidelines for delivery of culturally sensitive and flexible counselling for Indigenous carers*, at <http://www.carersaustralia.com.au/?>
- Care Giver Strain Index, at http://www.npcrc.org/usr_doc/adhoc/caregiver/Caregiver%20Strain%20Index.pdf

Case snapshot¹⁹

Frank and Ivy, aged in their 90s, lived reasonably independently with the support of home care once a fortnight. They had no children and had not been involved in community activities, being content with each other's company and their daily routine. As part of the service review and due to their age, a Living at Home Assessment was conducted. They said they were managing fine. Whilst talking to Ivy, the assessor observed significant memory lapses and sensed signs of stress in Frank.

Frank was given an opportunity to talk about his concerns while the assessor was walking to the gate. He explained he did feel stressed and was having trouble coping, feeling more alone because Ivy wasn't really the same companion he was used to. He couldn't see any options that would help as no one else understood and cared for Ivy the way he did. Together they clarified his goal was to keep things as they were, but feel less stressed and lonely. The agreed action was for the respite coordinator to visit them and discuss possible ideas for providing relief for Frank, without taking away his routine with Ivy.

¹⁹ Fictitious case study

9.4 Alcohol

Introduction

Alcohol can have a negative impact on health and wellbeing. Harm can result from a single episode of intoxication (accidents, adverse interactions with medications and so on), heavy regular use (financial hardship, chronic toxicity, relationship breakdown, legal issues) and dependence. The National Health and Medical Research Council recommend that to avoid long-term harm, healthy adults drink no more than two standard drinks on any given day.

A number of factors need to be considered when determining whether a person's level of alcohol use places them at risk of experiencing harm.

These include:

- medication use
- physical health and medical history
- functionality (such as increased risk of falling)
- psychological wellbeing
- age (it is recommended that older adults drink less than the guidelines).

Positive questions about alcohol use

- How often do you have a drink containing alcohol?
- How many standard drinks do you have on a typical day?
- How often do you have four or more standard drinks?

Strategies

Strategies for working with a person who is thought to be at risk of experiencing alcohol-related harm include:

- exploring the 'good' and 'less good' things about the use of alcohol
- avoiding confrontation or argument
- assessing the person's level of concern
- assessing the person's readiness to change
- developing discrepancy between the person's ideal self and actual self
- referral, with consent, to an alcohol service
- supporting the person in any decision to change their behaviour
- acceptance that not all people will want to change their alcohol use behaviour, and many of those that do will have 'slip ups'.

Resources

- NHMRC guidelines on drinking:
http://www.nhmrc.gov.au/your_health/healthy/alcohol/index.htm
 - Information can be obtained from Directline:
http://www.turningpoint.org.au/service_information/si_directline.html
-

9.5 Family violence

Introduction

Human service agencies, police and justice services (including family violence services) are required to work together to provide coordinated and streamlined responses at a local level to victims of family violence, regardless of where the support comes from.

All family violence services are available to older people, family members, carers and people living in the community, particularly in relation to elder abuse.

Managing risk involves the systematic application of management policies, procedures and practices to the tasks of communication, establishing context, identifying, analysing, evaluating, treating, monitoring and reviewing risk.

Positive questions and observations

Questioning about possible family violence should begin with an explanation that sets the context for such personal probing, for example:

- I am a little concerned about you because [list family violence indicators that are present] and would just like to ask you some questions about how things are at home. Is that okay with you?

Once the person has indicated a willingness to talk, more probing questions can be asked. The questions below are direct, because research indicates that victims are more likely to accurately answer direct questions:

- Are you ever afraid of someone in your family or household? If so, who?
- Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?
- Has someone in your family or household ever threatened to hurt you?
- Has someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?
- Are you worried about someone else in your family or your household?
- Would you like help with any of this now?

Questions should not be asked one by one in survey style. Rather, they should provide trigger points for a conversation about possible violence in the family home. Each question should be explored in detail if a response is ambiguous, for example 'Can you tell me more about that?' or 'Could you explain that a little more for me?' could help to clarify responses.²⁰

Strategies

Family violence service providers work in cooperation with health services and other community-based organisations as part of a local inter-agency response to elder abuse. The type of family violence service response required is determined on a case-by-case basis. Aboriginal Family Violence workers are available in most regions.

Resources

- The Family Violence and Risk Assessment Framework
<http://www.cyf.vic.gov.au/integrated-family-violence/guidelines>
- Family violence risk assessment referral information
<http://www.cyf.vic.gov.au/integrated-family-violence/guidelines>

²⁰ Family Violence Risk Assessment and Risk Management, Department for Victorian Communities, 2007

9.6 Elder abuse

Introduction

Most senior Victorians lead healthy, active and passionate lives, are independent and supported by caring family, friendships and service support networks of varying types. Sometimes older people experience abuse from people they trust, which must be addressed.

Elder abuse is a complex social problem requiring careful and considered responses. HACC assessment workers involved with older people may encounter suspicious or alleged abusive situations. Circumstances surrounding abuse may raise difficult legal, ethical and practice challenges, all of which can be addressed if well-managed.

The Victorian Government strategy recognises that confronting and reducing elder abuse requires a multisectoral and multidisciplinary approach, resting on key principles that empower the older person.

Possible risk factors

The complex dynamics in which abuse occurs make it difficult to determine or identify all factors associated with an increased risk of abuse. Some risk factors may include:

- stress in the care relationship
 - difficulties accepting care due to health status
 - family violence
 - isolation
 - dependency, including dementia
 - psychopathology in an abuser
 - older parents caring for a mature-aged child with a disability.
-

Types of abuse

Incidents can be defined by one or many types of abuse: financial, physical, sexual, psychological, emotional, social abuse and neglect (excluding self-neglect).

When abuse is suspected what should I do?

A HACC assessment worker should determine whether abuse has been/is occurring, through sensitive questioning of an older person and the older person's family and friends. Permission of the older person is required to ascertain observed or suspected abusive signs or symptoms, including severity and frequency.

Resources

- Department of Health, *With respect to age (2009)*
Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse at <http://www.health.vic.gov.au/agedcare/publications/respect/index.htm>
 - Victorian Government Elder Abuse Prevention strategy
<http://www.seniorscard.vic.gov.au/web19/osv/dvcosv.nsf/headingpagesdisplay/elder+abuse+prevention>
 - Seniors Rights Victoria on 1300 36 8821.
-

9.7 Financial and related considerations

Introduction

This section covers financial and other related issues, such as administration and guardianship.

There are two quite separate issues to consider under finances:

- A person's financial circumstances may impact on their health and wellbeing. Costs of care, aids and equipment, transport, housing, family circumstances and capacity to work can influence quality of life, social connectedness and emotional wellbeing.
- A person's capacity to manage their money and finances may be impacted by a physical or cognitive disability, or mental illness.

Positive questions and observations

- Does the person seem to be worried about money? Have they mentioned losing money or having less money than they used to have?
- Ask permission to discuss the person's financial situation to help understand what service/support options may be most suitable to meet their needs.
- Discussing financial circumstances can be uncomfortable for many people. Observe the person's response and body language when you raise the subject.
- Based on what you know about the person's housing, health, medical and family circumstances, discuss whether the person has difficulty paying bills and meeting basic needs, such as paying for food and medication.
- Look for evidence of how bills are managed, mail and other paperwork (piles of paper, unopened mail, overdue bills).
- Based on what you know about the person's abilities and cognitive status, ask whether they have difficulty managing their finances (doing the banking, paying their bills).
- Does the person need advice or help with making a will, administration of finances and legal decisions; power of attorney, or Guardianship issues?

Diversity

Use particular sensitivity with Aboriginal people, who may not be willing to disclose their financial situation. Many older Aboriginal people are from the Stolen Generation and may not understand the different roles of Commonwealth, State and HACC organisations in delivering care. They may fear that the discussion of financial circumstances and fees assessment is linked to their ability to care for their children and/or grandchildren.

Each Aboriginal community is unique. Engage with the local Aboriginal community-controlled organisation (or Aboriginal community if there is no Aboriginal organisation), and seek advice on how to discuss the financial status of local Aboriginal people. Be aware that inappropriate discussion of finances or HACC fees may result in a reluctance to disclose any more information and a refusal of the service, regardless of need.

Strategies

- Advise that fees for HACC services may be waived if a person is financially disadvantaged.
- Ask if there is a family member, friend or an advocate who could help manage their finances. Talk to the Guardianship Board if there is no one that can assist.
- Do not give financial advice yourself or offer to assist with managing a person's finances or legal affairs.
- Refer to Centrelink's Financial Information Service (FIS).
- If the person or their family needs advice about Power of Attorney, Administration of finance and legal decisions or Guardianship, refer to the Public Advocate's website for Fact Sheets and Forms.
- See the State Trustee of Victoria's website for advice on Wills.
- See Section 14: Fees Assessment; Section 9.6: Elder abuse and Section 8.2 Cognition.

Resources

- SCTT 2009 profile: Living and caring arrangements
<http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm#forms09>
 - Centrelink Financial Information Service:
<http://www.centrelink.gov.au/internet/internet.nsf/individuals/index.htm>
 - Power of Attorney, Administration and Guardianship:
<http://www.publicadvocate.vic.gov.au/>
 - Wills: <http://www.statetrustees.com.au/>
-

10 Ability and capacity

10.1 Domestic activities of daily living

Introduction Domestic activities of daily living are essential to maintaining independence at home. This range of activities generally includes:

- housework
- shopping
- meals and food preparation
- doing laundry
- using the telephone
- gardening and home maintenance tasks.

Assistance with most of these activities is provided by the HACC program, though domestic assistance and home maintenance.

MDS requirements When rating a person's capacity to undertake daily tasks for MDS purposes, always rate their **capacity** to do the task and not their **performance**. (See 'Notes' section of the SCTT Functional Assessment Summary for rating guidelines)

Positive questions and observations Ask how the person goes about doing their domestic activities. Focus on things that have changed and they want to get back to doing. Remember that gender and culture may influence the person's expectations and roles. General questions:

- Tell me about how you look after things at home. Has anything changed recently? Do you have help from family, carers or friends?
- What activities are you able to manage yourself? What is more difficult? Why? (For example: fatigue, pain, strength limits, disinterest, spouse recently deceased and does not have the skills/knowledge).

Discussing daily chores

- How do you manage your shopping? Where do you go? How often do you go? How do you manage carrying the groceries? Do you get anything delivered?
 - Do you do all the housekeeping and domestic chores? How do you get on with cleaning the floors (vacuuming and mopping), taking out the bins, getting to the letterbox?
 - What type of equipment do you use to do the house cleaning (for example, type of vacuum cleaner)?
 - Do you spread your housework over the week? How do you get on with cleaning the bathroom? What equipment do you use? Do you find it difficult bending or reaching? Can you show me?
 - How do you manage the washing, ironing and laundry? Is your washing machine a top or front loader?
 - How do you get on carrying wet laundry and stretching to peg clothes on the line?
-

Discussing garden and home maintenance

- How do you go with the garden and lawns? Are you a keen gardener? Is there anything that is stopping you in this area?
- How do you manage home maintenance tasks. For example, gutter cleaning, cleaning windows, changing light globes or checking the smoke alarm.
- Are there specific areas you would like help cleaning up? Is there spring cleaning that needs to be done?

Discussing priorities and ideas

- What would you like to do that you can't do at the moment?
- Out of everything we have discussed, what gives you most concern?
- What do you most want to change? Have you ideas about what might help?

Observations

- Ask to be shown around the house and for a demonstration of their usual cleaning equipment and behaviours. For example, opening jars, getting things down from shelves or picking things up from the floor.
- Observe their ability to do everyday tasks such as making a cup of tea to see how they function (balance, memory, cognition, planning and so forth).
- If there are signs of clutter and hoarding, ask: Are there areas you would like help cleaning up?

Strategies

Use your creative thinking and problem solving skills to develop strategies to improve functional capacity and safety around the home. Contact an occupational therapist for ideas on simple solutions and to determine the need for a referral. Interventions which you can discuss with the OT include:

- adaptive technology or techniques available; OTs provide education on best way of using them
- suggest a visit to the independent living centre
- energy conservation and joint protection strategies
- home maintenance and modifications.

Resources

- Independent Living Centre <http://www.yooralla.com.au/ilc.php>
 - Instrumental Activities of Daily Living Scale (IADL), M.P. Lawton & E.M. Brody at <http://www.health.vic.gov.au/older/toolkit/04Mobility/index.htm>
 - Modified Barthel Activities of Daily Living Index (BI) at <http://www.health.vic.gov.au/older/toolkit/04Mobility/index.htm>
 - See Section 12: Service specific assessment
-

10.2 Personal activities of daily living

Introduction

Personal activities of daily living are essential to maintaining independence at home. The HACC program provides assistance with a broad range of personal care tasks listed below. Personal care may be provided in the person's home, or as part of another HACC activity such as respite or planned activity groups.

HACC personal care assessment and service delivery must be conducted in accordance with the HACC Personal Care Policy: see *HACC program manual* Section 7.6 and amendments/updates. This policy includes the requirement for the assessment and care planning of personal care needs and the ongoing role of Division 1 nurses or other relevant health professionals in monitoring and supervising personal care for people with:

- unstable health status and/or complex care
- PEG feeding and other invasive procedures
- medication management. (see Section 8.9 Medication management)

HACC assessment services will have protocols with district nursing services which detail the circumstances in which Division 1 nurses will be involved in personal care assessment and service delivery.

Personal care tasks include:

- bathing, showering
- dressing
- eating
- toilet use
- managing continence (bowels and bladder)
- personal hygiene (shaving, hair care, grooming)
- limited nail care (only after professional assessment),
- mobility – transfers in and out of chairs, bed, wheelchair, vehicle
- assistance with prescribed exercise or therapy programs
- fitting aids and appliances
- monitoring self-medication (See Section 8.9 Medication management)
- escorting to medical or other related appointments of activities.

See the *HACC program manual* for more detailed description of personal care activities funded under the program. See also Section 12.2 Active service model and HACC activities.

MDS requirements

When rating a person's capacity to undertake personal care tasks for MDS purposes always rate their capacity to do the task not their performance. (See 'Notes' section of the SCTT Functional Assessment Summary for rating guidelines).

Positive questions

Be aware that there may be sensitivities related to gender or culture in discussing or providing personal care assistance. Use sensitivity in asking how the person manages their personal care:

- You mentioned it is difficult for you to get out of your chair – do you have difficulty stepping over the bath or getting off the toilet? Is the toilet a good height for you?
- How would you feel about me looking at your bathroom?
- Are you able to bathe and shower yourself? Do you find any aspects difficult, such as reaching to wash your hair? Is your bath/shower easily accessible? Where do you hold on for stability?
- Does the bathroom have adequate water pressure and temperature control? Is there heating? Are there hand rails for support if needed? Does the floor or base get slippery? Are you interested in improving safety in the bathroom?
- Do you need help getting dressed? What about zips, buttons, reaching shoes and tying shoe laces?
- How do you look after your skin, nails and feet? Do you ever see a podiatrist?

Observations

- Has the shower been used recently?
- How does the person look – is their personal and clothing appearance neat or untidy? Does their appearance validate what they have told you? Remember not to be judgemental.
- Is the person wearing appropriate footwear?
- Are they holding on to furniture for support?
- Are there odours that indicate difficulties with continence or personal care?
- Ask the person to demonstrate how they perform a task.

Strategies

Consider the underlying issue – is it physical frailty, strength or endurance related? Contact an occupational therapist for ideas on simple solutions and to determine the need for a referral. Interventions you can discuss with the OT include:

- The range of adaptive technology available (such as pick-up sticks), ways of assessing suitability and assessment/education required.
- Home safety modifications.
- See Section 12: Service specific assessment.

Resources

- HACC Personal Care Policy
(See *HACC program manual* and amendments/updates)
 - Modified Barthel Activities of Daily Living Index (BI) at <http://www.health.vic.gov.au/older/toolkit/04Mobility/index.htm>
 - *Best care for older people everywhere: The toolkit*, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>
-

10.3 Mobility

Introduction	<p>Mobility inside and outside the home is essential for daily and independent living. Consider:</p> <ul style="list-style-type: none">• walking, steps and stair climbing• chair, bed, toilet and shower transfers• falls• mobility aids or wheelchair• other aids and equipment• access to community resources.
---------------------	--

Positive questions	<p>Ask the person about their mobility around the house, garden and community. Be aware that the person may be embarrassed to disclose their limitations and may minimise the challenges.</p> <ul style="list-style-type: none">• Where do you walk to? How far can you walk? (50m or 200m) For how long can you walk? (10 or 20 minutes) How often do you walk?• How do you get about best – walk, use stick, walker, wheelchair (manual, electric) or other aid?• How confident are you getting around – is there anything that slows you down or bothers you?• Have you had any falls? What happened? Why do you think you fell? How did you manage to get up? Did you need help? What helped you most?• Do other health matters, such as breathing, strength, arthritis or medication affect your mobility? If so, how?• Do you limit activity for fear of falling? <p>(See Section 10.7: Transport options, 10.4 Falls Prevention)</p>
---------------------------	---

Observations	<p>The best way to assess mobility and aids is to observe how the person moves. Ask them to show you around and observe their mobility and signs of pain or difficulty:</p> <ul style="list-style-type: none">• in and out of the front and back doors• into the bathroom and toilet• into the bedroom – sit on the bed and stand up• into the kitchen and laundry• sitting and standing from their favourite chair. <p>Visually check the condition of equipment: wheelchair seat, tyres, brakes and cleanliness; walking frame wheels and sturdiness; walking stick height and tips; other aids. Is the equipment suitable and safe for the person? Where appropriate, refer for further advice or repair.</p>
---------------------	--

Strategies

Refer to physiotherapist for mobility assessment and/or an exercise program to improve strength, balance and mobility.

- Organise family members, carers or friends to provide transport.
- Access programs are provided within and around the home for people who have poor mobility or are isolated.

Resources

Best care for older people everywhere: The toolkit, Department of Health 2010
<http://www.health.vic.gov.au/older/toolkit>

Case snapshot²¹

George is 85 and has always been proud of his motor cars and mechanical skills in fixing them. He regularly drives his wife to the shops for their supplies. George was concerned about his deteriorating mobility, caused by arthritis and knee problems. He had trouble moving his leg between the accelerator and brake pedals and getting in and out of the car easily.

An occupational therapist organised a disabled parking sticker and a swivel seat in his car, enabling him to get in and out safely. A physiotherapist designed a set of knee/leg stretches and exercises to do before he went driving. These increased his flexibility and he no longer worries about moving his leg quickly between pedals. George also visited the Independent Living Centre to look at and test drive different types of scooters, in readiness for the time when he was no longer driving.

21 Fictitious case study

10.4 Falls prevention

Introduction	In Australia, falls and related injuries have been highlighted as a major public health issue. Age-specific rates of fall related injury incidents increase exponentially from the age of 75 years. ²² Many factors can contribute to a fall, either individually or in combination. Physical activity has been shown to reduce the number of falls by improving balance, flexibility, coordination and reaction time.
Fear of falling	Fear of falling is a major risk factor for falls in older people. Falls cause decreased confidence. Fear of falling is prevalent in between one third and one half of older people and contributes to decreased activity and mobility. It is important to assess for falls risk and address falls issues promptly.
Risks	Environmental, health and behavioral factors may also contribute to a high fall risk. Common examples are medication side effects, poor balance or strength, musculoskeletal disorders, obesity and arthritis which decrease agility, sore feet and inappropriate footwear, neurological disorders, hypotension, vision impairment and night-time falls due to incontinence and the need to toilet frequently.
Positive questions	<ul style="list-style-type: none">• Have you had any falls in the past six months?• Are you concerned about falling at home, in the garden or in the community?• If you had a fall and could get to the phone, how do you think you could get help?
Observations	Many falls occur in the home environment and are preventable. Assessors should note risk factors such as: <ul style="list-style-type: none">• vision impairment• poor lighting, particularly on stairs or in bathrooms• steep stairs, loose or worn carpets or rugs, slippery floors• badly fitting footwear or clothing• irregular walking surfaces• lack of safety equipment such as grab rails• position of power points and cords, shower heads and shelves• depression• more than four medications• restricted activities.

22 Victorian Injury Surveillance Unit (VISU) 2010. Data based on all fall-related hospital admissions in Victoria in 2008

Strategies

Strategies can relate to health, environmental modifications or a combination of both. Refer to an OT to assess for education, equipment and home modification to reduce falls risk; or a specialist multidisciplinary falls service (falls and mobility clinic) for people deemed to be at a high risk of falls.

Ideally, falls prevention strategies for individuals should contain more than one intervention, for example:

- diagnosis and treatment of underlying medical problems, such as medication reviews by a GP or pharmacist, or eye examinations to identify visual impairment
- physical activity programs or physiotherapy to improve confidence in mobility
- referral to a physiotherapist to teach techniques to get up after falling
- teaching awareness of hazards and how to avoid them
- removing, replacing or modifying any hazards in and around the home
- equipment, repairs and improvements
- refer to continence nurse for continence management.

Resources

- Refer to a falls and balance clinic.
 - For falls screening tools see *Best care for older people everywhere: The toolkit*, Department of Health 2010. <http://www.health.vic.gov.au/older/toolkit>
 - Victorian Falls Prevention website, <http://www.health.vic.gov.au/agedcare/maintaining/falls/index.htm>
-

10.5 Physical activity

Introduction

Physical activity has many positive health benefits. Medical evidence suggests that much physical decline is not the inevitable result of ageing, but of long term sedentary living. Such physical decline can be halted and even reversed by regularly exercising.²³ Regular physical activity can:

- improve fitness and balance
- have a positive impact on health concerns such as osteoarthritis, diabetes, weight management, blood pressure
- lift mood, confidence and self-esteem
- help deal with negative feelings and bring a sense of wellbeing
- improve sleep, which can improve emotional wellbeing
- reduce tension levels and feelings of stress or fatigue
- increase energy
- foster supportive relationships and friendships.

Positive questions

- See questions on SCTT Health Behaviours profile.
- What physical activity do you do most and how much do you do each day (walking, gardening, housework)?
- What type of physical activity do you most enjoy?
- What is stopping you from doing it?
- Have you ever thought about joining a strength training group or chair-based exercise group for older adults like yourself?
- Have you talked to a physiotherapist recently about what type of physical activity might be best for you?
- What do you think would motivate you to increase your level of physical activity?

Strategies

If the person does not have a usual exercise routine, refer to the GP or a physiotherapist to discuss particular health concerns and get expert advice on strategies for increasing physical activity and starting an exercise program. These would include

- Consider the exercise people get in completing activities they like and need to do.
- A pedometer is a fun way to keep track of the distance you are walking.
- Exercise and going to the gym does not need to be expensive, for example, cans of soup are a great hand weight to improve strength and muscle tone.
- Park further away or take the stairs if possible.
- Perform seated exercises.
- See the Go For Your Life website.
- Exercise to Channel 31 on weekdays from 8.30am.

²³ Victorian Department of Health, *Well for Life: Improving emotional wellbeing for older people at home*, Department of Health, Melbourne, p. 20.

Resources

- *Well for Life* publications available at <http://www.health.vic.gov.au/agedcare/publications/wellforlife.htm>
 - *Integrated health promotion resource kit* at http://www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm
 - Commonwealth of Australia and the Repatriation Commission 2005, *Choose Health: be active, a physical activity guide for older Australians*, Canberra.
 - Making A Move projects <http://www.dhs.vic.gov.au/health/agedcare/maintaining/falls/index.htm>
 - SCTT 2009 Profile: Health Behaviours http://health.vic.gov.au/pcps/downloads/coordination/sctt2009/health_behaviours_lo_3a.pdf
 - Kinect Australia Active Living for Healthier Communities, incorporating Vicfit <http://www.vicfit.com.au/content/Public/Homepage.aspx>
 - *Physical activity recommendations for older Australians* [http://www.health.gov.au/internet/main/Publishing.nsf/Content/85D45F1F05013209CA257585001C4679/\\$File/c.pdf](http://www.health.gov.au/internet/main/Publishing.nsf/Content/85D45F1F05013209CA257585001C4679/$File/c.pdf)
-

10.6 Emergency planning and home fire safety

Personal emergency plan

HACC assessment services are requested to prompt people to develop a personal emergency plan for extreme weather events, bushfires or an emergency. People need to be encouraged to develop their plans, where possible, in partnership with family members, carers, friends or neighbours who may need to provide support during an emergency.

A small number of people in high-risk areas who are socially isolated, have a cognitive impairment, are not receiving assistance from other services and have no family, carers, friends or neighbours, may need assistance from you to develop their personal emergency plan.

See Department of Health *Frequently asked questions for Home and Community Care (HACC) Community Service Organisations (CSOs) and summer planning* http://www.health.vic.gov.au/hacc/downloads/pdf/hacc_faqs.pdf

Home fire safety

Older people are one of the highest residential fire fatality and injury risk groups living in the community. People with a disability also experience increased risk in relation to fires in the home. It is vital that individuals who receive support to live in the community have access to basic home fire safety information and strategies.

Most residential fires are caused by unattended cooking, or associated with smoking and alcohol or drug use. Many fatalities occur when residents are unable to deal with the resulting fire.

Hoarding-related residential fires present a significant fire risk in the homes of people aged over 50 years. Seventy per cent of these fires are caused by cooking, heating or open flame. Hoarding is a complex issue and the idea of a clean-up may be very stressful for a person.

Strategies

Summer planning

- Prompt people to develop their personal emergency plan.
- Consider helping people who cannot develop their own plan, by assisting them to use the *CFA Fire Ready Kit* or the *Emergency REDiPlan: Household preparedness for seniors* (see link in Resources below).
- The purpose of helping someone to develop their plan is to link them into neighbours, friends, family or church groups who may be able to provide assistance in an emergency.

Home fire risk

- Reduce the risk of a fire occurring. This includes *smoke alarms* to provide early warning of a fire, and a *home escape plan* for safe evacuation.
- See 'Resources' for smoke alarms for people who are deaf or hard of hearing. There are also smoke alarms linked to personal alarms, which send a signal to the control base of the personal alarm provider if the smoke alarm is activated.

Hoarding

- Where there is a high level of hoarding, install smoke alarms and reduce the clutter in functional areas related to cooking and heating.

Chronic smokers

- For a chronic smoker with signs of small burns on an arm chair in the lounge and the bedside table, ensure there is a smoke alarm in both rooms and promote the use of heavy, high sided ashtrays.

Resources

- *Frequently asked questions for Home and Community Care (HACC) Community Service Organisations (CSOs) and summer planning* http://www.health.vic.gov.au/hacc/downloads/pdf/hacc_faqs.pdf
 - Environmental Health, Public Health Branch *Heatwave - Important information for summer* <http://www.health.vic.gov.au/environment/heatwave>
 - Better Health Channel, Preventing heat stress http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Heat_stress_preventing_heat_stroke
 - Australian Red Cross – Emergency RediPlan – Easy English <http://www.redcross.org.au>
 - *Fire Ready Kit* <http://www.cfa.vic.gov.au>
 - home fire safety training materials <http://www.mfb.vic.gov.au/Community-Safety.html>
 - hoarding <http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Hoarding-a-lethal-fire-risk.html>
 - *Hoarding – Don't Hide It Away* presentation http://www.flinders.edu.au/science_engineering/environment/fihure/presentations.cfm
 - hoarding clinic http://www.swinburne.edu.au/lss/psychology/pc/group_treatment_for_compulsive_hoarding.html
 - *Squalor and hoarding toolkit* <http://www.catholiccommunityservices.com.au/squalorandhoarding/>
 - Vicdeaf – *information and application for the smoke alarm subsidy for deaf and hard of hearing* <http://www.vicdeaf.com.au/smoke-alarm-subsidy>
 - Word of Mouth – *information and contact details of the distributor of smoke alarms for deaf and hard of hearing* http://www.wom.com.au/product_details.php?id=88
-

10.7 Transport options

Introduction

Regardless of age, most people rely on their car as their main mode of transport. However, the decision to give up the keys does not mean a person's lifestyle has to change. While a person may feel they are losing their freedom, it is important to reinforce that stopping driving does not mean a person has to stop enjoying life. Using alternative transport is usually cheaper than owning and running a car and simply requires a bit more time and planning.

Positive questions and observations

- How do you get about in the community: drive, use a scooter, with family, carer or friends, use public transport or a community bus? What do you prefer? Does this work well? How often do you go out?
 - Do you use the local library, community centre, attend a club or group or volunteer anywhere?
 - Are there places you would like to go that you can't get to? What is stopping you?
-

Strategies

- Walking, for those who are able.
 - Travelling with friends, family, carer or neighbours by car may be an option. If the person is reluctant to become dependent on others, suggest an exchange of services (such as child minding, home-made goods) to help the person pay their way.
 - Public transport. If a person is unfamiliar with using public transport, access information online with them or encourage them to ask a friend, carer or family member to show them how it works. A range of discounts are available, including Seniors Card, Health Care Card and Companion Card for carers.
 - Carrying a mobile phone while out and about may help a person feel more confident about travelling without their car.
 - Some people may be eligible for the Multi-Purpose Taxi subsidy scheme, which provides a discount on fares.
 - Refer to an OT for a suitability assessment for a motorised scooter. These are an effective way to get around the local community; ensure the scooter is insured and that the person has an emergency back-up plan.
 - Home delivery is provided by online shopping services and some retailers, such as supermarkets, greengrocers and pharmacies.
 - Courtesy vehicles or subsidised transport may be provided by some recreational venues and programs.
 - Community transport is available through some local councils and Aboriginal organisations.
 - Transport subsidies may be available for rural and regional Victorians to access medical or dental specialists.
 - Refer to an occupational therapist for a driver assessment.
 - Refer for vision assessment.
 - The Australian Red Cross Patient Transport service provides assistance for people who are isolated and have limited transport options to attend essential medical appointments.
-

Resources

- *Getting around if you no longer drive* pamphlet by the RACV
 - Driving assessments should be conducted by an occupational therapist qualified to assess driving ability. See website to locate nearest driving assessor. <http://www.parkinsonsvic.org.au/help-finder/driving-transport/documents/DrivingAssessments.pdf>
 - Vision Australia and some local councils offer confidence training in the use of public transport <http://www.visionaustralia.org.au/>
 - Australian Red Cross Patient Transport: for more information email viccommunityprograms@redcross.org.au or call 1800 246850
-

11 Diversity in practice

11.1 Diversity planning in the HACC program

Diversity planning

Diversity planning in the HACC program seeks to ensure that all service providers:

- understand the diversity of people within their catchment, including those who are marginalised and/or disadvantaged
- consider the implications of this diversity on service delivery
- ensure that suitable responses are framed.

For HACC assessment services, this means that assessments need to be responsive to diversity, in order for suitable care plans and service responses to be provided.

Assessment and care planning for people with diverse needs may take more time due to the complex nature of a person's disability, cultural issues, communication issues, or broader family and social issues. There may be additional people involved in the assessment and care planning process (support workers and interpreters) and a number of organisations involved in care planning and coordination. Each HACC assessment service will develop their own responses to meeting the challenge of diversity. Consider the following approaches:

- Employ assessors with specific skills and knowledge relevant to the diverse groups in the catchment population (such as bilingual assessors, Aboriginal assessors).
- Building partnerships: Consider which organisations have relevant skills and knowledge and how they can be engaged to assist with the assessment and care planning process for specific groups of people. Some ethno-specific, multicultural and Aboriginal organisations have HACC-funded support workers who may be available to attend assessments to support people from their communities through this process.
- There are other innovative mechanisms for providing skilled assessment for specific groups of people. Some councils have brokered out their assessments of younger people with a disability to local disability services. There are examples of similar mechanisms being utilised for people from CALD backgrounds.

The first stage in supporting diversity planning will be the development of a *Guide to diversity planning* with input from key stakeholders including agencies, regions and current access projects.

The timing for agency Diversity Plans is June 30 2011.

11.2 Strengthening practice: Aboriginal people

Definitions	<p>For the purposes of this document 'Aboriginal' refers to people who identify as Aboriginal, Torres Strait Islander or as both Aboriginal and Torres Strait Islander.</p> <p>Aboriginal organisations are Aboriginal controlled organisations or Aboriginal community controlled health organisations that receive HACC funding to provide services to the Aboriginal community.</p>
Cultural awareness²⁴	<p>Cultural awareness means understanding cultural difference, cultural diversity and that cultural difference may necessitate a different approach to people of that other culture.</p> <p>Aboriginal people are often, but not always, linked in with their local Aboriginal community controlled organisation (ACCO).</p> <p>All staff, including management, should be provided with Aboriginal cultural awareness professional development. Some Aboriginal organisations can provide cultural awareness professional development.</p>
Cultural respect	<p>Cultural respect is attitudes and values that accept and promote the uniqueness, diversity and strengths of other cultures. HACC assessors should work with Aboriginal Liaison Officers (where available) to support the assessment process.</p>
Cultural safety	<p>Cultural safety is providing an environment which is welcoming and respectful of the other person's culture.</p>
Cultural abuse	<p>Cultural abuse is the actions and attitudes that ignore, denigrate or intentionally attack the culture of a person or community.</p>
Self-determination	<p>Self-determination is a key principle developing service responses and care plans with Aboriginal people. It is foundational for better outcomes for Aboriginal people, families and communities.</p>

²⁴ Victorian Government Department of Human Services 2008, *Aboriginal Cultural Competence Framework*, Department of Human Services, Melbourne.

Cultural considerations

Keep in mind the following cultural issues.

Aboriginal identity

- Aboriginality cannot be judged by skin colour.
- The majority of Aboriginal people identify as such because it shows their connection to family, community and country.
- Many Aboriginal people have experienced discrimination and segregation, due to the past Stolen Generation policies. This impacts on their perception of non-Aboriginal service providers. Many continue to experience discrimination. Some people will choose not to identify as Aboriginal to service providers until they gain their trust.
- Significant grief and loss is experienced in Aboriginal communities in Victoria. Attending funerals and the mourning period is considered a high priority for all community members.

Family and community

- Aboriginal people are considered 'aged' from the age of 50 compared to age 70 for non-Aboriginal people. There is therefore no question about an Aboriginal person being assessed by an ACAS and being considered for Commonwealth funded aged care services from the age of 50.
- Elders are highly respected in the Aboriginal community.
- Not all older Aboriginal people are Elders. Many older Aboriginal people are referred to as Aunty or Uncle by the Aboriginal community. It is protocol to ask the person what they prefer to be called.
- Older Aboriginal people often have a range of community and family responsibilities and are often the main carers for their grandchildren and relatives children/grandchildren.
- Aboriginal families are often extended and complex and the 'person responsible' can change regularly.
- Aboriginal people may prefer to take time to discuss issues with others before making decisions, which needs to be considered in the development of care plans.
- Connection to family, community, land and place is important to the spiritual and emotional wellbeing of Aboriginal people.

Service providers

- The development of a trust relationship between an Aboriginal person, their support person(s) and the assessment service or service provider is critical.
 - Assessment processes and questioning can be seen as intrusive and culturally inappropriate. Ensure the questions asked are relevant and required for the provision of the particular services about which the person is seeking information.
 - Often the support person can assist with how and when to ask questions.
 - When referring an Aboriginal person to another service, it is important to follow up to ensure the service has contacted them and discussed service delivery.
-

Assessment practice**Aboriginal identity**

- All people should be asked if they are of Aboriginal or Torres Strait Islander descent or identify as such. Culturally appropriate practice is critical and there are extra support and services available.
- Explain to the person why the Aboriginal identity question is asked (so appropriate services and supports can be arranged).
- Be mindful of the diversity within and across Aboriginal communities, as each is unique.

Working with Aboriginal organisations

- Develop effective alliances and agreements with local Aboriginal organisations which may have staff available for joint assessments and care planning, to facilitate the process of engagement and understanding.
- Make sure that at a minimum, initial visits are undertaken as a joint visit with a local, available Aboriginal worker to ensure the introduction of the assessment worker is culturally appropriate (Aboriginal Health Education Officer, Aboriginal HACC worker, Aboriginal Health Worker, Aboriginal Liaison Officer, other local Aboriginal worker who is available and appropriate).
- Be aware of the competing demands of the Aboriginal community on Aboriginal workers.
- Maintain regular visits to the Aboriginal organisation to become familiar with the local Aboriginal culture and to build trust.

Assessment preparation

- Prior to the assessment, learn about local Aboriginal culture and history, as each Aboriginal community in Victoria is unique.
 - Plan to take multiple visits to build rapport and allow a longer time to do the assessment.
 - Ensure the assessment occurs in a culturally appropriate manner and is attended by people who are acceptable to both the person and their community. This includes awareness that an Aboriginal person may only feel comfortable meeting with a worker of the same sex (men's business and women's business).
 - Take into account the Aboriginal organisation's capacity and time to support the assessment process, ensure a mutually convenient time with an Aboriginal worker and allow flexibility for significant events (such as funerals).
 - Check if the person is comfortable with an assessment occurring in their home, and if not, offer an alternative safe location such as the Aboriginal Health Service or an Aboriginal community controlled organisation. Aspects of assessing the home environment can be followed up once trust is established.
-

Assessment visits

- Value the role of the Aboriginal staff member, who may be the most appropriate person to arrange the visit, explain the process and help with asking questions.
- Avoid use of jargon and gain feedback from the person to check they understand what is being asked or explained.
- Be sensitive to the numerous and complex family groups with a variety of opinions.
- Ensure that if the person becomes uncomfortable with the assessor, that there are procedures for another assessor to complete the process.
- Promote awareness of health and wellbeing issues and services within local Aboriginal communities, and act as a resource to communities by providing advice and information.

Key messages

- Cultural competence needs to be built over time, not overnight.
- Cultural competence relies on respectful partnerships with Aboriginal organisations.
- Cultural competence requires a whole-of-agency approach and strong and committed leadership at all levels.
- Cultural competence requires personal and organisational reflection.
- Aboriginal people should be offered the choice of having an Aboriginal staff member present during the assessment.
- Ensure a two way feedback process with HACC assessors and Aboriginal staff/community members.
- Cultural competence is a continual journey.

Resources

- Aboriginal community controlled organisations and Aboriginal community controlled health organisations <http://www.vaccho.com.au/>
 - Aboriginal staff in generic organisations, such as Hospital Aboriginal Liaison Officers, or HACC Aboriginal Liaison Officers.
 - HACC Coordinators or other program staff at Aboriginal organisations.
 - Aboriginal Health Workers and Stolen Generation staff located in local Aboriginal Health Services
 - <http://www.aihw.gov.au/indigenous/health/index.cfm>
 - Guidelines for delivery of culturally sensitive and flexible counselling for Indigenous carers <http://www.carersaustralia.com.au>
 - Making Two Worlds Meet? Aboriginal cultural competency http://www.whealth.com.au/ourwork/mtww/mtww_healthpromotion_aboriginal_lens.pdf
 - *Closing the Gap* <http://www.aihw.gov.au/closingthegap/>
 - *Strengthening Home and Community Care (HACC) in Aboriginal communities strategy* <http://www.health.vic.gov.au/hacc/publications/shac.htm>
-

Figure 9: List of HACC-funded Aboriginal organisations

Agency name	Suburb	Phone
Aboriginal Community Elders Services Inc	Brunswick East	03 9383 4244
Aborigines Advancement League Inc	Thornbury	03 94807777
Ballarat & District Aboriginal Cooperative Ltd	Ballarat	03 5331 5344
Bendigo and District Aboriginal Cooperative Ltd	Bendigo	03 5442 4947
Budja Budja Aboriginal Cooperative Ltd	Halls Gap	03 5356 4751
Dandenong and District Aborigines Cooperative Ltd	Dandenong	03 9794 5933
Dhauwurd-Wurrung Elderly and Community Health Services	Portland	03 5521 7535
Eastern Health - Yarra Valley Indigenous Health Team	Healesville	1300 130 381
Gippsland & East Gippsland Aboriginal Cooperative Ltd	Bairnsdale	03 5150 0702
Goolum Goolum Aboriginal Cooperative Ltd	Horsham	03 5382 5033
Gunditjmara Aboriginal Cooperative Ltd	Warrnambool	03 5564 3333
Kirrae Health Service Inc	Wangoom	5567 1270
Lake Tyers Health and Children's Services Association	Lake Tyers	03 5156 5482
Mildura Aboriginal Corporation	Mildura	03 5022 1852
Mullum Mullum Indigenous Gathering Place	Croydon	03 9725 2166
Mungabareena Aboriginal Corporation	Wodonga	02 6024 7599
Murray Valley Aboriginal Cooperative Ltd	Robinvale	03 5026 3353
Ngwala Willumbong Cooperative Ltd	Windsor	03 9510 3233
Njernda Aboriginal Corporation	Echuca	03 5482 3075
Ramahyuck District Aboriginal Corporation	Sale	03 5143 1644
Rumbalara Aboriginal Cooperative Ltd	Mooroopna	03 5825 2111
Swan Hill Aboriginal Health Service	Swan Hill	03 5032 5277
Victorian Aboriginal Health Service Cooperative Limited	Fitzroy	03 9419 3000
Wathaurong Aboriginal Cooperative Ltd	Geelong North	03 5277 0044
Western Suburbs Indigenous Gathering Place Inc	Maribyrnong	03 9318 7855
Winda Mara Aboriginal Corporation	Heywood	03 5527 2051

Case snapshot²⁵

A 55-year-old Aboriginal woman presented seeking help. She had diabetes, heart disease, asthma and a few other medical conditions. She didn't get out socially and had many issues within her family. She lived in a three-bedroom public housing home and was on a disability pension. She was looking after her four grandchildren because her son and his partner had split up.

The son had drug and alcohol issues and had also been diagnosed with depression and schizophrenia. The oldest grandchild was a boy of 17 years who had been caught riding in stolen cars and breaking into shops, and was waiting to go to court. Her 16-year-old granddaughter had just found out she was three months pregnant to her 18-year-old boyfriend. The other granddaughter, aged 14, was doing very well in school academically and excelling at basketball. She had been selected in the Victorian under 16's team to compete in Darwin, but the grandmother could not afford the \$1000 to send her. Her eight-year-old grandson had Attention Deficit Hyperactivity Disorder (ADHD) and she was looking for help for him. She did not have enough food to feed them all because the family allowance for the children was not set up to be paid to the grandmother.

The woman seeking help was more concerned about her family than her own health, so the HACC assessor sat down with her in a private room and spent the first half hour listening. She put the names of each family member on the whiteboard and wrote the concerns about each one under their names. Then she put the name of the woman and invited her to talk about her own needs, which were also listed. Then she drew a circle around all the names and asked about the main things that would help the whole family work better. A list of what each person needed was written under each name and all of this was put into a proposed action plan to be discussed with the family members.

The Aboriginal maternal health worker and the Aboriginal youth justice worker were introduced to the woman over a cuppa. She was provided with shopping vouchers from an agency that provided material aid and a home care staff member helped her with shopping for the family, giving advice on cheap healthy meal options. An appointment was made with the Centrelink officer to meet with the woman at the health service in two days time.

Over time, a coordinated plan was developed to support the whole family. It involved:

- an Aboriginal health worker, who conducted health checks for the whole family and started to visit regularly to keep a check on the woman's condition
- a community health service occupational therapist, who worked with the eight-year-old and his teachers
- an Aboriginal youth justice worker, who was able to link the 17-year-old into an environmental redevelopment project replanting an area of traditional land
- Centrelink outreach service sorting out the family allowance payments
- the local sports assembly accessing funds for the 14-year-old to go to Darwin
- a Koori drug and alcohol worker who commenced contact with the son, linking him into a range of mental health supports, GP, counselling, Aboriginal men's group and employment program
- a Koori maternity worker who supported the pregnant 16-year-old, introducing her to a group of young mums who met weekly.

After a year, when the family was more settled, the woman was ready to join the healthy living program at the local Aboriginal organisation, run by the Aboriginal Health Promotion and Chronic Care worker.

25 Fictitious case study

11.3 Strengthening practice: people from culturally and linguistically diverse backgrounds

Introduction

Cultural and linguistic diversity (CALD) refers to a wide range of cultural and linguistic groups that make up the Victorian population. This can include new arrivals, refugees, first-generation immigrants and members of subsequent generations.

The term acknowledges that groups and individuals have different ethnicity, racial background, language, customs, religion and spirituality. Cultural diversity in Victoria's population is a reality that will persist into the coming decades.²⁶

Concepts of health and wellbeing

The frameworks for health and wellness commonly used within Australia are predominantly based on the traditional Western and European concepts of health. However, the cultural values underpinning concepts of health and illness vary widely across the different cultural groups within Australia.

Although it is important to note that not all individuals within a cultural group will share the same views of health, it can be useful to make some generalisations based on the traditional views held by that group. Evidence now points to the importance of cultural sensitivity and knowledge of the participant's cultural values in developing and implementing health interventions. It is important to develop an understanding of the beliefs and concepts held by these different groups.²⁷

For example, social isolation and loneliness in old age are linked to a decline in both physical and mental wellbeing and in many societies, men are less likely than women to have supportive social networks.²⁸

In many cultures, older members of the community carry out an important and active role within their families, such as providing childcare. This needs to be considered in discussions around goal setting and care planning. Similarly, the role of adult carers may include supporting children as well as older and/or disabled family members. Dependency and inter-dependency is often a common way of thinking about family and carer relationships within CALD communities.

There may be multiple competing emotions for both the carer and care recipient such as feelings of guilt and abandonment or not fulfilling a 'duty' or 'role'. There may be gender differences regarding expectations of carer roles and expectations within a particular culture. For example, it may be acceptable or expected that females provide care.

Many older people from CALD backgrounds stay at home longer than the general population and may only contact services when they reach a crisis. Some have difficulty trusting people from government-run services or authorities, as a result of their history or past experiences. They may find the questions involved in assessment invasive or threatening. In some CALD groups there is shame and stigma associated with dementia, cognitive issues or disability.

26 Ethnic Communities' Council of Victoria 2010, *ECCV Response to the HACC Program Service Coordination Guide of the Department of Health*, ECCV, Melbourne.

27 <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing>

28 World Health Organisation 2002, *Active Ageing: A Policy Framework*, World Health Organisation, Geneva, p. 28.

Communication Many older people from CALD backgrounds have limited English language competence. People may speak English but may not be literate in English, or in their native language. It is critical to check literacy before assessment and before the person is asked to sign documents.

Staff from ethnic or multicultural organisations with specialist expertise may be able to provide resources, training and advice on a range of topics, including cultural competency.

Prior to the visit:

- access available existing translated information (SCTT consent form, HACC brochure, *HACC User Rights and Responsibilities*, *HACC Client Handbook* (prepared by selected local governments and Migrant Resource Centres)
- provide access to professional interpreters and translated information through a language service provider for people who speak a language other than English.

Language services policy

For people with a preferred language other than English, access to interpreters may be required. An interpreter accurately and objectively converts oral speech from one language into another language. Interpreting services can be provided face-to-face, via telephone, by video or internet conferencing, where the interpreter can be located anywhere in the world. For information about working with interpreters see the facts sheets below.

A translator converts written or recorded material from one language into another, while retaining the sense and content of the original text. Translations should only be done by a language service provider.

For information about when use of an interpreter is required see the Language Services Policy at

<http://www.dhs.vic.gov.au/multicultural/html/langservpolicy.htm>

Check understanding

Some cultural groups may not have the same words in their native language to exactly describe a health or some other issue. This may impact on their understanding of what is communicated to them. Therefore, communication with a person whose understanding might be compromised by language barriers needs to include a more detailed explanation of the issue, such as detailing symptoms or how it may impact on activities of daily living.

Some people may be embarrassed to admit that they do not understand, or cannot read or write in their own language, let alone in English, and may seem to respond to what is being communicated with understanding (such as nodding their head in agreement), when in fact they have not comprehended the message. It may be valuable to ask the person to relay the information back, to confirm that they have understood. It is also important to give permission for the person to stop you if they do not understand. Providing translated material to the person and/or their family is good practice, but this may not be sufficient to communicate the information effectively.

Family members Family members, particularly those who are proficient in English, are often a support to people of CALD backgrounds who do not speak English, in assisting them to navigate the service system, connecting them to other members of the community and helping them with communication on a day-to-day basis.

Assessors should consider the impact of this and should ensure they confirm the message relayed by a family member with the actual person through an interpreter or bi-lingual worker, where available. This ensures that the person's concerns or wishes are not misrepresented by another family member.

Carers The word 'carers' is not used in some CALD communities in the same way that it is understood in the mainstream. This means that assessors will need to be mindful about discussing the caring relationship or carer allowances/pensions in a way that is culturally understood.

Cultural awareness Cultural awareness training is important to improve assessors' cultural sensitivity to people from CALD backgrounds. A culturally appropriate service response can be enhanced by understanding the impact of a person's cultural background on their service needs.

Assessors need to understand their own values and beliefs, as this can influence their approach to an assessment. It is important not to make assumptions and encourage the person to inform the conversation regarding their culture and values.

Contributions from ethno-specific and multicultural agencies add value to the response of generic agencies to people from CALD backgrounds. Staff from ethno-specific or multicultural (ethnic) organisations often have well-established, trusted relationships with the service user. Where available and appropriate, it may be beneficial for them to be present at assessment.

HACC assessment services need to develop partnerships with ethnic organisations to identify practice and processes for supporting people through the assessment and care planning process.

Intake The following considerations should be incorporated into the assessment and care planning processes:

- At intake, find out the person's preferred language, the language they use at home and their proficiency in English.
 - The year of arrival in Australia is useful information, given that various measures of relative disadvantage tend to decrease over time in the host country.
 - Find out the person's CALD background: do some background reading on cultural beliefs and traditions prior to your visit.
-

Assessment

- Ask about the person's history of social and economic participation in Australia, as evidenced by work history, friendship networks and general capacity to negotiate life tasks.
- Find out the person's degree of self-identification with the original culture and level of adherence to its beliefs, mores and customs.
- Be aware and take into account the person's previous experiences which may have impacted on physical, social and emotional health such as imprisonment, war, trauma, living as a refugee, loss and separation.
- The factors identified above may influence the person's perception of the HACC assessor and building trust.
- Consider using a family-centred approach, such as taking time to communicate and build a rapport with the person, their family and/or carers.

Care planning

- Respect each person's CALD background and support their cultural practices (including dietary habits, traditions, beliefs, cultural conceptions of leisure, status, social and gender roles and decision making).
- While it is very important to understand about cultural beliefs and practices of a particular community, do not assume that they apply to every person. Ask the person what is important to them.
- Arrange translation of information and care plans where appropriate, undertaking secondary consultation to seek advice, input or collaboration with ethnic welfare and community-based organisations on culturally responsive issues.
- Some people may be suspicious of documentation and may be hesitant to complete and sign paperwork. This should not be interpreted as the client being difficult or resistant to service, but instead should be understood in the context of that person's experience in their native country or during their migration.

Goal setting

- The concepts of goal setting and care planning may not be understood. It isn't enough to have an interpreter interpret 'the words', as the meaning may not be communicated accurately or understood by the client.
- It is important to also understand how ageing is perceived in a particular CALD community, as some communities see ageing as an opportunity to have others care for older people. This may be viewed as a positive stage in their lives.

Positive questions

- Before I come to see you, I would like to know if there is someone you would like to be present at the assessment, perhaps the referrer, a family member, carer, friend or someone from an ethnic organisation, if available.
 - I don't know a lot about your culture. Can you tell me, what are the most important aspects of being (name of cultural or ethnic group) to you?
 - Are there special traditions you would like to observe or groups you would like to join that you haven't been able to be a part of lately?
-

Resources

- HACC user rights and responsibilities available in 20 languages
<http://www.health.vic.gov.au/hacc/language.htm>
- Cultural profiles contain information relating to migration, language, religion, attitudes to health and ageing, key greetings and celebrations. To assist in providing culturally sensitive care and effective communication
<http://www.miceastmelb.com.au/documents/mep/H&PCarekit.pdf> and
<http://www.sermrc.org.au/index.php?page=publications3>
- Centre for Ethnicity and Health fact sheets including:
 - Culturally inclusive health assessment
http://www.ceh.org.au/downloads/cult_inc_health_assess.pdf
 - Cultural competence: Professional Learning Calendar
http://www.ceh.org.au/downloads/CEH_Calendar_FINAL.pdf
 - Communication with clients with low English proficiency
http://www.ceh.org.au/downloads/comm_clients_low_english.pdf
 - Assessing the need for an interpreter http://www.ceh.org.au/downloads/CEH_TipSheet2_Assessing_need_for_interpreter.pdf
 - Arranging an interpreter http://www.ceh.org.au/downloads/CEH_TipSheet3_Arranging_an_interpreter.pdf
 - Working with interpreters http://www.ceh.org.au/downloads/CEH_TipSheet4_Working_with_interpreters.pdf
- *ECCV Multicultural Aged Care Directory 2009*. Order forms accessible at
<http://www.eccv.org.au/aged-care/aged-care-resources/>
- www.health.vic.gov.au/hacc/publications/cald_hacc_services.htm
- Service seeker for ethno-specific agencies <http://www.serviceseeker.com.au/>
- Centre for Cultural Diversity in Ageing <http://www.culturaldiversity.com.au/>
- Using language services
<http://www.dhs.vic.gov.au/multicultural/html/langservpolicy.htm>

Case snapshot²⁹

Mrs G was a 70-year-old Greek lady with limited English who had three daughters and eight grandchildren. Her family had always been the most important thing in her life. She loved to have them all around and cook for them. She had looked after her husband for the past 10 years since he had a stroke and was very proud of the fact that she had managed everything on her own. The family were used to her coping and were busy with their own lives.

Her health was deteriorating, she had fallen over several times in the past month and was starting to have trouble making it to the toilet on time. She hadn't told anyone about it. Her GP was a man and she did not feel comfortable talking to him about such things. She was also experiencing a lot of anxiety about leaving the house and had stopped going out. Her granddaughter was getting married in three months and she was thinking she would not be able to go. The GP noticed the bruising from the falls and talked with Mrs G about having someone come to the home to work out what she might need to help her feel more confident, then made a referral for a Living at Home Assessment. The assessment was conducted in the home with the support of a worker from the Greek organisation.

²⁹ Fictitious case study

Assessment Summary

Presenting issue Bruises prompted concerns by GP about general coping at home.

Revealed in conversation An interpreter and a support worker from a multicultural organisation attended the assessment visit. The main concern for Mrs G was attending her granddaughter's wedding. Mrs G preferred to speak in Greek to the HACC worker from the Greek organisation. After some time she told this person about the continence problems, when the other assessor had left the room. Lately she had gone for several days without seeing another person and would not ring her daughters because they already had too much to worry about with work and family. She would not use the walking stick because it made her feel old. One of the daughters came to assist with cleaning when she could, but didn't have time to stop and talk. A Greek neighbour and member of the church Mrs G used to attend occasionally visited and helped with minor tasks.

Observations by the assessor Mrs G struggled to get up from the chair, and nearly lost her balance.
There was a walking stick in the hall but it was not used. Mrs G was highly anxious. She cried when she spoke about her husband.
Urine odour on carpet in bedroom and lounge room.

Goal Main goal developed in conversation: To attend her granddaughter's wedding without having to worry about falling or making it to the toilet.

Short-term strategies

- Greek speaking worker to visit with continence nurse for continence assessment and management plan.
- Physiotherapist to conduct mobility assessment and develop a strengthening program to be carried out at home with the support of a Greek speaking worker.

Long-term strategies

- Provide culturally appropriate support to deal with emotional issues: grief, loss and anxiety.
- Gradually introduce supported shopping outings.
- Strengthen links with Greek social support opportunities; link back into church by arranging transport and addressing continence.
- Review needed for mobility aids, continence aids or handrails when Mrs G becomes more open to these.

11.4 Strengthening practice: people with insecure housing

Introduction

People who are homeless or living in insecure accommodation are a vulnerable and marginalised group who experience particular challenges in accessing services. Insecure accommodation refers to people living in rooming houses, caravans, refuges, pension-level supported accommodation services, low-cost accommodation (includes public housing), crisis accommodation facilities or friends' homes on a temporary basis.

Homeless people and those living in insecure accommodation are diverse and present with a broad range of needs (including pregnancy, drug or alcohol use, medical conditions, mental illness, chronic health problems and family conflict). They may require access to HACC services where there is an assessed need (such as personal care, domestic assistance, nursing or food services).

Considerations

People with multiple or complex needs who are homeless or living in insecure or low-cost accommodation (including public housing) are often very isolated and not well connected into health, housing or community services. These people tend to have difficulty negotiating their way around services and often slip through the gaps in service systems.

Particular sensitivity and expertise is needed to build rapport with a person who is homeless. Assessment is likely to occur over multiple visits as the trust relationship is developed and further information revealed.

Positive questions and observations

- Are you happy living here?
 - Do you find this is affordable for you – do you manage to keep up with the payments?
 - Do you feel safe living here? Have you had experience with the police or legal system?
 - Do you have anyone that will help you find somewhere else to live?
 - Explore what they would like to achieve.
 - Discuss practical ways of how you can help.
 - Elevate their sense of self worth and competency through focussing on achieving simple goals.
-

Strategies

The Department of Health funds the Low Cost Accommodation Support program, for people who lack supports from friends and family, have few links to services and have complex needs. The four main programs are as follows:

- The Community Connections program uses an assertive outreach model to proactively find, engage, assess and link people who are homeless or at risk of homelessness into the services they need. Each service has a pool of flexible care funds to help overcome a pressing need or crisis.
<http://www.health.vic.gov.au/agedcare/services/lowcost/connection.htm>
- The Housing Support for the Aged program provides support for older people to maintain their accommodation and support for people in insecure housing. Support includes low-level monitoring, case management to coordinate access to services and practical assistance, such as helping people get to appointments or linking them to social and recreational activities. For service providers <http://www.health.vic.gov.au/agedcare/services/lowcost/housing.htm>
- The Older Person's High Rise Support program employs funded workers to provide support to people living in older person's high rise public housing, such as linking people to local support services and social activities.
<https://www.health.vic.gov.au/agedcare/services/lowcost/highrise.htm>
- Supporting Accommodation for Vulnerable Victorians: Supporting Connections. This program works with residents of pension-level supported residential services to access a range of services. An additional key focus of Supporting Connections is to build the skills and capacity of supported residential service proprietors and staff to identify resident needs, improve care planning and better manage challenging behaviours.
<https://www.health.vic.gov.au/agedcare/services/lowcost/savvi.htm>

The RDNS Homeless Persons Program (HPP) can assist service providers to think about how to deliver services to people in insecure accommodation. The RDNS HPP provides holistic health care to people who are homeless or at risk of becoming homeless and facilitates access to mainstream services. Service delivery includes primary care (assessment, clinical care), health promotion, referrals and advocacy.

There are a range of community health and housing services, and services provided through non-government organisations. Some local governments provide low cost accommodation for older people, or services specifically for people with insecure housing or those living in supported residential services or boarding houses.

Crisis accommodation through the Transitional Housing Management Program is funded by the National Affordable Housing Agreement. It provides accommodation for up to 12 months (18 months for young people) to people who are homeless or at risk of homelessness. See <http://www.housing.vic.gov.au/homelessness-and-family-violence/homelessness/for-service-providers/housing-establishment-fund>

Refer for risk assessment to the Homelessness Support Program, formerly known as the Supported Accommodation Assistance Program (SAAP). This program is jointly funded by the Victorian and Commonwealth Governments under the National Affordable Housing Agreement. It assists people who are homeless or at risk of becoming homeless to achieve the maximum possible degree of self reliance and independence, by providing crisis and transitional support and a range of related support services. See <http://www.housing.vic.gov.au/homelessness-and-family-violence/homelessness/for-service-providers/housing-establishment-fund>

Local HACC services, such as HACC dementia-specific planned activity groups and cafe style food and support services may be available to support people who are homeless or living in insecure accommodation.

Resources

- Office of Housing <http://www.housing.vic.gov.au/home>
 - Department of Health, Aged Care <https://www.health.vic.gov.au/agedcare/services/lowcost/index.htm>
 - Help for people who are homeless or escaping family violence <http://www.housing.vic.gov.au/homelessness-and-family-violence/getting-help>
 - Residents of public housing requiring advocacy <http://www.housing.vic.gov.au/living-in-housing/support-services/social-housing-advocacy-and-support-program>
 - Aboriginal Housing Board <http://www.ahvic.org.au/>
-

11.5 Strengthening practice: people affected by mental illness

Introduction

Almost half of all Australians will experience mental illness at some time in their lives. About one in five Australian adults will be affected by mental illness each year. With appropriate treatment and support, most people affected by mental illness will recover.

Sometimes mental illness has a serious impact. Serious mental illness often manifests in late teens or early adulthood. Some people seriously affected by mental illness will be linked to the specialist mental health service system. The specialist system consists of the following broad components:

- Specialist clinical mental health services managed by public hospitals provide assessment, diagnosis, treatment, rehabilitation and case management to people with a serious mental illness.
- Psychiatric Disability Rehabilitation and Support Services (PDRSS) are designed to complement clinical services. They provide psychosocial assessment, rehabilitation and support and are managed by non-government organisations in the community.

HACC services can be an important adjunct to the specialist services, with the potential to significantly improve quality of life and support self-management and recovery.

Some people with a serious mental illness need assistance with daily living tasks, primarily due to affected motivation, cognition, organisational skills or judgement. In some cases this may fluctuate over time, so service may need to be provided on an episodic basis.

Many people need basic maintenance and support services because they do not have assistance from friends or family members in the carer role. A carer, if involved, may have carried responsibilities that span decades rather than years.

Lack of connection to the community can lead to social isolation and loneliness, so it is important to identify how they might link with their community through common interests and activities.

Social inclusion is an important dimension of the Victorian Mental Health Reform Strategy. It identifies that all services, including HACC, have a role to play in working with people with mental illness in the community.

See <http://www.health.vic.gov.au/mentalhealth/reformstrategy/index.htm>

Social inclusion is also supported by a Commonwealth Government policy framework and associated resources.

See <http://www.socialinclusion.gov.au/Pages/default.aspx>

Working with mental health services

People affected by mental illness may be linked to a range of health and community services, including community health centres, GPs, private psychiatrists and the public mental health system when referred for a Living at Home Assessment.

HACC assessors need to understand the person's goals and strengths in order to plan HACC service responses that build on existing care plans and support networks. HACC assessment services need to collaborate with mental health services and PDRSS to develop agreements about how relevant service user information is shared, taking into account privacy and consent issues. Useful information for HACC assessors would include:

- health condition and mental state and how it impacts on a person's daily living skills, carers and family and social engagement
- the person's goals and aspirations
- social network, family supports and carer issues
- housing issues
- psychosocial rehabilitation services (PDRSS) involvement, existing links to other community supports and activities including workforce participation
- occupational health and safety issues that HACC service providers should be aware of.

The following are elements of good practice:

- understanding the nature and impact of the person's illness (possible need for episodic support only)
 - understanding motivational issues and how this impacts on the person's life
 - identifying strengths, capacities and possible need for skills development in areas of domestic care and personal care
 - build on existing goals and aspirations (developed with PDRSS)
 - understanding their level of engagement in the community and social and recreational interests
 - considering a carer assessment, as the carer may need a separate assessment for their needs
 - consideration of occupational health and safety issues, such as behaviours of concern or acute episodes.
-

Consider the following issues

- How can this person's situation be improved while still promoting autonomy and independence?
- What biases and prejudices do I hold toward this person or group?
- Am I afraid of this person?
- What are the person's strengths and abilities?
- How does the person's mental illness impact on their ability to maintain their health and wellbeing? Is this ongoing or intermittent?
- How can the person be supported to establish a meaningful, accepted place in the community?
- What services should I collaborate with to support a holistic response for this person?
- What knowledge and skills should I acquire to understand and support this person?

Strategies or actions

- Establish and maintain strong collaborative relationships with health and community service providers, including specialist mental health clinical and PDRSS services.
- Foster a secondary consultation model with other services, to provide HACC services with supportive frameworks to extend practice and deliver services that are consistent and complementary to specialist services.
- Make appropriate timely referrals to specialist services when required.

Work with the person in collaboration with the mental health services to:

- prevent relapse
- help to identify early warning signs and actions to be undertaken (by self and/or services)
- promote recovery
- target rehabilitation interventions.

If the person's condition fluctuates, identify with them, in advance, the mental health circumstances under which HACC will be actively involved and what range of services will be provided.

Resources

- Pathways of recovery 4As framework for preventing further episodes of mental illness. <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-frame>
 - Mental Health Advice Line 1300 280 747
 - Pathways to Social Inclusion Proposition Papers http://vicserv.org.au/pdf/pathways/pathways_full.pdf
 - Better Health Channel http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness?open
 - *Well for Life: Improving emotional well being for older people at home* <http://www.health.vic.gov.au/agedcare/publications/wellforlife.htm>
-

Case snapshot³⁰

An older woman with chronic mental health, alcohol and drug issues chose to sleep outside a church, as she felt it kept her safe. Her behaviour included muttering, shouting at voices she heard, hand wringing and a general mistrust of people. The care plan developed with her included access to the shower and toilet in the church, supply of bedding designed for outdoors, going to the local cafe for lunch with her daughter twice a week and several times with HACC staff or volunteers. After a few months, the plan was reviewed and she felt safe enough to move into a supported accommodation facility. Over the next year, she slowly accepted a range of other supports to improve her health and wellbeing.

³⁰ Fictitious case study

11.6 Strengthening practice: younger people with a disability and their families

Expertise

Given the diverse circumstances of people with disabilities and their families, HACC assessment services need to ensure they have practitioners with expertise and awareness of disability issues and services, or have alternative mechanisms for providing expert assessment and care planning for this group. Some councils contract assessment and/or service delivery to community service organisations that deliver supports and services for people with a disability, or the Children's Services Unit as a method for addressing the needs of this special group.

Local council HACC assessment services should have close working relationships with their Children's Services Unit, including shared professional development opportunities, processes for accessing advice about services and supports for people with a disability, keeping shared resources lists of services and supports for people with disabilities of all ages in the local area.

Assessment and care planning is likely to take more time due to the complex nature of the person's disability, broader family issues, the number of people who may be involved in developing the care plan and the interfaces with other programs and services.

Working in partnership

To coordinate assessment and care planning processes and minimise duplication, HACC assessment services need to develop partnerships and understandings with community service organisations that deliver services and supports for people with a disability and their families or carers. These partnerships need to include agreements to:

- share (with consent) relevant service user information, including the support plan, to streamline the assessment and care planning process
- undertake joint assessment and case conferences where relevant, to coordinate care planning
- work together to coordinate ongoing care and support.

Inviting disability service providers to join PCP forums or Assessment Alliances provides opportunities to:

- build relationships, develop trust and gain a better understanding of each other's practice
 - work out where there is crossover and duplication
 - develop strategies to improve care coordination and identify key workers
 - develop joint training and orientation/induction opportunities.
-

ACAS-Disability protocol

Younger people (people under 65) with a disability who are at risk of entering residential aged care and may require an ACAS assessment are first referred to Disability Services to explore whether there are more appropriate options for their care. The *ACAS-Disability Services protocol* is available at <http://www.health.vic.gov.au/agedcare/services/assess.htm>.

Person-centred practice

Key principles are self-directed, individualised approaches to assessment and care planning.

Before the visit

- What has prompted the referral? Often supports are required at life transition points such as school entry or entering the workforce.
- What are the key areas of concern?
- What other supports/services are involved? Consider joint assessment or care planning/case conference.
- Request a copy of any existing plans from the person.
- Check whether specific needs have to be addressed to make the visit a success (for example: does the person have a communication difficulty; are they capable of making their own decisions; do they need a support person or advocate present?)

At assessment

- Discuss the person's goals and aspirations – broad goals as well as those relevant to the referral.
- Use 'age appropriate' assessment tools and/or disability specific assessment and care planning tools.
- Understand the family and social network and involve them in the process as appropriate. The Family and Social Network SCTT tool can be used to document the person's support network (this is not an assessment tool).
- Consider separate visits for family/carers with high levels of need.
- Refer to the appropriate disability service to assist the person with planning for their education, training and employment needs, if this has not already occurred.
- If respite services are required for children, consider activities that are meaningful for the child.

Care planning

- Care planning needs to focus on the principles of whole-of-life planning, self-determination and choice.
- Involve all relevant people in developing the care plan – parents, friend, neighbours, other service providers, case manager.
- Make sure the person and/or parents of the child with a disability take the lead.
- Build on existing support plans.
- Take a goal-directed approach. (See Part C, Section 15)

Care coordination

Depending on the circumstances, there may be a number of people who could undertake the care coordination role – the person themselves, a parent or family member, or an organisation that delivers supports and services for people with a disability.

Domains relevant to younger people with a disability

- overall health (includes medication routines)
- accommodation issues
- daily living skills – skills development, capacity to learn new skills and improve others
- aids and equipment
- psychological issues such as grief and loss, siblings issues
- carer assessment, including assessment for Commonwealth Carer Allowance (Child)
- education, employment, training
- access to recreation, sport and leisure activities, including transport
- respite needs, including access to the generic Commonwealth Respite for Carers Program
- social support and community engagement
- challenging behaviours
- financial stress
- occupational health and safety issues relating to the person, parents/carers and HACC support workers.

Transitioning to higher level of care

People in receipt of an Individual Support Package (ISP) are not automatically excluded from receiving basic HACC services. If a person is receiving or has placed a request for an ISP, then the HACC provider should take this into account when reviewing the services they are providing. The decision to provide basic HACC services to someone on an ISP should be made on a case-by-case basis and will depend on the level of demand for services within each HACC organisation.

For HACC to provide basic support to a large number of people, HACC agencies need to transition younger people with a disability requiring high levels of services to other, more appropriate services provided through disability services.

Linkages packages are available, depending on the person's assessed need and level of priority and the availability of packages. If a person has access to other program supports, such as Individual Support Packages, then this existing support should be taken into account when HACC providers are assessing or reviewing priority of need.

Younger people with a disability cannot access a Linkages package and an ISP at the same time. When younger people with a disability on a Linkages package make an application to the Disability Support Register (DSR) for an ISP, ongoing disability supports that are provided via the Linkages package should be included in the DSR application.

For people who have already been allocated an ISP and are also currently accessing a Linkages package, the Linkages case manager in consultation with the ISP facilitator can apply to the DSR for an increased ISP to cover the cost of the ongoing disability supports being funded via the Linkages package. In these situations, the Linkages package should continue until appropriate ISP resources have been allocated to the person via the DSR.

Case snapshot³¹

A 35-year-old single mother of three children has recently moved to the area after separating from her husband. Her oldest child is 10, was born with cerebral palsy and uses a wheelchair for mobility. The assessment officer and an occupational therapist visited the family together to help them identify needs and develop an individual support plan.

During the assessment, a series of open ended questions were explored in relation to the following:

- strengths and interests of mother
- strengths and interests of the child
- involvement of other services
- housing security and priorities for home renovation
- financial situation
- social and emotional support for the mother
- activities and supports for all three children
- goals for the mother and for the child.

The care plan included:

- application to Department of Human Services, Disability Services for an Individual Support Package
- referral to an after school program and holiday program for the three children
- bathroom modifications designed by the occupational therapist
- referral to TADVIC for further wheelchair modifications
- provision of HACC respite care
- links to a local family support agency for volunteer support.

31 Fictitious case study

12 Service specific assessment

12.1 What is service specific assessment?

Introduction

Service specific assessment is a face-to-face assessment which explores needs and detailed issues relevant to specific HACC services. The assessment is usually conducted by the HACC organisation providing the service. The assessment leads to the development of a service plan and OHS plan.

A service specific assessment is one component of a Living at Home Assessment. Where required, service specific assessments occur during the Living at Home Assessment process, or as a separate assessment visit.

See Section 4.2 for information on who should get a Living at Home Assessment, or a service specific assessment only.

Practice

Service specific assessment includes identifying the reasons behind the person's need for a specific type of support, before talking about the type of assistance that could be provided.

In practice this means using the skills and techniques described in Section 6 to build rapport and find out what the underlying issues are, people's strengths and where they need assistance. Typically you will ask about:

- what the person can and can't do in this area
- why they can't do various tasks
- what they would like to be able to do
- opportunities for improving their skills and capacity
- developing specific goals.

Service specific care plans (service plans) are developed in collaboration with the person and their family or carer, and individualised to meet their expressed needs and goals.

Identifying 'small' goals designed to improve capacity in a specific task or activity may require input from an allied health worker. An interim service plan may be required until the allied health recommendations are available.

See Part C for goal setting and care planning techniques.

Expanding the role of community care workers

A key assumption in implementing the Victorian ASM initiative is that community care workers are pivotal in delivering the new approach. The ASM seeks to maximise the opportunities provided by the ongoing relationship community care workers have with the people they work with across all HACC activities.

Service plans

The outcome is a written individualised service plan and an OHS care plan.

The plan details:

- the goals to be achieved (including time frames)
- the exact nature of the intervention (including tasks to be carried out by community care worker)
- tasks the person, family or others will do
- when the service will be delivered
- the fee structure
- review date(s)
- expected termination date
- OHS plan.

A copy is left with the person.

(See Section 13: OHS and Section 14: Fees assessment)

12.2 The active service model and HACCC activities

Taking on ASM approach

This section gives you some ideas about what an ASM approach might look like in assessment, care planning and service delivery for specific HACCC activities. As ASM practice is still in a developing phase, the information below represents 'point in time' examples. Active service model practice will expand and grow over the next few years.

Implementing ASM and goal-directed approaches to care planning means that HACCC service delivery will become more flexible and individualised, with a capacity building approach.

The role of clinical services such as nursing and allied health in implementing ASM approaches in HACCC service delivery is critical. Referrals to nursing and allied health practitioners will often be made in order to develop restorative interventions or programs. These programs can be supported by community care workers under the direction of the allied health practitioner.

Allied health professionals and nurses have specific clinical assessment tools and methods. Where the person's needs or the referral indicates, a joint assessment, case conference or secondary consultation with HACCC assessors may be arranged to ensure that the person's overall assessment and care planning is coordinated and streamlined.

Below is a brief, indicative description of the range of expertise provided by nursing and allied health services.

Nursing services

Nursing services employ generalist nurses and clinical consultants with expertise in diabetes, continence, dementia, wound management and medication management. Referrals can be made directly for these specialist areas, or ring for advice first.

Allied health

Physiotherapy: recent falls/history of falls; mobility or pain problems that affect the person's safety or that of the carer or support person; incorrect use or condition of mobility aids.

Podiatry: lower limb or foot problems affecting ability to manage daily living activities; inflammation or wounds in lower limb/foot; person with diabetes who has not had a foot assessment.

Occupational therapy: need for training, aids or equipment to support independence; need for home modifications, such as rails, ramps, bathroom renovation or structural changes; assessment for hoist, wheelchair or motorised chair/scooter; driving assessments.

Dietitian: significant change in food consumption or nutritional status; child with a disability where nutrition is a significant factor; person with a disability who is pregnant or breastfeeding; overweight; health conditions affected by diet, such as diabetes, anaemia, bowel conditions, celiac or Crohn's disease, ulcerative colitis, liver problems, anorexia, bulimia, osteoporosis, high cholesterol.

Counselling and social work: need for financial counselling, assistance with gambling problem, assistance with guardianship or pensions; significant grief or loss; anxiety or depression impacting on health and ability to function; relationship difficulties; difficulties adjusting to changes or impact of health condition; need for carer or family support.

Speech pathology: speech and communication disorders; eating and drinking difficulties; difficulties with swallowing or chewing.

Active service approaches to HACCC service delivery

The information below describes approaches to assessment, care planning and service delivery for some HACCC activities, from an ASM perspective. These ideas are drawn from existing practice and ASM pilot projects. Read Section 7 of the *HACCC program manual* for a full description of each HACCC activity and a broad description of the type of assistance that can be provided.

Domestic assistance

Helping people maintain or improve their capacity to carry out a wide range of domestic activities is a key feature of this HACCC activity.

Check appliances and accessibility of household items

- Have a look at household appliances: some appliances may be too old, heavy and not fit for use by the person or the community care worker. Solutions to unsuitable appliances need to be explored and negotiated.
- Consider the set up of furniture and facilities within the household and suggest options to reduce clutter.
- Move frequently used items to a more accessible place (waist height shelves or benches).
- Use a trolley for laundry, carry only a few items at a time, use an indoor clothes horse or alter the clothes line to be more accessible.

Skills development

- Find age and gender appropriate skills development classes (how to clean effectively, plan shopping, transport training and support).
- Use a calendar or diary to assist with remembering important dates and appointments, bill paying, shopping lists.
- Are important phone numbers accessible?

Energy conservation – discuss with an OT and consider a referral

- Energy conservation, such as how to carry out tasks within the constraints of the person's capacity (doing a little bit each day, rather than cleaning the entire house on a set day of the week or cleaning in the morning/ afternoon when you have more energy; showering every second day; sitting to undress, dry and dress; being prepared for the shower by having all clothes and equipment ready).
- Joint protection strategies, such as avoiding prolonged awkward postures, forceful movements or carrying heavy objects like shopping bags.
- Consider where pain is reported to limit function and ask if pain management has been discussed with the GP.

Use of aids and equipment, home modification – refer to an OT

- Consider what home maintenance and modifications may offer. Ask an occupational therapist for advice as there may be a simple solution to some problems that do not need a referral.
- Consider a visit to the Independent Living Centre to review adaptive technologies and techniques, and/or check out the local chemist for assistive equipment such as pick-up sticks, a kettle tipper or other lightweight items.

Divide up tasks

- Divide tasks into those the person can do and others the community care worker can either do or provide support for, and work as a team by doing 'with' not 'for'.
- For a person with an intellectual or psychological incapacity, you could introduce a coaching relationship where the person is guided and encouraged to do more while the worker is with them, so the person's capacity increases over time.

Building physical capacity

- Consider contacting an allied health practitioner (physiotherapist or occupational therapist) for general advice to discuss ideas, before making a referral.
 - Plan referrals for maintaining or improving mobility, functional capacity and strength training.
 - Consider referrals or secondary consultation with specialist areas, such as mental health teams or continence nurses.
 - Refer to home-based exercise programs such as Making a Move.
-

Personal care

Personal care (or personal assistance) offers many opportunities to implement an ASM approach. This is because personal care workers can assist people with activities that involve interaction with their bodies. They are not restricted to personal care tasks such as bathing, dressing, eating or toileting.

See Section 10.2 Personal care and the *HACC program manual* for a full list of activities that fall under personal care.

People with unstable health status

See the *HACC program manual* Section 7.6b for the HACC Personal Care Policy which describes the ongoing involvement of Division 1 nurses in assessing, developing care plans, monitoring and supervising personal care for people with unstable health status.

Different types of personal care plans can support an ASM approach. Many of the activities listed below require a prior referral to an allied health practitioner.

Capacity building with an allied health directed program

- Design a graded program of support that assists the person to maintain or progressively undertake more personal care tasks for themselves, such as dressing or showering.
- Support the person with a home exercise program, under the direction of an appropriate allied health professional.
- Escort the person and help them to get changed and participate in an activity such as water exercise (this may also involve taking them to purchase new bathers).
- Help the person become confident to take up a new activity such as Tai Chi, by going with them on a short-term basis to a couple of sessions.
- Walk with people to increase their physical activity, under the direction of an appropriate allied health professional.
- Assist the person to go shopping or participate in other community-based activities.
- Group activities help people reconnect and improve their confidence in community participation.

Most of these activities need the direction of an appropriate allied health professional. Allied health professionals will assess the person and communicate their recommendations to the HACC assessor and team leader who manages the community care workers.

For example, if a program for extending the person's capacity to walk longer distances is recommended, specific instructions should be provided to the HACC Team Leader, who will then instruct the personal care worker in the tasks to be carried out. Similarly, there will be a feedback loop from the personal care worker through the Team Leader to the allied health clinician about progress towards goals and reviewing the program as necessary.

Aids and home modifications

An OT assessment should be considered if the person is holding on to props like door handles, soap dishes or shower screens for stability. This is **not safe**. A discussion and referral to an OT for equipment such as rails, toilet frames and other bathroom equipment such as shower stools and hand-held shower should be considered.

Energy conservation – discuss possible referral with an OT

Consider discussing pacing and energy conservation techniques such as showering every second day, sitting to undress, dry and dress, being prepared for the shower by having all clothes and equipment ready.

Food services

Active service model responses depend on the underlying issue behind poor nutrition and the need for meals support. Consider:

- referral or secondary consultation with a dietician to address nutritional risk (an interim service plan may be necessary until this has occurred)
- skills development – cooking classes for people who need to acquire skills and knowledge of healthy eating
- aids and equipment – safety and independence in the kitchen
- social responses for people who are socially isolated, such as café style meals
- address oral health and dental issues
- support with shopping and specific cooking tasks
- cultural, cognitive and emotional barriers to skill development.

(See Part B: Section 8.7 Nutrition and hydration)

Linkages

Linkages is a HACC-funded case management service that has funds to purchase additional services for people whose needs cannot be met entirely by the usual level of HACC services. This constitutes a package of care for each consumer.

Identify strengths and abilities in the person, carer or support person that need to be promoted or maintained. Identify special needs or complex care needs that cannot be met by other services.

- What do you think you need to manage better?
- If you have a case manager (explaining what that is) do you have particular requests about the type of person they will be?
- What tasks would you like the case manager to do for you and what tasks do you want to do for yourself?

Refer to sections on personal activities of daily living, cognitive ability, continence, medication management, mobility, carers, chronic disease self-management, home environment and personal safety.

Planned Activity Groups (PAGs) Use the *Well for Life* information resources and help sheets which focus on physical activity, nutrition and emotional wellbeing, to promote physical and mental health and wellbeing among older people.

Use opportunities to maintain or improve people's function, nutrition, social connection and quality of life. Consider what activities the person likes to do. What were their interests, skills and abilities in the past? Are there new activities they would like to try or new skills they would like to acquire? Are there suitable physical activity options available at the PAGs? Does the person's cultural or diversity background guide you toward certain PAGs or activities to improve social connection?

Create a weekly or monthly activity calendar in collaboration with PAG participants. People then book themselves into specific activities, depending on their interests.

Consider the importance of matching a new participant with the most appropriate social grouping, in order to maintain and/or build social skills through small group interaction.

Respite Respite is an excellent opportunity to implement an ASM approach, creating respite activities that are individualised to the person's needs and interests. Key issues to consider include:

- What would the person like to learn, do or enjoy during respite?
- Preference for a group or alone? What time of day, or days of the week, are most suitable? How often?
- What activities can promote physical activity, good nutrition and emotional wellbeing?
- Are there particular considerations about the type of staff member who accompanies the person (male/female/older/ younger/same language or religion/Aboriginal)?
- Is there anything the staff member would need to know to provide the best care, such as a particular routine that needs to be maintained?
- Are there sensory considerations or behaviours to be taken into account?

(See Section 9.2 Family, friends and community, and section 9.3 Families and carers)

Property maintenance (including minor modifications) Approaches consistent with ASM include:

- Refer to an OT for home modifications to support safety and independence at home, such as bathroom rails or ramps
- development of low-maintenance gardens or modification of existing gardens to support ongoing independence with gardening.

Resources

- See the ASM website and ASM PREPARE for further information http://www.health.vic.gov.au/hacc/projects/asm_project.htm
- For a full description of each HACC activity type, refer to the Victorian *HACC program manual* and updates/amendments http://www.health.vic.gov.au/hacc/prog_manual/index.htm
- Well for life information and resources <http://www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm>

13 Occupational health and safety

Overview

The Occupational Health and Safety (OHS) legislation and current occupational health and safety practice is based on identifying workplace hazards, assessing risks and then controlling risks as far as is reasonably practicable.

The majority of HACC services are provided in the person's home. Since many HACC-funded home care and nursing organisations are also designated HACC assessment services it is likely that the Living at Home Assessment will include the service specific assessment. However, all Living at Home Assessments should observe and record OHS risk information to be utilised during a separate service specific assessment.

Where service provision occurs in employer controlled settings, addressing occupational health and safety issues will not be so closely aligned with the process of service user assessment, but usually addressed by implementing universal precautions.

The table below illustrates typical steps in assessment and care planning and how this might impact on OHS issues.

Service planning	OHS impacts
Referral	Transfer of available OHS related information
Needs/Service Assessment	Indication of possible OHS issues
Home Safety Assessment	Assessment of working environment
Care plan	Allocation of OHS responsibilities, OHS Plan
Assignment of employee	Training and information for employee
Equipment to assist	Suitable equipment to reduce risks
Service provision	Employee and service user safety

OHS plan

An OHS plan should be developed following the home safety assessment. This plan should include assessment of tasks involved, controls to manage the risks and the provision of suitable equipment. This forms part of the person's care plan.

The home safety assessment may be conducted by the community care worker at the beginning of the first service visit and the care plan amended following this. Refer to the *Victorian Home Care Industry Occupational Health and Safety Guide October 2005* pp 18–20 for a home safety inventory template.

Duty of care

It is recognised that HACC organisations will also owe a duty of care to those for whom they are providing home care services, both at common law and sometimes under statute. The OHS Act does not require a service organisation to sacrifice the interests of one party for the other. A service organisation must, so far as is reasonably practicable, ensure the safety of both the worker and the person receiving the service. Where possible, conflicts need to be resolved by strategies that do not disadvantage either party.

Resources

There are three Victorian OHS publications of specific relevance to HACC services.

1. Victorian home care industry occupational health and safety guide October 2005

In Victoria HACC service providers who provide home care services (as defined in the guide) are required to implement methods and measures to manage the risks of providing home care services. The information is structured to be compatible with common approaches to managing home care services and to cover the common health and safety hazards found in the industry. It covers services provided by paid employees and volunteers working in the home and in the community (such as shopping or escorting). The home care services covered are home maintenance, delivered meals (Meals On Wheels), respite, attendant care, personal care, home care and travel and escorting as part of the delivery of these services. Available at <http://www.health.vic.gov.au/hacc/> and <http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/WorkSafe>

2. Home care – occupational health and safety compliance kit: How to control the most common hazardous tasks in the home care sector

This kit describes the seven most common hazardous tasks that cause workplace injuries in the home care sector and includes seven health and safety solutions to outline ways to control the risks. The emphasis is on preventing musculoskeletal injuries while undertaking tasks such as vacuuming, mopping showering people in the home. This kit and the *Victorian home care occupational health and safety guide October 2005* should be used together. The kit is available at <http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/WorkSafe>

3. Working Safely in Visiting Health Services 1st Edition June 2006

Aimed at employers or duty holders, and employees who provide health services in an environment external to a purpose built workplace. That is, health professionals such as nurses, occupational therapists and medical practitioners who provide assessment and treatment services in private homes and other community settings. Under occupational health and safety (OHS) legislation, employers have a duty to control risks associated with visiting health services. Sets out practical ways to prevent the two principal hazards associated with visiting health services – occupational violence and musculoskeletal disorders.

Available at <http://www.worksafe.vic.gov.au/wps/wcm/connect/wsinternet/WorkSafe>

OHS and HACCC assessors

Occupational health and safety issues and procedures for HACCC assessors themselves includes:

- office workstation suitability
- vehicle safety
- staff whereabouts recorded and known, including expected return times
- staff carrying mobile telephones with a speed dial to the office when in a person's home.

If staff are concerned for their safety, they should leave the house immediately and return to the office.

There are two significant areas of OHS for HACCC assessors: client interaction and stress.

Client interaction

A HACCC assessor may encounter abuse or threats from a service user, family member or carer during the course of an assessment. This is called occupational violence.

WorkSafe Victoria's publication, *Prevention of bullying and violence at work: guidance note (2003)* defines 'occupational violence' as 'any incident where an employee is physically attacked or threatened in the workplace'. Within this definition:

- 'threat' means a statement or behaviour that causes a person to believe they are in danger of being physically attacked
- 'physical attack' means the direct or indirect application of force by a person to the body of, or to clothing or equipment worn by, another person, where that application creates a risk to health and safety.

The most common forms of assault against staff are verbal abuse and threats of harm. Verbal abuse includes shouting, intimidation, sarcasm and personal insults. Staff might also be subjected to sexual or racial harassment through offensive suggestions and remarks. The impact of verbal assaults on staff can be considerable and can affect their psychological wellbeing.

Managing risk factors

If risk factors are identified at initial contact or initial needs assessment, assessment staff should discuss their concerns with their team leader and decide whether to organise an additional staff member to attend the home visit, or whether to ask the person to meet the assessor at another destination. The assessor should determine at the time of assessment whether carers can be provided in the home situation and to consider alternative strategies to meet the person's needs and worker safety. If safety concerns arise, discuss your concerns with your manager. It may require that the service is suspended or terminated if safety of staff cannot be guaranteed. Referrals to other service providers should alert them to identified risks.

Dealing with anger

A person may present as angry and frustrated. When a person is hostile or verbally abusive, keep in mind the following:

- you do not have to tolerate abusive or threatening behaviour
- keep a safe distance from the person
- avoid touching the person
- try to defuse the situation by listening and remaining calm
- be quietly assertive, note facts calmly, avoid heated discussions
- be mindful of power struggles and remain courteous
- be sincere in your attempt to help, avoid an aggressive response
- use simple, direct and brief statements
- speak slowly, clearly and use language the person can understand
- discuss problems and issues in a straightforward manner
- try to maintain empathy and paraphrase their comments
- time responses carefully to help the person focus on the issues or problems causing anger, and try to identify solutions
- demonstrate that you are trying to find solutions to problems
- do not belittle the person's concerns
- acknowledge the person's feelings and put the anger in context.

Work-related stress

'Stress' is a generic term widely used to describe the feelings and physiological responses that some people have in response to pressures they face in their lives. In the workplace, stress can be experienced as a 'challenge' and can produce positive effects, such as the maximisation of output and creativity. However, prolonged or intense stress (distress) can result in psychological and physical harm.

A range of factors related to the content and context of work can cause distress. Distress can result when people have work demands and pressures that are not matched to their needs, knowledge and abilities and that challenge their ability to cope. This may arise when demands and pressures are considered unrealistic or unreasonable, or when a person's skills and abilities are not well matched to their role. Distress is likely to result in a decline in functioning, performance and overall levels of wellbeing. If there are stressors in the workplace or job, they should be raised with peers and supervisors. If stressors arise from personal or family matters, but impact on the ability to manage work, assistance should be sought through employee assistance programs. Most regions provide confidential counselling support for employees. Counselling may be available through GPs.

Support

Examples of support that can assist with stress include: peer support and meetings, case meetings and discussions, shadowing another worker, interdisciplinary practice, role-playing scenarios and responses and external supervision.

**Tips to minimise
work related
stress**

HACC assessment and care planning is a complex and at times demanding and stressful role. People may have unrealistic expectations about what HACC can and cannot provide. Experienced assessors have the following advice:³²

- When a person asks a question and you are unsure of the answer, do not hesitate to say so and seek advice from your colleagues. You may feel pressured to be able to answer all questions, but it is preferable that you get further information instead of providing incorrect information.
 - As the person is speaking, you should be evaluating and thinking about options and strategies.
 - Understand the boundaries of your role and how to effectively link with other service providers. It is unwise and unprofessional to allow the person to become dependent on you. Your role is to build the person's capacity and confidence.
 - Some assessments will be difficult. You need to expect and be able to manage a wide range of emotions including anger, resentment, sorrow, depression and frustration.
 - Remember that HACC assessors are facilitators who offer assistance to people. They are not expected to solve all issues or problems, even though they may wish they could.
 - Take the opportunity to debrief issues with your manager or other team members.
-

³² Australian Government Department of Health and Ageing 2008, *Introduction to Aged Care Assessment Program*, PowerPoint presentation.

14 Fees assessment

Introduction

People using HACC must be informed of the HACC fees policy, what it is and how it works at the time of assessment. Fees can only be determined after consideration of the person's income and other factors that affect their ability to pay the fee. Fees are not charged for all services or in all cases.

Fees assessment must occur in accordance with the Victorian HACC Fees Policy. HACC assessors should read the policy and be fully aware of the principles and processes involved.

The fees policy should be implemented flexibly and sensitively, based on individual circumstances. People cannot be refused a service because of their inability to pay.

Observations

- Discussing financial information and money can be uncomfortable for many people. Observe the person's response and body language when you raise the subject.
- Check the person's willingness to pay for the service.

Strategies

- Assessment of the person's capacity to pay fees should be as simple and unobtrusive as possible, with due regard for their privacy and confidentiality.
- Acknowledge that most people value a service which they contribute to and that revenue obtained from HACC fees is used to enhance or expand services.
- Tell the person fees are set according to income levels and different fee levels and waivers are provided, depending on their circumstances.
- Provide the person with written information about the Fees Policy. An 'information package for consumers' is provided in the HACC Fees Policy update document.
- Provide a simple income form declaration for people to fill out themselves and a list of identifying factors affecting ability to pay (see HACC Fees Policy for a template).
- You may have already discussed whether the person has difficulty paying bills and meeting basic needs, such as paying for food and medication, before getting to the point where a fees assessment is required. If so, this will help to determine the fees level. (See Section 9.7 Financial considerations)
- Use particular sensitivity with Aboriginal people. You do not want your approach to diminish trust. (See Section 11)
- HACC assessment services should discuss the best approach to determining HACC fees with their local Aboriginal community controlled organisation (or Aboriginal community if there is no Aboriginal organisation).

Resources

- HACC program website http://www.health.vic.gov.au/hacc/hacc_victoria/index.htm for the Victorian HACC fees policy update, September 2006.

PART C

Care planning

15 Goal-directed care planning

15.1 Goal development

Introduction

The ASM and person-centred approach in assessment focuses on helping people to set their own goals.

The evidence shows that an assessment process alone is insufficient to improve outcomes. It has to be followed by goals, actions and interventions to address the issues identified.

Goal development is the process by which goals are developed and agreed. Depending on the person's circumstances, the goals will be developed in conjunction with carers, family members, support workers and other key people. For example, support workers from Aboriginal and CALD agencies may be able to assist in this process. (See Section 11: Diversity in practice)

Evidence has linked goal setting to improved performance, especially when goals are specific and challenging. Goals are usually hierarchical, with broad higher order goals at the top and sub goals represented underneath.

Care planning identifies how the broader service sector can assist the person to achieve these goals. In many cases, short term care coordination is required to coordinate different elements of the care plan. A referral to a case management program sometimes needs to be made if the person has a more complex set of needs and circumstances. (See Section 17: Care coordination)

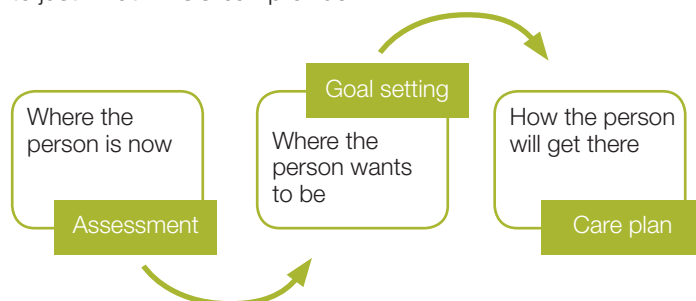
Benefits

Goal development assists with:

- ensuring a person and family-centred approach
 - ensuring people are empowered to make decisions about their care and support
 - providing purpose and motivation for the person
 - linking between assessment and care planning
 - easier communication across organisations and between staff
 - greater satisfaction with services and sense of achievement for individuals
 - providing a focal point for integrating and coordinating care between organisations.
-

Model

The ASM describes goal setting as the interface between assessment and care planning. The person's goals should drive service response and not be limited to just what HACC can provide.



Ranking priorities

It is important to have a shared understanding of desired outcomes with the person and, where relevant, other family members. For example, in CALD communities extended family members may play a key role in goal setting, agreeing on priorities and providing support.

It is likely that the person will have referred to various goals during the assessment process. One approach is to summarise:

- What are the person's or family/carer's concerns?
- What are the assessor's concerns?
- What are the person's priorities when considering both the assessor's concerns and their own?

Ask the person to rank in order of importance each issue and how much they want to change. This should assist everyone involved to understand what is most important to the person and lead to the identification of a main goal.

Prompts to identify goals

If it is difficult to identify a clear goal, several strategies can be used:

- Ask the person if there is something they have not done for a while that they would like to do again.
- Pick a cue from the conversation, for example they might mention that they normally go to a club or meeting but have stopped this for some reason.
- Ask the person if they have a special family event coming up that they would like to attend.
- Discuss activities that the person used to do but now find difficult.
- Encourage the person to take time to think about their goals. This may mean you have to return at a later date to continue with goal setting (with the person's permission you might like to arrange a family member to help with the goal setting exercise).

See page 148 for goal facilitation case example.

SMART objectives

Goals can be documented as specific, measurable, achievable, realistic and time-oriented (SMART) objectives. This will assist everyone involved to have a clear understanding of what is trying to be achieved, how and by when. (see page 149 for case snapshot of SMART goals).

Tips

Typical examples of goals that are not specific and where you need to investigate more deeply are:

'I want to remain at home'. The prompts then could be:

- What do you need to do to stay at home? (It could be that the steps required are to shower independently, make my own meals, get in and out of bed, get to the toilet in the middle of the night safely).
- What is it about being at home that is important to you? (It could be that they need to be able to look after their cat, that this is where they have lived for 60 years and they love walking around the garden).

'I want to get back to driving'. The prompts then could be:

- What is it about driving that is important to you? (It could be that they need to be able to get to the local church or they need to be able to do the shopping).

'I want to keep independent'. The prompts then could be:

- What do you need to be able to do to remain independent? (It could be that they need to be able to take their dog for a walk twice a day or that they need to be able to get on and off the toilet or be able to dress themselves in the morning).

Underpinning each main goal may be a series of steps. For example, if the main goal is to have coffee in a local café with a grandchild, the steps could include walking to the front door, getting in a car, balancing a cup of coffee and so forth.

When the person's priorities and goals are clear, it may also be helpful to ask them to rate out of three how much they want to achieve each goal (1 low importance to 3 high importance). This will assist to further understand the relative importance of each goal and where to focus support.

Not for everyone

Some people may not be motivated to set goals. This does not mean that they cannot be encouraged to do more for themselves, improve their skills and experience the benefits of increased independence.

Goal development tends to work best for:

- people who are motivated toward achieving or participating in something specific
 - people who have had a recent change (or decline) and are motivated to act
 - people of any age or functional ability with the capacity for functional improvement or restorative gains.
-

Resources

- Readiness to change ruler, at http://www.adultmeducation.com/AssessmentTools_3.html
-

Case example: Goal facilitation (summary)³³

<p>The presenting problem according to Mrs Jones</p>	<p>I would like some assistance to clean my unit as I can no longer do the vacuuming or clean the bathroom. My daughter has asked for council home help for me. I am also worried about the lawn and garden which is looking very shabby.</p>									
<p>What is revealed in conversation (as part of the assessment process)</p>	<p><i>‘Tell me about yourself and how things have changed since you feel you have needed some assistance...’</i></p> <p>Because she feels she is unable to clean her house, Mrs Jones has ceased inviting her friends for card mornings and this has resulted in her becoming more sedentary and socially isolated. She no longer cleans her unit or rearranges her furniture for the occasion, or does a special shopping trip to buy the cooking ingredients to bake cakes for morning tea.</p>									
<p>Observation by the HACC assessor</p>	<p>It is apparent from discussion and observation that Mrs Jones cannot bend over or kneel to plug in the vacuum cleaner, has limited strength and stamina to clean her unit in a single session, cannot move the table into the middle of the room for the card game, and is becoming increasingly lonely, with the risk of depression.</p>									
<p>Main goal</p>	<p><i>‘Mrs Jones, can you tell me what would make you feel better in yourself and better about your current situation? Is there something you would like to be able to do again?’</i></p> <p>Mrs Jones replied that she would ‘dearly love to host card mornings with her friends again’ like she used to, although she can’t see how that will be possible.</p>									
<p>Other goals</p>	<p>Other goals included being able to do the crossword (she could no longer read the fine print) and to better manage her back pain.</p>									
<p>Discussion regarding possible solutions and interventions</p>	<p><i>‘Mrs Jones, what would need to change so that you could do that again?’</i></p>	<table border="1"> <tr> <td data-bbox="336 1238 564 1373"> <p>Address physical issues</p> </td> <td data-bbox="576 1238 1240 1373"> <p>For example through physiotherapy, strength training or hydrotherapy – refer to physiotherapist at the CHS or access the new MBS allied health program. Possibly to GP for pain management or to a pain management clinic.</p> </td> </tr> <tr> <td data-bbox="336 1384 564 1518"> <p>Equipment modification</p> </td> <td data-bbox="576 1384 1240 1518"> <p>Demonstrate a lightweight carpet sweeper and lightweight card table. Ask a family member to take Mrs Jones to the local aids and equipment supplier to look at bathroom cleaning aids.</p> </td> </tr> <tr> <td data-bbox="336 1529 564 1630"> <p>Behavioural change</p> </td> <td data-bbox="576 1529 1240 1630"> <p>Do initial house clean to prepare for first card morning, then encourage Mrs Jones to vacuum one room each day and clean in small sessions.</p> </td> </tr> <tr> <td data-bbox="336 1641 564 1742"> <p>Other family support</p> </td> <td data-bbox="576 1641 1240 1742"> <p>Encourage Mrs Jones to ask her grandson to mow the lawns; property maintenance could possibly do an initial clean up; or replace the small lawn area with synthetic turf.</p> </td> </tr> </table>	<p>Address physical issues</p>	<p>For example through physiotherapy, strength training or hydrotherapy – refer to physiotherapist at the CHS or access the new MBS allied health program. Possibly to GP for pain management or to a pain management clinic.</p>	<p>Equipment modification</p>	<p>Demonstrate a lightweight carpet sweeper and lightweight card table. Ask a family member to take Mrs Jones to the local aids and equipment supplier to look at bathroom cleaning aids.</p>	<p>Behavioural change</p>	<p>Do initial house clean to prepare for first card morning, then encourage Mrs Jones to vacuum one room each day and clean in small sessions.</p>	<p>Other family support</p>	<p>Encourage Mrs Jones to ask her grandson to mow the lawns; property maintenance could possibly do an initial clean up; or replace the small lawn area with synthetic turf.</p>
<p>Address physical issues</p>	<p>For example through physiotherapy, strength training or hydrotherapy – refer to physiotherapist at the CHS or access the new MBS allied health program. Possibly to GP for pain management or to a pain management clinic.</p>									
<p>Equipment modification</p>	<p>Demonstrate a lightweight carpet sweeper and lightweight card table. Ask a family member to take Mrs Jones to the local aids and equipment supplier to look at bathroom cleaning aids.</p>									
<p>Behavioural change</p>	<p>Do initial house clean to prepare for first card morning, then encourage Mrs Jones to vacuum one room each day and clean in small sessions.</p>									
<p>Other family support</p>	<p>Encourage Mrs Jones to ask her grandson to mow the lawns; property maintenance could possibly do an initial clean up; or replace the small lawn area with synthetic turf.</p>									
<p>Other</p>	<p>Motivational support and encouragement</p>	<p>Worker attend card game to meet other people and provide informal education and health promotion information. After the game, discuss the situation with Mrs Jones and identify any further issues, monitor her confidence and ability, and other opportunities for good health and independence. Home support worker to help prepare for first card game and then gradually reduce as Mrs Jones is able to do the preparation herself. Telephone review to follow up at agreed time.</p>								

33 Fictitious case study

Case snapshot: SMART goals³⁴

This case snapshot illustrates the use of ‘SMART’ goals, which are goals or objectives that are expressed so as to be:

S: Specific

M: Measurable

A: Achievable

R: Realistic

T: Time oriented.

An existing HACC client identified some new goals - to attend a granddaughter’s wedding in twelve weeks and be included, without a walking stick, in the wedding photos.

The goals were ‘unpacked’ to be more specific with input from a physiotherapist. SMART objectives were developed to achieve each goal.

Goals		SMART objectives to support goal attainment				
		Specific	Measurable	Achievable	Realistic	Time oriented
1	Be physically capable of attending grand-daughter’s wedding	Physio-therapist designed home-based exercise program	A home-based program, for 30 minutes each day, implemented over an eight week period	Yes – person is motivated; physio-therapist is available	yes	Exercise program to commence by 1 June and finish by 30 August
2	Be included without a walking stick in the wedding photos	Be able to stand for 15 minutes at any one time without a walking stick	As above	Yes – Up until quite recently person was able to stand independently	yes	Achieved by date of wedding – 15 September

This information was then translated into a care plan.

- The physiotherapist designed the home-based program.
- The physiotherapist demonstrated the program and provided instructions to the person and the HACC Team Leader. The HACC Team Leader then wrote the service plan with instructions for the community care worker detailing the specific role and tasks, and provided a copy to the person.
- The community care worker prompted the person and provided motivational support and encouragement during the (existing) home care visits.
- The person completed a simple checklist each time the 30 minute exercise program was completed.
- After six weeks the HACC Team Leader faxed a copy of the checklist to the physiotherapist, who reviewed progress based on telephone discussion with the person. The physiotherapist kept the person and HACC Team Leader (including the community care worker) in the communication loop if any program changes or adjustments were required.

34 Fictitious case study

15.2 Care planning

Overview

Assessment and goal setting informs the development and implementation of individual care plans.

Care planning aims to assist the person to maximise their independence and achieve their identified goals.

The care planning process involves a collaborative approach with the person, family, carers and other stakeholders to:

- identify and prioritise issues arising from the assessment
- set goals relevant to the most important issues
- develop strategies and timeframes for addressing the issues and achieving the goals
- document an individual care plan and/or service plan.

What is care planning?

The overall goal of care planning is to maximise and enhance the person's independence and quality of life. Care planning recognises and supports the person's strengths and abilities, and lists strategies to respond to their needs. Care planning occurs in consultation with the person, and with their carers, family, friends, guardian and other organisations where relevant.

Care planning:

- is a dynamic process that incorporates interpreting assessment information, referral, feedback (to the person, the referring agency, Aboriginal or CALD workers), review, monitoring and exiting
- involves balancing relative and competing needs, and helping the person make decisions appropriate to their needs, wishes, values and circumstances
- addresses the needs of the family or carer and the person needing care
- is responsive to the cultural requirements of the person and maintains cultural sensitivity
- may require access to advice or information from a range of sources to develop an appropriate solution
- takes into account the availability of services (within and beyond the organisation) and develops creative and flexible solutions to proactively support the person to achieve their goals
- may be a staged process.

Care plans continually change as a person achieves their goals or their preferences or situation changes.

Care plan components of a Living at Home Assessment

- a **care plan** resulting from a holistic assessment which documents the priority issues, goals and actions identified.
- a **service specific care plan** (also known as service plan) which details the type and level of each HACC service to be delivered by your organisation and includes an OHS plan
- a **referral action plan** which translates information collected about the broad range of the person's needs into agreed referral actions for services not provided by your HACC assessment service
- **information** about services or activities that the person chooses to follow up themselves.

Figure 10: Care plan components in a Living at Home Assessment

Care plan	<p>The care plan resulting from the holistic assessment should be documented in a standard form or template (SCTT Care Coordination Plan (page 2) or agency care plan template) and a copy kept by the person. The care plan is an important record for the person, their family or carers and service provider organisations. Each of the key participants should have a copy of the plan (with consent).</p> <p>The people involved in the care planning process are listed and care plan summarises the person's issues and goals, and family/carer issues and goals in order of priority. Specific actions of the person, the service provider and/ or family members or carers to address issues and achieve goals are described, with timeframes for action. As some actions may not occur immediately, but over a period of time, the care plan acts as a reference point, and is used at review and reassessment.</p>
Service specific care plan or service plan	<p>A service specific care plan (or service plan) is the written individualised plan for provision of a HACCC service. The plan includes agreed goals and timeframes for review or exit and an OHS plan. A copy of the plan is provided to the person.</p> <p>The service plan details the exact nature of the HACCC service to be provided, activities and tasks that the community care worker will do, when it will be delivered and the fee structure. The service plan also documents agreed tasks or activities that the person or family members will do to support the person achieving their goals.</p> <p>An interim service plan may be required while other actions such as allied health interventions occur. Short term care coordination may be required to coordinate the outcomes from referrals to other organisations and communicate with other service providers prior to developing a final service plan. The final service plan may not be developed for some months.</p>
Referral action plan	<p>The referral action plan translates information collected about the broad range of the person's needs into agreed referral actions for services not provided by the HACCC assessment service. These are documented on SCTT Summary and Referral Information form, so that other organisations are aware of referrals that have been made.</p>
Coordinated care plan	<p>Where there is multi-agency involvement in delivering services to a person, care planning between agencies is needed to coordinate care. For example, with people who have complex needs or circumstances or multiple health issues such as chronic disease. A lead agency and key worker will need to be identified to take overall responsibility for care plan coordination and/or communication between service providers, the person, their family and relevant carers.</p> <p>The SCTT Care Coordination Plan template (pages 1–3) can be used to:</p> <ul style="list-style-type: none"> • articulate shared goals and outcomes • outline the roles and responsibilities of each service provider • coordinate service provision to support the person to achieve their goals • facilitate communication of agreed strategies and interventions, to ensure all support providers are well-informed and working towards the same goals • identify the person responsible for care coordination, such as a key worker, care coordinator or case manager, as appropriate • monitor and review service provision and plan for discharge, transition or exit from the service. <p>Coordinated care planning can be challenging. Potential barriers (coordination; role boundaries; competing priorities) should be overcome through discussion, creative problem solving and remaining focused on the shared interest – supporting the person to achieve their goals.</p>
Information, brochures, self-referrals	<p>Information about activities or services that the person or family members choose to follow up themselves. For example: health promotion, social or active living opportunities in the local area, self-management activities and information for self-referrals to other services.</p>

**Finding
appropriate
solutions**

An ASM and person-centred approach gives assessors permission to be flexible and creative with care planning.

This involves thinking creatively and having a broad knowledge of the service system and what it can offer. **Ensure the person** (and their family or carer) **take the lead in the care planning conversation**, which should focus on:

- what they believe is the best solution, remembering that ‘people are their own experts’
- exploring what options might be possible.

Working out what type of service response will meet the person’s specific needs may not be straightforward and may take additional time. (See Section 12: Service specific assessment)

Care plans are living documents which can be adjusted and refined as relationships and trust develops between the person, the HACC service provider and their community care workers.

Assessors may need to discuss their ideas and the person’s preferences with peers and their manager to ensure that solutions are possible and achievable. If a solution cannot be found using HACC services, then discussion with partner organisations could identify other options.

**Personal Alert
Victoria (PAV)
HACC Response
Service**

HACC assessment services are designated PAV assessment agencies.

Following a Living at Home Assessment, PAV may be a recommended service outcome. PAV eligibility criteria reflect high health and support needs and people are likely to require other services and/or advice along with, or instead of PAV.

Alternatives to a PAV ‘like’ service include those services listed in the Yellow Pages under ‘Alerting Systems or Services’; pre-programmed telephones, or mobile telephones to family or carer, friends, or 000; telephone products with functions to assist people who are mobility impaired and/or with emergency pendants that activate calls to programmed chosen numbers. Other support options are listed in the PAV program and Service Guidelines. For example, encouraging family, carer or friends to make a daily phone call or visit, and other community services that provide a monitoring welfare role.

The HACC Response Service provides the incident contact for PAV clients who do not have family and informal contacts. If a person using PAV loses their nominated contacts, they can be referred to the HACC Response Service. See PAV Guidelines for the HACC assessment service role in this circumstance.

See Personal Alert Victoria program and service guidelines 2010 at <http://www.health.vic.gov.au/agedcare/policy/pav.htm>

Figure 11: Care plan process requirements



Challenges

Various challenges may arise during the care planning process. Conflicting ideas within families, limited service availability and a person's expectation of 'entitlement' to services are just a few. Skilled care planners require good communication skills to manage these challenges. You may wish to discuss these with your colleagues:

- How do you work with family members or carers that have conflicting views and expectations about the type and level of service they want?
- How do you handle a situation where your views conflict with the person, for example if you are concerned about the person's safety and your duty of care?
- What processes do you have in place to balance the assessor's perception of risk and duty of care with a person's risk taking behaviour or service refusal in the context of their right to self-determination and autonomy?

Care plan implementation

A care planning process that results in multiple interventions, referrals, goals and timeframes may be overwhelming for the person. Be careful not to set up the person for failure. Many people can only take on so much change and intervention in their lives at any one point. Use professional judgement to stage interventions or the introduction of new services, starting with the person's highest priority, and/or the agreed highest risk area.

Staggering the care plan implementation may be valuable in building a relationship with the person. Trust and confidence can be enhanced when the person experiences initial success and improvement. Positive feedback and achievement of small steps towards larger goals can assist in motivating and empowering the person.

Implementation of the HACC service plan

Assessors or team leaders need to communicate the person's goals and service plan to community care workers within their organisation and explain the context and rationale for the type of assistance to be provided. Team leaders need to match community care workers to the person and tasks required, to ensure they are not being asked to exceed the scope of their role.

Community care workers need to be clear about the division of tasks, the reasons for this and feel confident that they can undertake the roles and responsibilities required. Some community care workers may feel more comfortable and more motivated than others to implement an ASM 'doing with, not for' approach. Training in the broad concepts of an ASM approach is essential for community care workers to understand the rationale and benefits as well as their responsibilities and role boundaries.

More individualised training maybe required, depending on the specific requirements of a service plan.

Regular communication and feedback from community care workers back to the HACC assessor or team leader will assist to ensure the service plan is accurately implemented and updated as necessary. (See Section 15.5: Monitoring)

Predictors of effective care plans

A person is more likely to follow care plan strategies if:

- there is shared understanding and respect for the person's goals and beliefs
- goals are considered realistic and achievable by the person and support services
- barriers to implementation are addressed through monitoring and problem solving
- support, coaching, information and reminders are provided
- follow-up appointments and multiple communication methods are used (written material supported by verbal explanation)
- there is positive feedback about gains, progress and goal achievement.

People with chronic disease and complex needs

Care planning is more complex for people with chronic diseases and complex needs and circumstances. Interdisciplinary assessment and care planning is essential to improving the person's health status, functional abilities and quality of life.

HACC services are only one among many that will be involved in service provision. HACC assessors should build on existing goals and care plans where they exist. For people with complex needs, HACC may not be the lead agency or provide the care coordination.

If the person is not receiving sufficient support to manage their chronic disease, social, psychological or housing issues, HACC assessors should refer on to specialist programs designed for the person's specific health condition or needs. For example, community connections, Linkages package provider, HARP, health services, mental health, disability services.

Resources

- *SCTT User guide 2009*
<http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm>
 - *SCTT 2009 Care Coordination Plan* http://health.vic.gov.au/pcps/downloads/coordination/sctt2009/care_coordination_plan_lo_3c.pdf
 - *Victorian service coordination practice manual*, Section 4
http://health.vic.gov.au/pcps/publications/sc_pracmanual.htm
 - Other resources on care planning practice, implementation and web links to related sites are available at
http://health.vic.gov.au/pcps/coordination/care_planning.htm
-

Figure 12: Example of care coordination plan for a young adult with a disability

(using excerpt from SCTT Care Coordination Plan)

Issues/problems (in priority order)	Agreed goal (measurable)	Action/s to be taken and by whom	Target date
1 Shopping (short term)	1.1 As directed by the person, provide assistance with weekly shopping whilst usual support person (family member/carer) is away for two months	Action: Discuss and demonstrate on-line and telephone ordering options; arrange fortnightly shop and contingency plan Who: Person, HACC community care worker	
2 Domestic assistance (short term)	2.1 As directed by the person, provide assistance with house cleaning whilst usual support person (family member/carer) is away for two months	Action: Arrange for short term domestic assistance Who: Person, HACC community care worker	
3 Recreation (longer term)	3.1 The person wishes to join and attend an accessible fishing club within six months	Action: Support the person to contact Activities for All Abilities and provide short term transport assistance and travel-training Who: Disability worker; HACC community care worker	
4 Shopping (longer term)	4.1 The person aims to undertake 50% of their shopping independently within six months	Action: Work with person and their family/carer to develop a shopping program. Break the program into steps (telephone ordering, on-line ordering, community shopping bus, travel training) and work through each step. Who: Disability Services worker; HACC community care worker	

Figure 13: Example of care coordination plan for an Aboriginal person

(using excerpt from SCTT Care Coordination Plan)

Issues/problems (in priority order)	Agreed goal (measurable)	Action/s to be taken and by whom	Target date
1. Diabetes – need to keep blood sugar levels under control	1.1 Aunty (older Aboriginal person) will cut down the sweet biscuits to one per week and replace with enjoyable healthy snack on other evenings, as per nutritionist's advice.	Action: Stop buying sweet biscuits; find enjoyable alternative Who: Aunty, Aboriginal worker, nutritionist	
	1.2 Aunty will exercise for 15 minutes each day, gradually increasing to 45 minutes each day	Action: Home-based exercise plan and chart Who: Aunty with encouragement from daughter; physiotherapist	
2. Pain in knees – need to investigate cause and treatment options	2.1 Aunty would like to find out causes of her knee pain by the end of March	Action: Arrange a visit to the GP Who: Aunty; HACC coordinator or Aboriginal worker will provide information to the GP with Aunty's consent	
	2.2 Seek advice about treatment and/or pain relief for the knee	Action: Following the GP visit, and if appropriate, arrange an appointment with the physiotherapist at the community health centre Who: Aunty, Aboriginal worker, HACC coordinator	
3. Unsafe back steps leading to Aunty's lack of confidence to walk down steps and enjoy back garden	3.1 To improve safety of steps immediately	Action: Repair rails and clean up area around steps Who: Occupational Therapist, HACC home maintenance	
	3.2 Increase Aunty's confidence to walk down steps into the garden by Christmas	Action: Make sure the home-based exercise program is designed to take this into account Who: physiotherapist Action: Practice going up and down the steps when there is a carer present Who: Aunty, HACC, Aboriginal worker	
4. Transport to attend community funerals	4.1 Support Aunty to attend community funerals as this is culturally important	Action: Organise transport Who: HACC Aboriginal service	

15.3 Priority of access for service delivery

Priority of access

Where demand for a service exceeds supply, it is the responsibility of all HACC organisations to allocate resources in a way that provides the most benefit to the greatest number of people.

Priority of access processes ensure that service allocation is transparent and consistent. Factors to be taken into consideration in exercising this judgement include:

- the level of service to be provided given that the HACC program funds provision of basic maintenance and support
- the vulnerability of the individual to further deterioration
- the effect of service delivery on the family or carer
- the likely effect of the service provided in assisting individuals to attain their goals, for example maintaining quality of life in the community
- the effect on other existing and prospective service users of providing services for this individual. (*HACC program manual 2003*, pg 7).

Priority of access decisions should be guided by professional judgement and supported by practice tools. Various priority of access tools are used by HACC agencies. For example:

- the NARI Priority of Access tool which uses multiple criteria, weighted to provide an overall priority score.
See http://www.mednwh.unimelb.edu.au/publications/pdf_docs/POA3.pdf
- tools developed by HACC agencies.

Regular reviews must be carried out to reprioritise need for service and ensure equitable access, based on an ongoing appraisal of prioritised need.

15.4 Referral practice

Sending referrals

All HACC assessment services are required to have established referral processes for referring people and families or carers, with consent, to needed services. Referrals must be made using the statewide SCTT and in the context of the *Victorian Service Coordination Practice Manual 2009*, as well as agreed local protocol developed by each PCP.

When making a referral, HACC assessment services are required, as a minimum, to complete the following SCTT forms:

- Confidential Referral Cover Sheet (includes priority for referral)
- Consumer Information
- Summary and Referral Information (with the person's consent all referral agencies can be listed in the action plan section)
- Living and Caring Arrangements
- Supplementary form Functional Assessment Summary which is only filled out after an assessment has been completed
- Consumer consent to share information (this form is not sent with the referral).

In addition a copy of the overall care plan stating the person's issues, goal(s) and actions should be provided with the referral (with consent).

Aboriginal people or people from CALD backgrounds may have a support person who assisted in the assessment and care planning process. It is important to involve these people in the referral process and keep them well-informed.

Making referrals and reducing duplication

To reduce duplication of assessment and to implement an ASM approach, the SCTT Functional Assessment Summary should be sent when referring to:

- HACC-funded organisations
- ACAS, HARP, CDM, health services and disability services
- other organisations as relevant.

Consideration should be given to how recently the summary was completed (for example, within 12 months).

Receiving referrals

When a HACC assessor receives a referral from another organisation (such as ACAS, HARP, allied health, Linkages) existing information should be accessed and used to minimise duplication in the assessment and care planning process.

Depending on how much information is provided with the referral, it may be necessary to contact the referrer for additional information, prior to the home visit. This will enhance understanding of the person and their needs ensuring that aspects of the assessment and care planning processes that have already been covered are not unnecessarily repeated.

Resources

- Service Coordination Tool Templates (SCTT) and User Guide can be downloaded from <http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm>
-

15.5 Monitoring

Monitoring

Once a care plan has been developed and implemented, its impact and effectiveness needs to be monitored.

Monitoring of the person's service specific care plans involves formal and informal monitoring to identify how effectively services are meeting their needs, including how OHS issues are being effectively managed.

The concept of service users providing regular feedback directly to the assessor or team leader should be introduced early in the relationship, so that emerging issues or concerns are addressed quickly.

Monitoring can occur when a community care worker, other support worker or volunteer reports concerns about the person's health or wellbeing; concern regarding service delivery is also raised by the person or their family or carer. Monitoring includes keeping workers informed from other agencies involved, such as Aboriginal or multicultural agencies.

Monitoring should be undertaken in a streamlined manner to ensure effective use of time. Professional judgement should be applied to ensure the type of monitoring (informal, telephone, formal, face-to-face) is appropriate to the situation.

Questions

Typical monitoring questions, asked by an assessor or worker may include:

- How do you think things are going — do you feel you are making progress?
 - Is there anything that is worrying you about the services being provided?
-

15.6 Review

What is review? Implementing an ASM approach means a greater focus on planned reviews. Regular review is a key element to successful service delivery and achieving care plan objectives.

Where the care planning process has identified that a HACC service will be short term, then reviews are key to ensuring that the person transitions off the service at the appropriate time. In summary:

- A review is a process to check with the person about their progress towards goals, and adjustment of care plan if needed.
- Review can lead to cessation of services, provision of a defined period of ongoing services, or transition onto other services such as packaged care.
- Review can lead to reassessment if the person or family or carer's circumstances have changed significantly.

Practice Reviews allow time for reflecting with the person on their progress towards their goals and how well the service system is supporting them to achieve their goals. Typical questions may include:

- How well is the intervention meeting your needs?
- Has the intervention been implemented as planned?
- Are the goals still meaningful and achievable?
- Does the care plan (tasks or timeframes) need to be altered?

Review dates, progress and outcomes must be documented in the care plan and adjustments communicated to other people or agencies involved in care plan.

How and when The method of review will depend on each person and the complexity of their needs and care plan. Assessors should use their professional judgement in deciding whether a review is most appropriately carried out by telephone, face-to-face, or through a coordinated case conference with relevant organisations, the person, family members and carer, as relevant. The review process includes liaison with the support person from an Aboriginal organisation, multicultural organisation, disability service or mental health service as appropriate.

Review dates are documented on the care plan. The length of time between review points will be dependent on the person and their agreed goal. For example, a short term goal supported by service provision may require a shorter review period than a medium or longer term goal.

Each organisation should have a review policy with priority categories that support an ASM approach.

Where goals have been established, the timeframe for review will have been set, and will usually be between three and six months. For people who have not set specific goals, a formal review should occur within 12 months of service allocation.

Figure 14: Example of care coordination plan review

Issues/problems (in priority order)	Agreed goal (measurable)	Action/s to be taken and by whom	Target date
1. Shopping (short term)	1.1 To have help with weekly shopping whilst person recovers from illness	Action: Fortnightly shopping assistance Who: Person, HACC community care worker	Goal fully achieved; shopping assistance no longer required.
2. Domestic assistance	2.1 To have help with house cleaning until the person can self-manage this again	Action: Arrange for short-term domestic assistance; train person in energy conservation methods; arrange light weight equipment Who: Person, occupational therapist, team leader and community care worker	Goal partially achieved; person now able to fully complete some tasks and partially complete others. See revised care plan for new actions.
3. Emotional wellbeing - lonely/ social isolation	3.1 To attend community group or club	Action: Supported attendance at various groups until finds preferred one Who: HACC community care worker, volunteer	Goal partially achieved – has tried three groups and found one they like. See revised care plan for new actions re transport and attendant care.

16 Partnerships and interdisciplinary practice

16.1 Interdisciplinary practice

What is interdisciplinary practice?

Interdisciplinary practice is a team approach to providing services and supports. It supports shared decision making by valuing and respecting the contributions of each individual, family, and professional discipline. Interdisciplinary practice creates an integrated effort that exceeds the abilities and resources of any single professional discipline, provider organisation, family, or individual.

Key features of interdisciplinary practice for HACC assessment services will include:

- sharing the person's agreed goal(s) with key organisations such as allied health practitioners in community health services, disability services, other community service organisations and mental health services
- agreements to communicate and share information across key organisations and disciplines to work towards the person's agreed common goal
- engaging in joint visits, joint assessments, case conferences, secondary consultations and other communication forums to provide a coordinated and integrated approach to assessment, care planning and service delivery.

Interdisciplinary practice requires a good understanding of different practitioner's roles and clear agreements and understandings between organisations on a range of processes such as:

- the triggers for joint assessments/visits
- how assessments and care planning processes will be prioritised, recorded and information shared, to support an ASM approach
- the role of secondary consultation versus a referral to another discipline
- opportunities and triggers for case conferencing
- the expected timeframes for responses to requests for assistance.

Interdisciplinary practice requires good working relationships to ensure arrangements are streamlined and effective. Primary Care Partnerships play a key role in facilitating service coordination practice between agencies. Innovative approaches can assist to streamline interdisciplinary assessment and care planning processes (such as location of an occupational therapist with a council for half a day per week; location of a council assessor with a community health service allied health team for half a day per week; protocols with local Divisions of General Practice).

A key principle of interdisciplinary practice is to avoid duplication of processes. For example, poor interdisciplinary practice may result in assessments that are duplicated and failure to share information, which in turn reduces the effectiveness of service provision.

Interdisciplinary practice is relevant to both Living at Home Assessments and service specific assessments. Interdisciplinary practice is supported by local protocols between agencies.

Interdisciplinary processes

Interdisciplinary processes such as case conferences and secondary consultations are important elements to care planning in an ASM context.

Consulting with other people in your team or people in partner organisations such as community health services, or people who have previously assessed the person such as an allied health practitioner, ACAS or disability services is good practice.

Involvement in the care planning process by an Aboriginal worker, CALD worker, disability worker, mental health worker or advocate is critical, as the person will seek clarification of the care plan from people who were involved in the assessment process. These workers should receive a copy of the care plan when it is finalised.

As this takes time, you may need to develop an interim service plan or delay implementing the care plan until you are confident that the approach will work.

16.2 Strengthening partnerships

Strong partnerships

Partnerships between service providers is one of the core principles of assessment, care planning and the ASM.

Implementing Living at Home Assessments relies on strong partnering relationships which ensure timely involvement of expertise relevant to the person's needs and circumstances. *Evaluation of the Assessment partnering development pilot projects* (Department of Health, 2010) found that successful partnering requires:

- a clear sense of shared purpose and objectives
- a relationship to be established before project work can realistically begin
- the engagement and support of staff and executive level management
- respect for different ways of working
- structures and resources which will support and progress the work at the project/practice level.

Outcomes

The best outcomes to date have been achieved where partnering projects have gone beyond the development of higher level organisational protocols. Partnering projects that focused on activities at the practitioner level which build relationships and promote interdisciplinary practice are the ones which demonstrated tangible benefits to service users and each partner organisation.

The department is continuing to promote partnership building through the provision of project funding for a range of different activities and organisational innovation including:

- establishing secondary consultation roles and case conferencing processes
 - trialling joint assessment and care planning
 - trialling co-location of key staff in partner organisations
 - establishing case practice/peer review forums
 - developing and implementing local agreements that articulate processes for coordinated care planning
 - finding solutions to overcome local system problems, such as long waits for HACC service users to access allied health practitioners
 - partnering for in-service training. For example, local allied health practitioners or nurses providing training to HACC assessors in local councils to broaden their knowledge and identify triggers for referral to appropriate programs such as continence management, nutritional risk, functional assessment and mobility.
-

16.3 Joint assessments

Joint assessment

Some people will require assessment and care planning from more than one discipline or organisation, so that a coordinated process occurs.

In the context of this document, joint assessment occurs when two staff members from different organisations conduct an assessment together (for example: HACC assessor, allied health workers, ACAS staff member, nurse).

Outcomes of joint assessment include:

- minimised need for the person to repeat information or duplicate the assessment and care planning process
- jointly observing and assessing related aspects of the person's needs
- a reduced need to repeat or communicate information
- capacity to respond to the person and their family members or carers as individual clients
- providing a collaborative, coordinated, systems response.

Triggers

Triggers that highlight a joint assessment may be needed:

- the person is from a vulnerable group (such as insecure housing, physical, intellectual or acquired disabilities, mental health issues, dementia) and a range of expertise is required
- complex and multiple issues are indicated – for example, pre-assessment information such as that generated through initial needs identification or secondary consultation, indicates that multiple assessments or services are likely to be required
- pre-assessment information indicates that both a general holistic assessment plus specialist assessment is needed and that it would be beneficial for these to occur simultaneously
- the assessing organisation believes that their involvement is likely to be short term and specific (nursing) and that the longer-term involvement of another service (home care) may be required
- multiple services are already involved in the person's care
- the person and their family member or carer may both require assessments
- the joint assessment process provides an opportunity for targeted professional development.

Coordination

If there is an urgent need for assessment and only one organisation has an assessor available, the assessment process should commence. Consultation with the other organisation can occur as soon as possible following the assessment.

Who should take the lead?

Deciding who should take the lead role in conducting the assessment should be based on common sense and be mutually determined prior to the assessment. The person's area of highest priority may be the determining factor.

The method and responsibility for documentation and communication of assessment results should also be agreed. A lead assessor would normally have primary responsibility for logistics communication (organising a mutually convenient assessment date and time with the person, family members or carers and joint assessor). Factors to consider include:

- whether the person has an existing relationship with either assessor or their organisation
- which assessor has the most relevant experience
- which assessor or organisation is most likely to have an ongoing role
- capacity to document and communicate findings
- whether one assessor will lead part of the assessment and the other assessor lead another part (use of specialist skills).

Agreements

There are no simple rules for joint assessments. HACC assessment services should develop agreements with other agencies that cover the procedural aspects of joint assessments. Examples of key points to include in agreements are:

- how to determine the lead assessor
- the method of assessment and care planning (as per each program and organisation guidelines)
- documentation of the assessment findings
- communication of assessment outcomes to the person and family member or carer, including specialist issues
- responsibility for documenting and disseminating the coordinated care plan to relevant stakeholders
- conflict management.

Case snapshot: Joint assessment³⁵

An elderly person was referred for a Living at Home Assessment. Based on information revealed through the initial needs identification process, a joint assessment with an alcohol and drug agency was arranged with the person's consent.

The HACC assessor and specialist Alcohol and Drug Worker attended the assessment home visit together. During the assessment, although the person had been referred for home care and food services, the person identified their main goal as to be able to cut down their drinking, budget more effectively and not run out of food.

Based on the assessment and care plan, the Alcohol and Drug Worker assisted the person to attend Alcoholics Anonymous meetings; a financial counsellor helped the person to develop a budget and set financial goals. HACC provided an initial spring clean and some home maintenance, and supported the person in their shopping.

A six month review showed that the person had been successfully progressing towards their goals and the HACC service was reduced, as the person felt able and confident.

17 Care coordination for people with multi-agency involvement

17.1 Care coordination

Care coordination

All HACC assessment services will play a role in care coordination. Care coordination describes activities undertaken following a Living at Home Assessment for a subgroup of people with complex needs and circumstances and multi-agency involvement.

In many cases the person, carer or support person are capable of, and have a preference for, coordinating their own services.

People needing care coordination include those receiving services from multiple organisations who are not receiving case management as part of a package of care. Care coordination for this group is an extension of the care planning and care plan implementation process for people who cannot coordinate their own care.

Whenever care coordination is required and there is multi-agency involvement, the lead care coordination agency and key worker should be identified.

To avoid duplication of effort, HACC assessment services should build relationships and procedures with service providers outside the HACC program, to facilitate a greater understanding of agencies' role in care coordination and their capacities.

Tasks

Care coordination may include the following tasks:

- facilitating inter-agency care planning due to multi-agency involvement in service delivery
- facilitating development and review of the care coordination plan
- monitoring and review of service specific care plans within the coordinated care plan.

HACC assessment services should use the SCTT Care Coordination Plan when there are multiple agencies involved in a person's care plan.

Boundaries

Moving to an ASM does not mean that HACC assessors automatically are responsible for all aspects of a person's assessment, care planning and care coordination.

A HACC assessor should **not** take responsibility for the care coordination role if another organisation is coordinating or case managing the person's overall care. In these instances people will have been assessed, goals identified and referrals to HACC services made specifically for home and/or community support. The HACC assessment service role should remain within those boundaries.

Duration of care coordination HACC care coordination may be short term or episodic in nature. With the implementation of an ASM, there may be higher levels of care coordination that is short term. For example, this may require increased communication and coordination between services such as allied health, nursing, local councils, Aboriginal organisations, ethnic and multicultural organisations to determine the best options for increasing the person's independence – or until care coordination by another organisation, case management, or packaged care becomes available.

HACC assessors may participate in case conferences for service users who are on Linkages packages.

Case management Care coordination is not case management. Care coordination can be regarded as a less intensive form of case management.

For example, in addition to the care coordination task described previously, case management includes arranging additional services through brokerage, sub-contracting, purchase or maintenance of effort agreements between organisations, organising case conferences and actively monitoring care plans for changes in the person's or carer's circumstances (see the *HACC program national MDS user guide, Victorian modification*, November 2005, pp. 65-66).

17.2 Key worker

Introduction

A key worker is the nominated person who works with the person, family or carer and other service providers to facilitate care planning and care coordination. A key worker ensures that people with multi-agency involvement know which service provider to contact. Where possible, the key worker should reflect the person's choice, for example, a key worker from an Aboriginal, ethno-specific or CALD organisation.

Refer to the *Victorian service coordination practice manual and SCTT 2009 user guide* for further information about the role of a key worker.

The decision to appoint a key worker should be made carefully, in the light of limited resources for this activity and the person's need for a key worker or lead agency to coordinate care. As stated previously, HACC assessment services should not take on the care coordination and key worker role if another organisation is coordinating or case managing the person's care. The role of the HACC assessment service is to develop a service specific care plan to support the overall care plan which is coordinated by another organisation.

Protocols

To streamline care coordination processes between HACC assessment services and other agencies, local protocols should be developed which describe the key worker roles and responsibilities, and how the key worker and lead agency is determined.

Some community health services are developing protocols for determining the key worker role within their organisation if multiple allied health disciplines are involved. Be aware of local developments and statewide policy initiatives in other program areas (for example in mental health and disability services), in which greater recognition is given to the need for funded care coordination and case management.

Case example³⁶

Mr Jones was assessed by a chronic disease management program. As part of the care plan, a referral was made to HACC for domestic assistance. The chronic disease management program undertook care coordination and a key worker monitored service provision and goal attainment. HACC provided domestic assistance support and provided information for the review process, but did not coordinate care.

18 Reassessment and service exit

18.1 Reassessment

Reassessment Reassessment is an activity carried out by a HACC assessment service because of changes to the person's circumstances that necessitate reappraisal of the care plan.

A Living at Home *reassessment* is usually carried out when the circumstances of the person, family or carer change significantly enough to require a complete reappraisal of needs. This could be prompted by changes in the health of the person or carer, a review of risk management and OHS, or a pre-determined time linked to a review of the care plan.

Reassessment builds on previous assessment information and reflects a range of appropriate assessment domains (see Part B).

Who Where there are multiple organisations involved in delivering services to a person, a lead assessment service should be nominated for the purposes of reassessment. This may be a HACC assessment service or other organisation.

18.2 Service exit

Exit The introduction of the ASM and a goal-setting intervention approach may result in more short term service provision, followed by exit from HACC services.

The expectation that a service may be short term due to the person improving their capacities should be established at intake and again during the assessment and care planning process. Managing people's expectations right from the beginning is a key element to successfully managing the exit process.

Transition Reassessment plays a critical role in recognising if a person's declining abilities and increasing need for support requires transitioning from the HACC program to a more suitable care option.

For older people this would include transitioning to Commonwealth funded services in a timely manner, such as Community Aged Care Packages (CACPs), Extended Aged Care in the Home (EACH or EACHD) or residential aged care.

Statewide guidelines for streamlining assessment pathways between HACC assessment services and ACAS have recently been developed by the Department of Health. These guidelines provide information on transition issues between HACC services and Commonwealth funded aged care packages or residential care. HACC assessment services and ACAS will use the guidelines to develop regional or sub-regional MOUs/protocols.

For younger people with a disability, transition may involve moving from basic HACC Services or Linkages to an Individual Support Package. (See Part B, Section 11.6)

Resources *Statewide guidelines for streamlining pathways between ACAS and HACC assessment services*, Department of Health, 2010.
<http://www.health/vic/gov.au/hacc>

Glossary

Term	Definition
Aboriginal	For the purposes of this document, Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or as both Aboriginal and Torres Strait Islander. Aboriginal organisations are Aboriginal controlled organisations or Aboriginal controlled health organisations that receive HACC funding to provide services to the Aboriginal community.
Active ageing	Active ageing is the process of optimising opportunities for health, participation and security to enhance quality of life. Active ageing applies to both individuals and diverse population groups. It allows people to realise their potential for physical, social and mental wellbeing throughout life and to participate in society according to their needs, desires and capacities, while giving them protection, security and care when they need assistance.
Active service philosophy	Active service philosophy is the term used in this document to refer to the principles underpinning the active service model. These include 'People have the potential to improve their capacity' (see <i>Victorian HACC active service model discussion paper</i> pp. 10–11). Experience in Victoria, interstate and internationally indicates that this approach represents a specific way of thinking about and providing services to the HACC target group. The shorthand version of this is 'Doing with, not for.' With this as the underpinning philosophy, it can prompt different ways of thinking about relationships with clients, direct practice, service systems and strategies, as well as partnerships with other organisations.
Active service model	The quality improvement initiative currently being implemented in the HACC program in Victoria, which explicitly focuses on promoting capacity building and restorative care in service delivery.
Activities of daily living	Activities of daily living are everyday tasks performed by people for living. They include personal activities of daily living (dressing, bathing, grooming), domestic activities of daily living (domestic chores) and community activities of daily living (access, transport). The ability or inability to perform these activities is used as a practical measure of functional ability.
Allied Health	Allied health comprises a wide range of clinical services, including podiatry, occupational therapy, physiotherapy, social work, dietetics etc.
Assessment domains	A domain is a broad area of health and wellbeing such as 'mental health' or 'physical functioning'. The extent to which each domain is assessed will vary according to the person and their needs.

Term	Definition
Care coordination	Care coordination describes activities undertaken following a Living at Home Assessment for a subgroup of clients with complex needs and circumstances. Clients needing care coordination include clients receiving services from multiple organisations who are not receiving case management as part of a package of care.
Care Coordination Plan	The Care Coordination Plan is a Service Coordination Tool Template that documents issues/problems for a client - their goals, actions that will be taken to achieve these goals - and identifies a key worker responsible for liaising between relevant organisations. A Care Coordination Plan is developed for clients with complex needs and/or multi-agency involvement. However, the template itself can be used for HACC clients to summarise their care plan and goals.
Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or who are frail aged. In assessing eligibility for the HACC program, someone is defined as a carer if they receive HACC services because they care for a frail or disabled person.
Case management	Case management refers to the assistance provided by a formally identified agency worker to a client with complex care needs. The case manager will coordinate the planning and delivery of services from more than one agency. A case manager is different to a care coordinator in that they usually manage brokerage funds which purchase services on behalf of the client, such as in a Linkages package.
Chronic condition	A condition of at least six months duration that can have a significant impact on a person's life and requires ongoing supervision by a health professional. Amongst Australia's national health priorities are chronic conditions that are our greatest burdens of disease: asthma, cancer, cardiovascular disease, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.
Client	A person who receives HACC services due to frailty or disability.
Complex care needs	People with complex care needs have multiple health, functional and/ or social issues and are at risk of functional decline and/ or hospital admission. The complexity of the individual's care needs are compounded by the presence of one or more of the following: an unstable or deteriorating condition; increasing frailty and/or dependence; development of complications; co-morbidities; significant change in social circumstances; three or more hospital admissions in the past twelve months.

Term	Definition
Cultural and linguistic diversity	Cultural and linguistic diversity (CALD) refers to a wide range of cultural and linguistic groups that make up the Victorian population. This can include new arrivals, refugees, first-generation immigrants and members of the next generation. The term acknowledges that groups and individuals have different ethnicity, racial background, language, customs, religion and spirituality. Cultural diversity in Victoria's ageing population is a reality that will persist into the coming decades. (<i>ECCV response to the HACC program Service Coordination Guide of the Department of Health, ECCV 2010, Melbourne</i>)
Disability service	In this document disability service refers to community service organisations that are funded to provide specific services to people with a disability.
Diversity planning	A quality improvement initiative which promotes a holistic, person-centred approach to service planning, delivery and evaluation.
Evidence-based practice	Evidence-based practice is the conscientious use of current best evidence in making decisions about assessment and service delivery for people. Consultation with the person is implicit in the process.
HACC activities	The types of service funded by the HACC program.
HACC service provider	An organisation providing HACC-funded services.
Initial contact	Initial contact is the person's first contact with the service system. Initial contact usually includes the provision of accurate, comprehensive service information, including health promotion literature, and facilitated access to initial needs identification.
Initial needs identification	Initial needs identification is a broad screening process to uncover underlying and presenting issues. During initial needs identification, the assessor engages in a broad conversation about the person's health and wellbeing to identify the full range of the person's needs, including health promotion, illness prevention, early intervention, self-management capabilities and restorative options.
Interdisciplinary practice	Interdisciplinary practice is a 'team' approach for providing services to people in a way that supports shared decision-making by valuing and respecting the contributions of each individual, family or carers, and professional discipline. Interdisciplinary practice creates an integrated effort that exceeds the abilities and resources of any single professional discipline, provider agency, family or individual.

Term	Definition
Key worker	The nominated person who works with the client and family or carer and other organisations to facilitate inter-agency care planning and care coordination. Key workers are only nominated for clients with complex needs and/or multi-agency involvement.
Linkages	Linkages is a HACC-funded case management service that has funds to purchase additional services for people whose needs cannot be met entirely by the usual level of HACC services. This constitutes a package of care for each consumer.
Living at Home Assessment	A Living at Home Assessment is a broad, holistic needs-based assessment that occurs in the client's home. A Living at Home Assessment includes service Specific assessments for services provided by the assessing organisation, an occupational health and safety assessment (OHS), care planning and care coordination.
OHS Plan	An OHS plan is developed following a home safety assessment. This plan should include assessment of tasks involved, controls to manage the risks and the provision of suitable equipment.
Packaged Care	HACC-funded Linkages or case-managed Commonwealth funded services – Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH), Extended Aged Care at Home Dementia (EACHD). Eligibility for Commonwealth packages is determined by the Aged Care Assessment Service.
Partnerships / Primary Care Partnerships	A Primary Care Partnership or PCP is a group of services that has formed a voluntary alliance to work together to improve health and wellbeing in their local community.
Person	The term person is used in preference to the term client in this guide.
Person-centred	Person-centred practice is respect for a person's or family's right and desire to make their own decisions. A person-centred approach focuses on self-determination and empowerment. Delivery of services configured around the needs of the person.
Polypharmacy	Polypharmacy refers to the use of multiple medications. The <i>SCTT 2009 user guide</i> states that 'polypharmacy is indicated if the consumer is taking five or more different medications' and that a medication review may be desirable.

Term	Definition
Prevention	There are three types of prevention: primary, secondary and tertiary prevention. Primary prevention is an active, assertive process of creating conditions and or personal attributes that promote the wellbeing of people. Secondary prevention is early detection and intervention to keep initial problems from becoming more severe. Tertiary prevention is the effort to rehabilitate those affected with severe disorders.
Referral Action Plan	The Referral Action Plan outlines the referrals that will be made and actions taken for the person as determined through the Living at Home Assessment and agreed with the person and/or their carer. The SCTT Summary and Referral Template has a table for documenting referral actions.
Self-management	Self-management is the active participation by people in their own health care. Self-management incorporates health promotion, risk reduction, informed decision making, care planning and medication management, while working with health care providers to attain the best possible care and effectively negotiate the often complex health system. (<i>Complex and Chronic Conditions: Strengthening Victoria's response</i> , Department of Health, February 2010)
Service coordination	Service coordination places people at the centre of service delivery to ensure that they have access to the services they need, opportunities for early intervention, health promotion and improved health and care outcomes. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give people a seamless and integrated response.
Service Coordination Tool Template (SCTT)	The Service Coordination Tool Templates (SCTT) is a suite of templates developed to facilitate and support service coordination. The SCTT supports the collection and recording of initial contact, initial needs identification, referral and coordinated care planning information in a standardised way. Use of the SCTT is intended to improve communication, information sharing, and the quality of referrals and feedback between service providers.
Service specific assessment	An assessment for a specific service type such as home care, delivered meals, nursing or allied health.
Service specific care plan	A care plan that is developed and documented using specific program or agency tools and may be referred to as a Client Care Plan, an Individual Treatment Plan, a Self-management Plan, a Personal Action Plan, a Service Plan, or a GP Management Plan.
Service user	See person or client.

Acronyms

ACAS	Aged Care Assessment Service
ASM	Active service model
CALD	Cultural and linguistic diversity
DBMAS	Dementia Behaviour Management Advisory Service
DH	Department of Health (Victorian)
DSR	Disability Support Register
EiCDM	Early Intervention in Chronic Disease Management
HACC	Home and Community Care
HARP	Hospital Admissions Risk Program
HAS	HACC assessment services
ISP	Individual Support Package
MOU	Memorandum of understanding
SCTT	Service Coordination Tool Template
OHS	Occupational Health and Safety
PAG	Planned Activity Group
PAV	Personal Alert Victoria
PCP	Primary Care Partnership
VSDP	Victorian state disability plan

