

**Central Highlands HACC Assessment Services  
Grampians Region**

**LIVING AT HOME ASSESSMENT  
Memorandum of Understanding**

**November 2010**



This is an agreed HACC Assessment Service MOU between HAS agencies in the Central Highlands catchment area. This is not a HACC program policy document.

## **Contents:**

<b>1. Introduction</b>	<b>Page 4</b>
Grampians Region Designated HACC Assessment Services	Page 4
Central Highlands Designated HACC Assessment Services	Page 5
Context of this MOU	Page 5
Acronyms	Page 5
<b>2. Living at Home Assessment</b>	<b>Page 6</b>
2.1 The purpose of a Living at Home Assessment	Page 6
2.2 Principles that underpin a Living at Home Assessment	Page 7
2.3 Assessment mode	Page 7
2.4 Referral process and timelines	Page 7
2.5 SCTT templates and profiles for a Living at Home Assessment	Page 7
2.6 Key outcomes of a Living at Home Assessment	Page 8
2.7 The agencies agree that:	Page 9
<b>3. Access to a Living at Home Assessment</b>	<b>Page 10</b>
3.1 Who should receive a Living at Home Assessment	Page 10
3.2 Supported Access	Page 10
3.3 Service specific assessment	Page 11
<b>4. Referral pathways and processes</b>	<b>Page 12</b>
4.1 Referring to a HAS agency – SCTT templates and profiles	Page 12
4.2 Undertaking a LAHA – SCTT templates and profiles	Page 12
4.3 HAS outgoing referrals – SCTT templates and profiles	Page 13
4.4 Service Coordination	Page 13
4.5 Referral processes and timelines	Page 14
4.6 Non-HAS agencies referring to a HACC assessment service	Page 14
<b>5. Implementing collaborative assessment</b>	<b>Page 15</b>
5.1 Joint assessment	Page 15
5.2 Joint assessment roles	Page 16
5.3 Secondary consultation	Page 17
5.4 Assessor conflict	Page 17
<b>6. Care Planning</b>	<b>Page 18</b>
6.1 The care planning process	Page 18
6.2 What should a care plan include	Page 18
6.3 Care planning encompasses	Page 29
<b>7. Care Coordination</b>	<b>Page 20</b>
7.1 The key worker	Page 20
7.2 Key features of care planning and care coordination	Page 22
7.3 Care coordination meetings	Page 22

<b>8. Monitor, Review and Reassess</b>	<b>Page 24</b>
8.1 Monitor	Page 24
8.2 Review	Page 24
8.3 Reassessment	Page 24
8.4 Service closure	Page 25
<b>9. Cross Boundary Considerations</b>	<b>Page 25</b>
<b>10. Summarising the agreements:</b>	<b>Page 26</b>
<b>References</b>	<b>Page 28</b>
<b>Appendices</b>	<b>Page 29</b>
Appendix 1 Indicators for a nursing specific assessment	Page 29
Appendix 2 Indicators of unstable health	Page 30
Appendix 3 Sample Living at Home Assessment checklist	Page 31
Appendix 4 Outcome of Referral/Assessment form	Page 33
Instructions for sending forms via Connecting Care	Page 34
Appendix 5 Grampians Region Home Safety Checklist	Page 39
Instructions for using electronic form	Page 41
Protocol for implementing the form	Page 42
Appendix 6 MOU Endorsements	Page 45
Ballarat District Nursing and Healthcare	Page 45
City of Ballarat	Page 46
Golden Plains Shire Council	Page 47
Hepburn Shire Council	Page 48
Moorabool Shire Council	Page 49

## **Central Highlands Living at Home Assessment Services**

### **1. Introduction**

This Central Highlands HACC Living at Home Assessment (LAHA) MOU is the outcome of a consultative process undertaken within the Wimmera, Grampians Pyrenees and Central Highlands catchment areas. HACC Designated Living at Home Assessment Services (HAS) worked collaboratively within their catchment areas and more broadly across the Grampians Region to develop this document as a catchment specific MOU for the delivery of Living at Home Assessments.

Whilst some differences were identified within each catchment, the primary processes for the delivery of HACC Assessment Services are the same within the Grampians Region.

The Wimmera Home and Community Care (HACC) Living at Home - Integrated Assessment Partnership Project (2009-2010) undertook the lead role within the project and a significant amount of research to document this practice approach to the implementation of Living at Home Assessments. The Ballarat Partnering Project (2008-2009) contributed to the initial discussions surrounding the delivery of Living at Home Assessments. The Victorian Department of Health provided the initial funding for the development of this regional protocol.

The Grampians Pyrenees and Central Highlands LAHA working parties reviewed the Wimmera MOU and adapted the model and key strategies to suit each of their catchment areas.

The aim of these three Memorandum of Understanding is to:

- Outline the agreed and accepted ways of working together to conduct Living at Home Assessments across the Grampians Region.
- Clarify the roles and responsibilities of agencies where joint assessments are indicated.
- Promote effective service coordination for clients and agencies.

It is anticipated that these three MOU's will contribute to the levels of trust and networking between agencies, which will in turn, increase the Grampians regions capacity to implement the LAHA framework with a focus on providing services within a culture of maintaining and improving clients' health and functioning.

### **Grampians Region Designated HACC Assessment Services**

Ararat Rural City Council  
Ballarat District Nursing and Healthcare  
East Grampians Health Service  
Golden Plains Shire Council  
Hindmarsh Shire Council  
Moorabool Shire Council  
Pyrenees Shire Council  
West Wimmera Health Service  
Yarriambiack Shire Council

Ballarat City Council  
Dunmunkle Health Service  
Edenhope & District Memorial Hospital  
Hepburn Shire Council  
Horsham Rural City Council  
Northern Grampians Shire Council  
Wimmera Health Care Group  
West Wimmera Shire Council

## Central Highlands Designated HACC Assessment Services

Ballarat District Nursing and Healthcare  
Golden Plains Shire Council  
Moorabool Shire Council

City of Ballarat  
Hepburn Shire Council

### Context

This protocol should be read in conjunction with the:

- Victorian Government Department of Health Framework for Assessment in the Home and Community Care Program,
- Victorian Service Coordination Practice Manual 2009,
- Service Coordination Tool Templates (SCTT) 2009 user guide,
- HACC National Service Standards and other guidelines that are progressively being developed
- Strengthening assessment and care planning: A guide for HACC assessment services in Victoria
- HACC Assessment induction guide

In relation to undertaking Living at Home Assessments, the agencies agree to implement and comply with the:

Victorian Service Coordination Practice Manual 2009 (VSCPM) standards located at [http://www.health.vic.gov.au/pcps/downloads/sc\\_pracmanual2.pdf](http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf)

Service Coordination Tool Templates (SCTT) 2009 user guide located at <http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm>

HACC privacy resources: In relation to consent, agencies will comply with the Victorian Service Coordination Practice Manual (VSCPM), Service Coordination Tool Templates (SCTT) 2009 user guide and privacy resources located at: <http://www.health.vic.gov.au/pcps/coordination/privacy.htm>

This MOU relates specifically to those agencies involved in the Central Highlands area and within the context of their role as HACC assessment agencies undertaking Living at Home Assessments.

### Acronyms

ASM	Active Service Model
DHS	Department of Human Services, Victoria
DH	Department of Health, Victoria
HACC	Home and Community Care
HAS	Home and Community Care Assessment Services are referred to via the acronym HAS or HACC Assessment Services
IC	Initial Contact
INI	Initial Needs Identification
LAHA	Living at Home Assessment
OHS	Occupational health and safety
MAV	Municipal Association of Victoria
MOU	Memorandum of Understanding
RDNS	Royal District Nursing Service
SCTT	Service Coordination Tool Templates
VSCPM	Victorian Service Coordination Practice Manual 2009

## 2. LIVING AT HOME ASSESSMENT

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 the intervention of formal services. In this sense, assessment is usually not a one-off event but a continuum. It is an ongoing process of building trust and understanding. An active service 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<sup>1</sup>.

Assessment is a decision-making methodology that collects, weighs and interprets relevant information about the consumer<sup>2</sup>. The Service Coordination Tool Templates (SCTT) are the screening tools used to support and guide the breadth and depth of assessment and to facilitate and support service coordination practice<sup>3</sup>.

A Living at Home Assessment (LAHA) is the process of undertaking a broad holistic assessment of general health and wellbeing in the context of active ageing and independent living<sup>4</sup>.

A LAHA may include a service-specific assessment<sup>5</sup> for services provided by the assessing organisation, risk management and occupational health and safety assessment (OH&S).

### 2.1 The purpose of a Living at Home Assessment

The purpose of undertaking Living at Home Assessments 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, and to build a person's capacity to continue living as independently as possible.<sup>6</sup>

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 active service approach to:

- building on the person's and carer's autonomy by offering choices and focussing on individual strengths and interests,
- encouraging people to do more for themselves by regaining skills and capacities wherever possible,
- strengthen social, community and family connections,
- recognise if a clients declining abilities and increasing need for service requires transitioning from the HACC Program to a more suitable care option.

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<sup>1</sup> Strengthening assessment and care planning: A guide for HACC Assessment Services in Victoria, Final Draft September, 2010, p 14

<sup>2</sup> Victorian Service Coordination Practice Manual [VSCPM] 2009, p.20

<sup>3</sup> Service Coordination Tool Templates [SCTT] 2009 user guide, p.1

<sup>4</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.7

<sup>5</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.1

<sup>6</sup> Strengthening assessment and care planning: A guide for HACC Assessment Services in Victoria, Final Draft September, 2010, p14

## 2.2 Principles that underpin Living at Home Assessment <sup>7</sup>

- Assessment is interactive and client focused
- Assessment is a continuum
- Assessment is underpinned by the Active Service Model (ASM) and Well for Life approach
- Assessment is undertaken by staff with appropriate expertise
- Assessment is responsive to issues of culture, language, belief and identity in the provision of relevant, meaningful and easily accessible services
- Assessment is a collaborative process between one or more agencies and the client and carer
- Repetitive information gathering and the duplication of assessments is minimised with each assessor accepting and building on information gathered in prior assessments
- Clients with basic, one-off or short-term needs are not over assessed
- Clients must provide consent to each stage of assessment and to the sharing of their information.

## 2.3 Assessment mode

Most referrals will prompt a Living at Home assessment<sup>8</sup>. However:

Assessment 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. Key factors in initial needs identification are to ensure that:<sup>9</sup>

- 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

**NOTE\*** When a clients needs are urgent, a service specific assessment and service provision should take place *prior to* a Living At Home Assessment.

## 2.4 Referral processes and timelines

The timeframe and priority for acknowledging referrals for a Living at Home Assessment and providing feedback to the referring organisation will be determined in accordance with the Victorian Service Coordination Practice Manual (VSCPM). For more information, refer to section 4 of this document.

## 2.5 SCTT templates & profiles for a LAHA

The Central Highlands team agree that the information/screening questions contained on the SCTT templates and profiles will be addressed in order to ensure a holistic assessment. The following templates/profiles are considered to provide the range and depth of information, which should be collected during a Living at Home Assessment:

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<sup>7</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.5

<sup>8</sup> Strengthening assessment and care planning: A guide for HACC assessment services in Victoria, 2010, p.19

<sup>9</sup> Strengthening assessment and care planning: A guide for HACC assessment services in Victoria, 2010, p.18

- Referral cover sheet (including priority of urgency)
- Consumer information
- Summary and referral information
- Consumer consent to share information (to be completed but does not need to be sent)
- Living and caring arrangements
- Functional assessment summary
- Need for Assistance
- Health Behaviours
- Health Conditions
- Psychosocial
- Family & Social Network
- Palliative Care (if relevant)
- Care Plan/Care Coordination Plan (for a specific service or intra-agency or inter-agency dependent on client or situation needs)
- Carer profile
- Personal Alert Victoria checklist
- Grampians Region Service Provider Home Safety Checklist or their own OH&S form

Living at Home Assessment officers should document their assessment in each of these areas (even if it is “not applicable”) so that further assessments/assessors are aware that the area has been explored and thus repetitive questioning can be reduced. This model of documentation will support the agreed principle that each assessor builds on previously collected information.

## **2.6 Key Outcomes of a LAHA<sup>10</sup>**

A LAHA results in the development of a written care plan that details the clients goals, any services to be delivered by the assessing organisation, and referral to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation.

Written care plans will be based on a collaborative approach to support the consumer to achieve their goals.

A written care plan includes

- an outline of the consumer’s stated and agreed goals, based on a collaborative care team approach<sup>11</sup> and
- a service-specific care plan for any HACC service provided by the assessing organisation

Dependent on client need and consent it may also include

- a referral action plan for referrals to both HACC and non-HACC funded services for needs that cannot be met by the assessing organisation;
- intra and/or inter agency care plans if more than one service is provided;<sup>12</sup>
- information provision on services, or activities, including health promotion and social activities that the client may choose to follow up themselves.

<sup>10</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.7

<sup>11</sup> A care team refers to the care planning and delivery relationship between the assessor/client, assessor/client/carer, assessor/client/carer/other provider or a combination of all.

<sup>12</sup> Victorian Service Coordination Practice Manual [VSCPM] 2009, p. 28-29



For more detail on assessment role refer to section 5 and for care planning, refer to section 6.

## **2.7 The agencies agree that:**

In relation to the processes, timeframe and priority for acknowledging referrals, the agencies will:

- send and acknowledge referrals using the Service Coordination Template Tool (SCTT) wherever possible
- use Connecting Care (RIMS or similar) for secure electronic transfer and sharing of client information between agencies
- share relevant information including assessment and care planning reports and the Grampians Region Service Provider Home Safety Checklist
- comply with the time frame and priority for acknowledging referrals and providing feedback to the referring organisation as detailed in the Victorian Service Coordination Practice Manual (VSCPM) and section 4 of this document
- complete and forward a Grampians Region Outcome of Referral/Assessment form (4) and transmit this to the referring agency to provide feedback to the referee.

### **3. ACCESS TO A LIVING AT HOME ASSESSMENT**

#### **3.1 Who should receive a Living at Home Assessment<sup>13</sup>:**

The agencies agree that new clients (who are not brokerage or episodic<sup>14</sup> or who have not received a LAHA (including by another HACC Assessment Service) or comprehensive assessment within the last six months) should receive a LAHA, based on the underpinning philosophy of the Active Service Model (ASM) which aims to maintain and improve client functioning, wellbeing and independence.<sup>15</sup>

In addition, the following circumstances serve as triggers for undertaking a LAHA:

- A client has received a service-specific assessment in the past however, because of changed circumstances a more extensive assessment is indicated e.g. recent health decline, hospital admission, death of spouse.
- A current HACC client who has not previously had a LAHA is due for their annual review. The review process will be completed utilising the Living at Home Assessment and collaborative team approach to determine potential strategies for increased client independence (e.g. environmental strategies, allied health responses etc.).
- Other triggers for assessment/reassessment utilising the LAHA and collaborative team approach include when:
  - client circumstances change significantly to warrant a LAHA reassessment within the six month period,
  - carer stress is evident,
  - there is differing viewpoints between what the client wants and what carers/other services /referrer believe is needed, and
  - there are multiple clients in the one household with competing needs.

#### **3.2 Supported access**

In general, HACC funded agencies (eg non-HAS services) undertake service specific assessments but not a Living at Home Assessment. However, if a non-HAS agency assessor believes a client would benefit from a holistic assessment rather than/as well as, a service-specific assessment and/or believes the client may have a broader set of unmet needs than can be met by their own organisation, they should consider referral to a designated LAHA service.

The agency can complete the service specific assessment and refer to a HACC Assessment Service (HAS) for a LAHA – or – refer directly to a HAS for a LAHA, depending on the client's need.

Agencies who are referring a client for a Living at Home Assessment are urged to make initial phone contact with the local HACC Assessment Service (HAS) to check if the client has recently been assessed to avoid the potential duplication of services. By undertaking this action and/or using a secondary consultation approach when appropriate, the practitioner can reduce the time-delay for a client and provide a more efficient service response (rather than making a referral and waiting for a response).

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<sup>13</sup> Royal District Nursing Service Victoria (RDNS) and Municipal Association of Victoria (MAV) Protocol Agreement, Draft 2008

<sup>14</sup> Episodic may be a one off or time limited service provision.

<sup>15</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.1

### **3.3 Service Specific assessment**

Service-specific assessment can be defined as *a face-to-face interaction with a consumer who has a straightforward and distinct need for a specific service* (such as home care, nursing, podiatry, etc). This assessment is conducted by the service provider responsible for delivering the service and leads to the development of a service specific care plan.

## **4. REFERRAL PATHWAYS AND PROCESSES**

### **4.1 Referring to a HAS agency - SCTT templates and profiles**

Agencies referring to a HACC Assessment Service (HAS) should provide the following Service Coordination Tool templates:

- Confidential referral cover sheet
- Consumer information
- Summary and referral information
- Consumer consent to share information
- Grampians Region Service Provider Home Safety Checklist or their own OH&S form
- Any other templates or profile considered appropriate

### **4.2 Undertaking a LAHA - SCTT templates and profiles**

The Central Highlands team agree that the information/screening questions contained on the SCTT templates and profiles will be addressed in order to ensure a holistic assessment. The following templates/profiles are considered to provide the range and depth of information that should be collected during a Living at Home Assessment:

Core Templates:

- Referral cover sheet
- Consumer information
- Summary and referral information
- Consumer consent to share information

Profiles:

- Need for assistance
- Health behaviours
- Living and caring arrangements
- Health conditions
- Psychosocial
- Family & social network

And:

- Functional assessment summary
- Palliative Care supplementary summary (if relevant)
- Care Plan/Care Coordination Plan (for a specific service or intra-agency or inter-agency dependent on client or situation needs)
- Carer profile
- Personal Alert Victoria checklist
- Grampians Region Service provider Home Safety Checklist

In order to develop an holistic assessment the screening information contained in the SCTT templates and profiles should be addressed and documented using the SCTT templates/profiles and the agency specific assessment tool (e.g. nursing or Living at Home Assessment report). These documents should include comment in each of the areas (even if it is "not applicable") so that further assessments/assessors are aware that the area has been explored and thus repetitive questioning is reduced. This model of documentation will support the agreed principle that each assessor builds on previously collected information.

As a number of other HACC and non-HACC, funded agencies require such things as client pension type and number, Medicare number and other evidence of financial status please include these details when you are completing and documenting your assessment.

#### **4.3 HAS out going referrals - SCTT profiles and templates**

Any referral from a HACC Assessment Service (HAS) will be based on consumer consent to share and 'need to know', unique to each referral. The *minimum* templates/profiles to be forwarded are:

- Confidential referral cover sheet
- Consumer information
- Summary and referral information
- Consumer consent to share information
- Functional assessment summary
- Living and caring arrangements
- Any other templates or information considered appropriate
- Grampians Region Service Provider Home Safety Checklist

When referring to another HACC Assessment Service please ensure that you include a full handover of information to ensure that the second HAS does not repeat the same information gathering. e.g. advise them that a LAHA has been completed and include material based on the discussion in Section 2.5

#### **4.4 Service Coordination**

The agencies agree they will follow the Victorian Service Coordination Practice Manual guidelines and:

- send and acknowledge referrals using the SCTT templates;
- use Connecting Care (RIMS or similar) for secure transfer and sharing of client information between agencies;
- share relevant information including assessment and care planning reports, and the Grampians Service Provider Home Safety Checklist - as appropriate and with client consent - when referring the client to another organisation, within case conferences and inter-agency care plans;
- support and promote the implementation of intra and inter agency care planning and care coordination; and the associated roles of Lead Assessor and Key Worker;
- indicate on the Referral Cover Sheet if a Living at Home Assessment has been completed and the date completed;
- indicate on a referral whether the service initiating the referral has been and/or is continuing in a care co-ordination and/or Key Worker role;
- provide feedback and referral outcome information to the initiating service provider within 14 working days of the client being assessed. Feedback should be provided on the Grampians Region Outcome of Referral/Assessment form (Appendix 4).

## 4.5 Referral processes and timelines

### The service provider sending a referral agrees to<sup>16</sup>

- send urgent referrals within no-more-than 1 working day of obtaining client consent;
- send low or routine referrals within no-more-than 7 working days of obtaining client consent;
- make immediate referrals (for example, over the phone when a client is in crisis) and follow this up with a more detailed referral using the SCTT;
- retain responsibility to the client and monitor the client's status until a response to the referral is received and accepted. At this point, both service providers should agree who is responsible for monitoring the client if they are placed on a waiting list.
- check to ensure the referral has been received if the receiving service provider does not respond within agreed timelines (see below).

### The Assessment Service receiving the referral agrees to<sup>17</sup>

- acknowledge receipt of the referral using the SCTT Confidential Referral Cover Sheet - referral acknowledgement section, to the initiating service;
- state the referral has been received and the estimated date of client assessment, or the reason why the referral is not proceeding;
- acknowledge referrals using the Connecting Care (RIMS or similar) system within the timelines clarified in the VSCPM (below):
  - urgent referrals within no-more-than 2 working days of receipt
  - low or routine referrals within no more than 7 working days of receipt
  - provide feedback and referral outcome information to the initiating service provider within 14 working days of the client being assessed. Feedback should be provided on the Grampians Region Outcome of Referral/Assessment form.

## 4.6 Non HAS Agencies referring to a HACC Assessment Service

All HACC Assessment Services provide a similar holistic assessment, information gathering, documentation and referral process.

Some HACC Assessment Services are actually housed within a health service – this does not automatically mean that a qualified nurse is the LAHA officer. Therefore, client's immediate needs such as unstable health or medical concerns must take precedence to a LAHA through a medical or service specific nursing referral.

Indicators for a nursing specific assessment and Indicators of unstable health are found in Appendix 1 and 2.

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<sup>16</sup> Victorian Service Coordination Practice Manual 2009, p. 43

<sup>17</sup> Victorian Service Coordination Practice Manual 2009, p.43-44

## **5. IMPLEMENTING COLLABORATIVE ASSESSMENT**

Assessment is an ongoing cyclic process in care delivery that incorporates collecting, weighing and interpreting relevant information about the client.<sup>18</sup>

Joint assessment and secondary consultation approaches are opportunities to gain a fuller understanding of client circumstances and need, to enhance the coordination and continuum of care, and avoid duplication and/or a multiplicity of individual assessments.

### **5.1 Joint assessment**

Joint assessment refers to staff from two or more agencies conducting an assessment together. Joint assessments may occur at the time of the first assessment or following an assessment, whereby an Assessment Officer determines that expertise from another agency/discipline is required to complete a full assessment.

The decision to conduct a joint assessment will be based on consent from the client, consideration of the potential benefits to the client, and determined by discussion between the relevant agency assessment staff.

When undertaking a joint assessment, the lead agency is the HACC Assessment Service who received the referral. The lead agency delegates an Assessment Officer who is then (in general) the Lead Assessor.

In rural areas the capacity to undertake joint assessments may be limited due to distance, travel time and limited multi disciplinary resources. However, in some instances, joint assessment may be completed over a period of time with only one assessor being present at a time – followed by collaboration; or be carried out by videoconferencing or telephone using a secondary consultation approach.

Careful consideration must be given to the most appropriate way to implement assessment for the individual client and awareness of any immediacy for the introduction of services/support while preparing for a broader multi agency/discipline assessment.

#### **The benefits of conducting a joint assessment**

- Streamlining communication between all parties in order to increase the effectiveness of the care continuum and coordination of care
- Minimising duplication of the assessment process
- Joint observation and assessment in order to gain a broader and more comprehensive understanding of a client's circumstances and needs
- Improving client outcomes by utilising a collaborative, shared care, multi-disciplinary team approach to goal setting, problem solving and care planning

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<sup>18</sup> Victorian Service Coordination Practice Manual 2009, p. 20

## **Triggers for conducting a joint assessment**

- A client has complex or unclear needs
- Pre-assessment information indicates that multiple assessments or services are likely to be required
- The HACC Assessment Service that has been approached to provide the LAHA believes their involvement is likely to be short term and/or specific (e.g. nursing) and that the longer-term involvement of another service (e.g. home care) may be required and that it is efficient and effective to collaborate at an early stage
- A client is from a vulnerable group with complex or multiple needs (insecure housing, physical, intellectual or acquired disabilities, mental health issues, dementia, chronic health condition) and a range of expertise is required

## **5.2 Joint assessment roles**

The Lead Assessor role refers to that of the Assessment Officer from the HACC Assessment Service who received the referral and was delegated to complete the assessment.

The Lead Assessor has primary responsibility for communication and organising the assessment.

### **The Lead Assessor is responsible for**

- organising the assessment date and time with the client and their preferred contact/advocate and the joint assessor(s)
- organising informed consent from the client
- developing a client care coordination plan (using the SCTT Care Coordination Plan)
- developing and communicating their agency client assessment report (based on existing agency specific expectation)
- ensuring the client (and their preferred contact/advocate) and other engaged service providers receive a copy of the client care coordination plan
- completing the Grampians Region Outcome of Referral/Assessment form and transmitting this to the referring agency; and
- organising any necessary secondary consultations and referrals

### **The Joint Assessor is responsible for**

- supporting and assisting with the documentation required; and
- developing and communicating their agency client assessment report (based on existing agency specific expectation).

**NOTE\***If there is an urgent need for assessment and only one agency has an assessor available, the assessment will be conducted and consultation with the other agency will occur as soon as possible following the assessment.

**NOTE\***The Lead Assessor role is different from the Key Worker role. [Section 7.1](#) provides information about allocating a Key Worker and their role.



### **5.3 Secondary consultation**

Secondary consultation refers to one practitioner consulting other practitioners to benefit from their specialist skills or expertise, gain another opinion and to ensure a well-informed approach.

Secondary consultation is dependent on client consent (if client information is to be shared) and can occur at any stage of the care pathway – that is, before, during, after assessment, or during care planning.

#### **Triggers for accessing a secondary consultation**

- The assessor wishes to check or clarify certain information in relation to a client condition, possible need, possible response etc. The assessor therefore contacts the secondary consultation practitioner to discuss the situation and discuss an appropriate action.
- The assessor is unable to answer a client query about a particular matter. In order to provide an immediate response, the assessor contacts the secondary consultation practitioner on the spot, thus providing an efficient response to the client.
- The assessor has considered assessment information and wishes to clarify a particular matter or gain advice from another discipline or specialist area to inform the care planning process.

### **5.4 Assessor conflict**

Conflict arising between assessment officers from different agencies will be managed according to their own agency protocols. For example, conflict may be related to not reaching agreement as to the most immediate care needs of the client, differing options to meet client needs or difference in assessment practice between disciplines.

Assessors must ensure the client is not disadvantaged due to worker conflict and that clear recognition is given to the client and/or their advocate always being the final decision maker in relation to preferred outcomes.

## 6. CARE PLANNING

Care Planning is a dynamic process that incorporates a range of activities including decision support, care coordination, referral, feedback, review, re-assessment, monitoring and exiting.<sup>19</sup> Care planning supports the consumer to identify goals and agree on strategies, actions and services to achieve those goals.

### 6.1 The Care Planning process<sup>20</sup>

- involves gathering and interpreting assessment information including consumer and other sourced information to make care decisions in collaboration with the consumer and carer
- is based on and documents the consumer's goals and agreed upon actions
- involves negotiating and documenting roles and responsibilities, and with the client's consent, distributing copies of the care plan to the client, carers and service providers involved in the care of the client
- includes ongoing monitoring and review processes; and
- should be person centred and worded in a way able to be understood by the consumer and any other providers involved in the consumers care.

For further detail on the objectives and principles of care planning, refer to the Victorian Service Coordination Practice Manual p.25.

### 6.2 What should a care plan include?<sup>21</sup>

A care plan is the documentation of items agreed to in the care planning process. All care plans should include these items:

- date the care plan was developed
- participants in development of the care plan
- consumer-stated and agreed issues or problems
- consumer-stated and agreed goals
- agreed actions and the name of person or service responsible for each action
- timeframe for attaining goals and actions
- planned review date
- consumer acknowledgement of the care plan (signed or verbal)

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<sup>19</sup> Victorian Service Coordination Practice Manual 2009, p.25-

<sup>20</sup> Victorian Service Coordination Practice Manual 2009, p25

<sup>21</sup> Victorian Service Coordination Practice Manual 2009, p. 27

## 6.3 Care planning encompasses<sup>22</sup>

### **Service-specific care plan(s)**

A service specific care plan is developed by a single service and details the type and level of each specific service to be delivered by the assessing agency such as domestic assistance, personal or allied health services. A service specific care plan is documented using agency specific tools or a SCTT Care Coordination Plan.

### **Referral Action Plan**

The Referral Action Plan translates information collected about the broad range of client needs into agreed referral actions for services not provided by the HACC Assessment Service. The Summary and Referral Template of the SCTT tools contains the template for documenting referral actions.

### **Information provision**

The client should receive information on services or activities that the client may choose to follow up themselves. This may include for example, health promotion/social or active living opportunities, self-management activities/strategies, self-referrals to other services.

### **Care Coordination Plan**

This is developed utilising the SCTT 2009 template for clients with complex needs who request/require ongoing support and service coordination from an agency worker, (e.g. key worker)

Where a client receives multiple services there may be an intra or inter agency care plan in order to coordinate service delivery and share relevant information and resources:

#### *An intra-agency care plan*

Is developed for a client who requires more than one service from within a single organisation

#### *An inter-agency care plan*

Is developed for a client with complex or multiple needs who require services from more than one organisation

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<sup>22</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p. 17-18

## 7. CARE COORDINATION

Coordinated care planning is important in facilitating appropriate care for consumers with multiple or complex needs<sup>23</sup> and those who are likely to experience a better outcome if the care and services they receive are coordinated<sup>24</sup>.

The distinctive aspects of Care Coordination are:

- the development of a Care Coordination Plan (sometimes referred to as a Service Coordination Plan <sup>25</sup>) as detailed under the previous section on Care Planning; and
- the nomination of a single Key Worker when a care plan/care coordination plan is established, as a single line of communication for each client<sup>26</sup>.

### 7.1 The Key Worker

The role of the nominated Key Worker<sup>27</sup> is to be the central contact for the client and/or their carer/advocate; to promote effective communication between the client and service provider(s); and coordinate the delivery of care by their own organisation and other providers.

The decision to appoint a Key Worker should be based on client need, as where possible, clients and/or carers should be empowered to coordinate their own services.

Triggers for needing a Key Worker include

- multi-agency involvement
- clients with complex needs or circumstances
- clients requiring, but waiting for, a case management service

The decision to appoint a Key Worker may be for an ongoing need or temporary need and determined by the cyclic ongoing processes of review, reassessment, monitoring and care planning.

**NOTE\*** The terminology Key Worker is a title which has been in general use in some agencies for many years. Sometimes this title is used to refer to the role that is played within the service delivery agency as the client's key contact in the agency, (e.g. in local government this can refer to the Assessment officer and nursing services as the Primary Nurse). The term Key Worker within a multi-agency care coordination plan is intended to mean the role taken in coordinating a group of provider agencies and their service delivery strategies to meet the needs of the client as stated on the Care Coordination Plan.

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<sup>23</sup> Good practice guide 2009, p.12

<sup>24</sup> Victorian Service Coordination Practice Manual 2009, p.35

<sup>25</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.18

<sup>26</sup> Victorian Service Coordination Practice Manual 2009, p.26

<sup>27</sup> Victorian Service Coordination Practice Manual 2009, p.30

## **Key Worker role**

- should be fulfilled by a trained service provider with the skills and competence to undertake care coordination<sup>28</sup>
- develops their organisational client care plan
- is responsible, within the scope of their role, for ensuring the Care Coordination Plan is developed, distributed and monitored; review dates are set, re-assessments are initiated where appropriate, and feedback about the outcome of the referral is provided to a referring service provider<sup>29</sup>
- ensures that people with multiple agency involvement have a single point of contact in the service network and promotes effective communication between the consumer and the group of service providers<sup>30</sup>.

## **Key Worker responsibilities include<sup>31</sup>:**

- maintaining client and/or carer contact which may be frequently during periods of crisis or changing needs, or less frequently, dependent on need. It is recommended that contact is made with the client and/or carer at least six weekly during periods of crisis.
- liaising with the client and/or carer and other providers (including within their own organisation) as issues are raised or care coordination plans require change. This liaison should include the General Practitioner.
- ensuring their agency progress notes are up to date; and maintaining an up to date Care Coordination Plan (including monitoring and review processes).
- ensuring copies of the Care Coordination Plan are forwarded to each engaged provider as changes are made (in accordance with the Health Records Act and relevant privacy legislation<sup>32</sup>).
- organising a care coordination meeting/case conference with the client and/or carers and other service providers as required, but at least annually to review the care plan.
- communicating discharge and/or re-entry with other engaged providers.

Further aspects of this role are detailed in the Victorian Service Coordination Practice Manual p.30.

## **Considering who will be the Key Worker**

The agencies agree that when multi-agency care coordination is required, mutual agreement will determine which agency takes on the Key Worker role based on the following considerations<sup>33</sup>:

- Which agency/worker has an existing relationship and rapport with the client (if any)?
- Which worker or service is likely to have an ongoing role?

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<sup>28</sup> Victorian Service Coordination Practice Manual 2009, p.30

<sup>29</sup> Victorian Service Coordination Practice Manual 2009, p.26

<sup>30</sup> Victorian Service Coordination Practice Manual 2009, p.26

<sup>31</sup> Victorian Service Coordination Practice Manual 2009, p.26

<sup>32</sup> Victorian Service Coordination Practice Manual 2009, p.30

<sup>33</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.18

- Which worker/agency has the most relevant experience?
- Client preference.

## **7.2 Key features of Care Planning<sup>34</sup> and Care Coordination**

- The nomination of a single key worker when a care plan/care coordination plan is established.
- A range of staff and services participate in care planning and communicate outcomes of referrals, progress and reviews to the Key Worker.
- Effective monitoring (both formal and informal) of a client's health and wellbeing, and the effectiveness of services being delivered, for example, through regular reviews.
- Referral and other information is coordinated, planned and efficient, and specific feedback loops are in place for other service providers and the client.
- Care planning is underpinned by communication between all participants and activities are integrated (from the simple timing of services through to comprehensive care coordination), where a client requires multiple services or has complex or multiple needs.
- Assessment and care planning considers the social, emotional and health needs (beyond presenting issues).
- Care includes health education and encourages and empowers clients to self manage.

## **7.3 Care Coordination Meetings**

A care coordination meeting (also referred to as a case conference) is a tool to support and integrate teamwork within the processes of assessment, care planning and care coordination. These meetings should be held when a client is identified as having unstable health, complex care needs and/or multiple service providers (intra or inter agency).

A care coordination meeting is a care planning meeting (face-to-face, video-conferencing or using a secondary consultation approach) of providers from all involved services.

The aims of the meeting are:

- to develop an integrated Care Coordination Plan
- to ensure a client's Care Coordination Plan is underpinned by communication between all participants; and
- to ensure services are planned and delivered through a coordinated and integrated approach

### **Initiating a Care Coordination meeting**

A care coordination meeting will be initiated by the Key Worker, where one is appointed.

Each service provider is also responsible for requesting the Key Worker initiate a care coordination meeting if issues arise.

<sup>34</sup> Victorian Service Coordination Practice Manual 2009, p. 26

## **Aspects of a Care Coordination meeting**

- identification by The Key Worker is responsible for initiating and facilitating a review (or the agency assessment worker if a Key Worker has not been appointed).
- Obtaining and recording client consent is essential prior to the sharing of client information with participants in a care coordination meeting and the subsequent development of a care coordination plan. The Key Worker (or the agency assessment worker) seeks client consent.
- The role of the client and/or their nominated contact or advocate is paramount and should include:
  - Identification by the client of people involved in their support, e.g. advocate, interpreter, carer, family member, substitute decision maker
  - direct participation of the client and/or significant others, if appropriate
  - consultation with the Key Worker prior to the meeting to identify any concerns or issues they may wish to raise

**NOTE\*** In some instances it will be important for service providers to meet separately as a group to discuss potential difficulties between providers or to negotiate who is more able to deliver specific services. However, the client *must* still provide documented consent to the sharing of information.

- All providers engaged in service delivery for the particular client should attend. Where a service provider cannot attend, consultation with them should be sought either by phone and/or by them sending a copy of their current client care plan. In some instances, it may be inappropriate or logistically impossible for all service providers to attend and secondary consultation approaches may be utilised.
- Review dates should be developed and further meetings held as necessary.

**NOTE\*** Refer to the Victorian Service Coordination Practice Manual 2009, p.35-37 for further detail and steps in the development of a Care Coordination Plan

## **Additional information - Care Planning and Care Coordination**

The Care Coordination Plan Template (SCTT 2009) is the tool used for Care Coordination.

Consumer pathway through care planning:-Refer to VSCPM, p.37.

Practice standards and good practice indicators for care planning:-Refer to VSCPM, pp.32-33.

Steps to develop a Care Coordination Plan:-Refer to VSCPM, pp.35-37.

## **8. MONITOR, REVIEW AND REASSESS**

### **8.1 Monitor**

Management of client's care plans (whether clients self manage or a Key Worker has been appointed) involves formal and informal monitoring of client and carer's health and well being, how effectively services are meeting their needs and if OH&S issues have arisen and are being managed. This is the responsibility of all HACC organisations<sup>35</sup>.

### **8.2 Review**

All clients should be systematically reviewed to ensure that care planning is meeting the assessed and agreed need.

Timing for reviews

- will be according to the review date recorded in the care plan,
- in accordance with organisational protocols, or
- as indicated by a change in circumstances, client triggers or service provider/client requests.

The review process will be coordinated and collaborative.

- Coordination will be by the Key Worker (where one is appointed) or the agency assessment worker in the case of service specific or intra-agency care plans. The Key Worker will undertake an appropriate role such as that detailed in section 7.
- Collaboration may involve a Care Coordination meeting depending on the complexity of the care plan and client need. The key focus is on joint reviews however, where this is not practical, each agency undertakes their own review and collaborates using a secondary case conferencing approach to ensure a holistic client centred approach.
- Where service specific reviews occur, it is the responsibility of the agency completing a review to convey the outcomes to the Key Worker (if one is appointed) to inform the overall review, using the SCTT 2009 Care Coordination Plan. The Key Worker then develops and circulates a new Care Coordination Plan if required.

### **8.3 Reassessment**

A Living at Home reassessment is carried out

- when client or carer circumstances change significantly requiring a complete reappraisal of the client and/or carer needs<sup>36</sup>
- at a pre-determined time linked to a review of the service-specific care plan<sup>37</sup>

As with reviews, the reassessment process will be coordinated and collaborative.

Where there are multiple organisations involved in delivering services to one client, the Key Worker should be nominated for the purposes of initiating the reassessment.

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<sup>35</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.19

<sup>36</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.20

<sup>37</sup> Framework for Assessment in the Home and Community Care Program in Victoria 2007, p.20



## **8.4 Service closure**

Assessment, care planning, care coordination, monitoring, reviewing and reassessment are all components of the LAHA process and continuum. Some clients may achieve their goals and be discharged from the service(s) whilst a review of other clients may result in the development of new client goals and/or maintenance services. Clients may exit one service e.g. nursing but may continue with other services such as personal care or home maintenance.

Service closure (discharge or exiting a service) will be based on goal achievement, review and an agreed cessation of service date.

Re-entry information and contact details will be provided to clients (e.g. based on changed needs or referral) at the exit point.

## **9. CROSS BOUNDARY CONSIDERATIONS**

Agencies have a shared responsibility to provide services to clients and should not use geographical boundaries to limit service access where it is clear that a cross boundary response will be most efficient and effective for the client.

It is agreed that:

- Each agency will work within their mandated boundary and referrals should be made recognising this.
- Should a client live near a boundary, the assessment staff will liaise to clarify which agency can best provide the service, based on what may be reasonable and efficient, and preferable for the client.

## 10. SUMMARISING THE AGREEMENTS:

In relation to the Central Highlands HACC Assessment Service, agencies undertaking a Living at Home Assessment it is agreed that:

New clients (who are not brokerage or episodic or who have not received a comprehensive assessment or Living At Home Assessment within the last six months) should receive a LAHA based on the underpinning philosophy of the Active Service Model which aims to maintain and improve client independence.

In order to develop an holistic assessment information contained in the full set of the SCTT templates and profiles should be addressed and documented using either the SCTT templates/profiles or in combination with the agency specific assessment tool.

Any referral from a HACC Assessment Service (HAS) will be based on consumer consent to share and 'need to know', unique to each referral. The *minimum* profiles to be forwarded from a HAS are:

- Confidential referral cover sheet
- Consumer information
- Summary and referral information
- Consumer consent to share information
- Grampians Region Service Provider Home Safety Checklist
- Functional assessment summary
- Living and caring arrangements
- Any other templates or information considered appropriate

In relation to the processes, timeframe and priority for acknowledging referrals, referral processes and consumer privacy, the agencies agree to:

- send and acknowledge referrals using the SCTT templates
- use Connecting Care (RIMS or similar) for secure transfer and sharing of client information between agencies
- share relevant information including assessment, care planning information and the Grampians Region Home Safety Checklist as appropriate and with client consent – when referring the client to other organisations, within Care Coordination planning/case conferences and inter-agency care plans
- indicate on the Referral Cover Sheet if a Living at Home Assessment has or has not been completed and the date of assessment
- indicate on a referral whether the service initiating the referral has been and/or is undertaking a care co-ordination and/or Key Worker role
- provide feedback and referral outcome information to the initiating service provider within 14 working days of the client being assessed on the Grampians Region Outcome of Referral/Assessment form.

In relation to collaborative practice, the agencies agree to:

- support and promote the role of Key Worker and the implementation of intra and inter agency care planning and care coordination

- support joint assessment and the role of Lead Assessor
- utilise joint assessment, secondary consultation and Care Coordination Meeting approaches in order to gain a fuller understanding of consumer circumstances and need, and to enhance the coordination and continuum of care and avoid duplication and/or a multiplicity of individual assessments
- improve client outcomes by utilising a collaborative, shared care, multi-disciplinary team approach to goal setting, problem solving and care planning.

In relation to care planning and care coordination the agencies agree to

- develop and implement care planning, implementation and reviews in accordance with the guidelines and standards outlined in the VSCPM 2009 (p.25-31);
- nominate a single Key Worker when a care coordination plan is established, to promote effective communication between the consumer and service provider(s) and to provide care coordination (as appropriate);
- communicate outcomes of referrals, progress and reviews to the Key Worker;
- work together to coordinate service delivery and support the consumer to achieve their goals in an integrated manner;
- use the SCTT Care Coordination Plan for complex clients requiring care coordination and intra and inter agency care plans;
- notify other agencies when a client is being discharged or exiting the service and there is more than one service involved.

Summary information should note

- if the discharging agency undertook a LAHA and the date of assessment and review;
- if the discharging agency undertook a Key Worker role, and if so, summary information and interagency care planning will be forwarded to the other agency

In relation to cross boundary considerations, the agencies agree that

- each agency will work within its mandated boundary and referrals should be made recognising this
- should a client live near a boundary, the assessment staff will liaise to clarify who can best provide the service based on what may be reasonable, efficient, and preferable for the client.

Broadly, the agencies agree to comply with the:

Victorian Service Coordination Practice Manual 2009 (VSCPM) standards located at [http://www.health.vic.gov.au/pcps/downloads/sc\\_pracmanual2.pdf](http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf)

Service Coordination Tool Templates (SCTT) user guide located at <http://www.health.vic.gov.au/pcps/coordination/sctt2009.htm>

HACC privacy resources located at <http://www.health.vic.gov.au/pcps/coordination/privacy.htm>

## REFERENCES

- Victorian Service Coordination Practice Manual [VSCPM] 2009, Primary Care Partnerships Victoria, Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.
- Service Coordination Tool Templates [SCTT] 2009, user guide, Published by the Primary Health Branch, Victorian Government Department of Human Services, Melbourne, Victoria, Australia.
- Framework for Assessment in the Home and Community Care Program in Victoria 2007, Published by Aged Care Branch, Rural and Regional Health and Aged care Services Division, the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.
- Good Practice Guide 2009: A resource of the Victorian Service Coordination Practice Manual, Primary Care Partnerships, Victoria. Published by the Victorian Government Department of Human Services, Melbourne, Victoria, Australia.
- Royal District Nursing Service Victoria (RDNS) and Municipal Association of Victoria (MAV) Protocol Agreement, Draft 2008.
- Strengthening assessment and care planning: A guide for HACC assessment services in Victoria, 2010 (final draft August 2010)

## APPENDICES

### 1 INDICATORS FOR A NURSING SPECIFIC ASSESSMENT<sup>38</sup>

- Has unstable health status and/or has complex needs and requires personal care
- Has unstable health status and/or or multiple health conditions which require monitoring
- Client needs assistance with, or monitoring of medication
- Where there is uncertainty regarding the client's health status
- Needs education and information on general health care needs and advice on other health related services
- Needs advice on the management of particular health problems
- Needs a nursing service e.g. a Registered Nurse to perform certain procedures such as wound dressing, injections, manage chronic pain or medications
- Has any of the above and been identified as 'at risk'  
i.e. requires services within the immediate or short term or at risk of inappropriate admission to residential services, hospitalisation, neglect, injury or death; or at risk of requiring an emergency or life saving procedure or intervention; e.g. suctioning.

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<sup>38</sup> Royal District Nursing Service Victoria (RDNS) and Municipal Association of Victoria (MAV) and Protocol Agreement, Draft 2008

## 2 INDICATORS OF UNSTABLE HEALTH

The following list of indicators is used as a guide to assess the existence of unstable health<sup>39 40</sup>.

A single factor does not necessarily indicate unstable health status.

The indicators are to assist in a *judgement* about what is meant by unstable health and the need for a health based assessment.

- Poor mobility
- Giddiness/falls
- Loss of bladder or bowel control
- Special dietary requirements/ limitations e.g. percutaneous endoscopic gastrostomy (PEG) feeding regimes
- Pain
- Difficulty with breathing/advanced respiratory disease
- Disoriented/ confusion/memory loss
- Terminal or life threatening illness in palliative care stage
- Nausea/vomiting
- Recent changes in sensory status e.g. visual or hearing
- Diarrhoea/constipation
- Apparent fever/persistent excessive coldness
- Wound (surgical/non-surgical)
- Persistent bruising and/or skin integrity break down
- Significant recent changes in medications
- Multiple (more than 5) and frequent use of medications
- Several recent hospital or respite admissions
- Progressive deteriorating chronic illness

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<sup>39</sup> Royal District Nursing Service Victoria (RDNS) and Municipal Association of Victoria (MAV) and Protocol Agreement, Draft 2008, p.20-21

<sup>40</sup> Grampians Region Personal Care Protocol, October 2009, p. 7

### 3 SAMPLE LIVING AT HOME ASSESSMENT CHECKLIST

## Central Highlands and Grampians Pyrenees Living at Home Assessment Client Assessment Check List

The role of this checklist is:

- To act as a record of the assessment process
- To capture the timeframes from referral receipt to assessment
- To acknowledge that not all information is collected or provided at the initial assessment – extra columns are to capture the ongoing nature of assessment
- At annual review a new checklist should be completed.

Client Name:

Date of Birth:

Record No:

New Client?

Client review due to change?

Annual Review?

LAHA Steps	Signature	Date	Signature	Date
<b>Review Service Eligibility</b>				
Check HACC eligibility				
Check financial status – record pension(Centrelink/DVA and Medicare numbers				
Seek consumer consent to assessment				
Determine with client who will be present at assessment				
Confirm time and date with all intending to attend				
Commence Grampians Region Service Provider Home Safety Checklist				
<b>Assessment Process</b>				
<b>Explain</b> (and provide service documents related to)				
Overview of services				
Confidentiality/privacy of information and how it will be used				
Advocacy and client’s right for others to be present				
Complaints system				
Consumer rights and responsibilities				
<b>Undertake</b> holistic assessment and capture/document information contained within the SCTT forms below:				
Consumer information				
Living and caring arrangements				
Functional assessment summary				
Need for assistance				
Health behaviours				
Health conditions				
Psychosocial				
Family and social network				
Palliative care (if appropriate)				
Complete Section Two of the Grampians Region Service Provider Home Safety Checklist				
<b>Consider and discuss other services of relevance to client such as:</b>				
Social support/ social connections				
Informal support with family/friends				
Allied health, ie OT, dietitian, balance, podiatrist, nursing				
Complex health assessment ie ACAS, CACPS, Linkages, EACH, EACHD				
Home support and maintenance				

LAHA Steps	Signature	Date	Signature	Date
<b>Client Consent to referrals, agreed care plan and information sharing</b>				
Discuss and clarify the clients goals and agreed action plans				
Discuss with the client and/or carer if a Care Coordination plan or Service Specific plan is required – complete the agreed care plan				
Client (or carer) signed the agreed care plan				
Assessor signs the agreed care plan and goals				
Document consumer consent to service delivery and referrals				
<b>Undertake referrals as agreed – refer using Connecting Care or RIMS using the following SCTT forms:</b>				
Consumer information				
Consumer consent to sharing information				
Summary and referral information				
Living and caring arrangements				
Functional assessment summary				
Any other relevant SCTT profiles				
If referring to another LAHA service – attach copy of full SCTT/referral Assessment report				
Attach the Grampians Region Service Provider Home Safety Checklist to all referrals				
Document in your records that your referral has been acknowledged, accepted, rejected				
Send the Outcome of Referral/Assessment form to the referring body				
<b>Completing a Care Coordination Plan – are the client care requirements complex, there is more than 1 agency/provider involved and client is requesting/requiring assistance to manage their care?</b>				
Document client consent to participate in/allow a Care Meeting to occur				
Advise client of which other services providers will attend				
Ensure client understands that they are welcome to have an advocate				
Organise Care Meeting – allocate Key Worker if appropriate				
Document and distribute Care Coordination Plan				
<b>Client Support Information</b>				
Personal emergency plan document (fire, heatwave, flood)				

Name of Assessor:

Position:

Present at Assessment:

Signature of Assessor:

Date of Assessment:

Date of Referral:

Date of First Contact:



## 4 OUTCOME OF REFERRAL/ASSESSMENT form

Click to insert  
your logo



**Grampians Region  
Outcome of Referral/Assessment**



**Client Name:**..... **Date of Birth:**.....

**Address:**.....

**Worker Who Referred:**..... **Date of Referral:**.....

**Agency Name:**.....

**Reason for Referral:**.....

**The referral did not proceed to assessment for the following reason(s):**

- Change in consumer situation – assessment no longer appropriate:
- Consumer Declined
- Other (please explain):

**Thank you for your referral of this client.**

**Date of Assessment:**..... **Planned Review Date:**.....

**The assessment outcome was as follows:**

**Goal of Intervention (as agreed by client and Assessor):**

**Name of Assessor:**..... **Signature:**

Click to insert signature scan or sign by hand

**Contact Details:**

**Agency:**.....**Phone No:**.....

Save As

This Outcome of Referral/Assessment form was developed by the Ballarat Partnering Project in 2009 and subsequently adopted and adapted by the Grampians Region Living at Home Assessment Services in 2010.

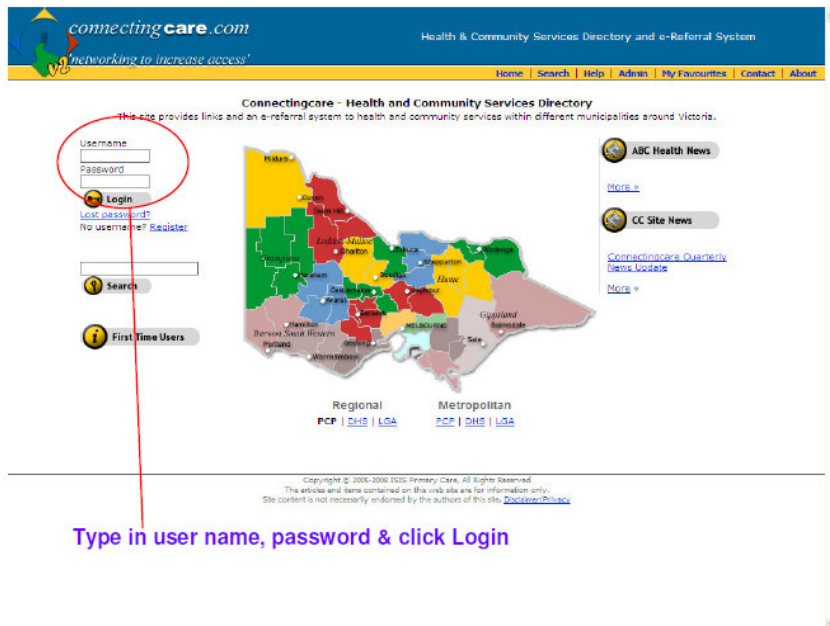
# INSTRUCTIONS FOR SENDING OUTCOME OF REFERRAL/ASSESSMENT FORM VIA CONNECTING CARE

## Grampians Region Outcome of Referral/Assessment form

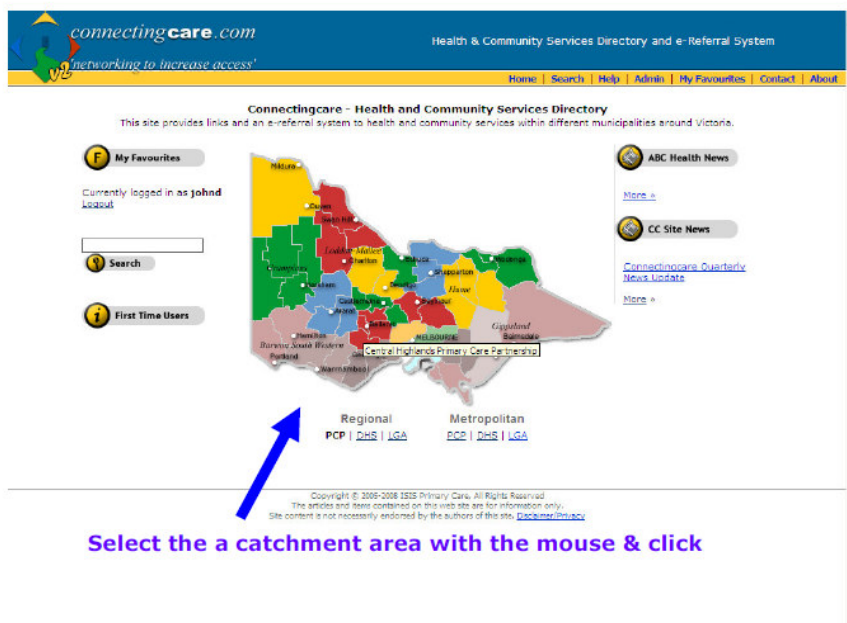
How to send it using Connectingcare (otherwise fax or mail if necessary):

Method: Go to [www.connectingcare.com](http://www.connectingcare.com)

1. Proceed to login with your username and password,



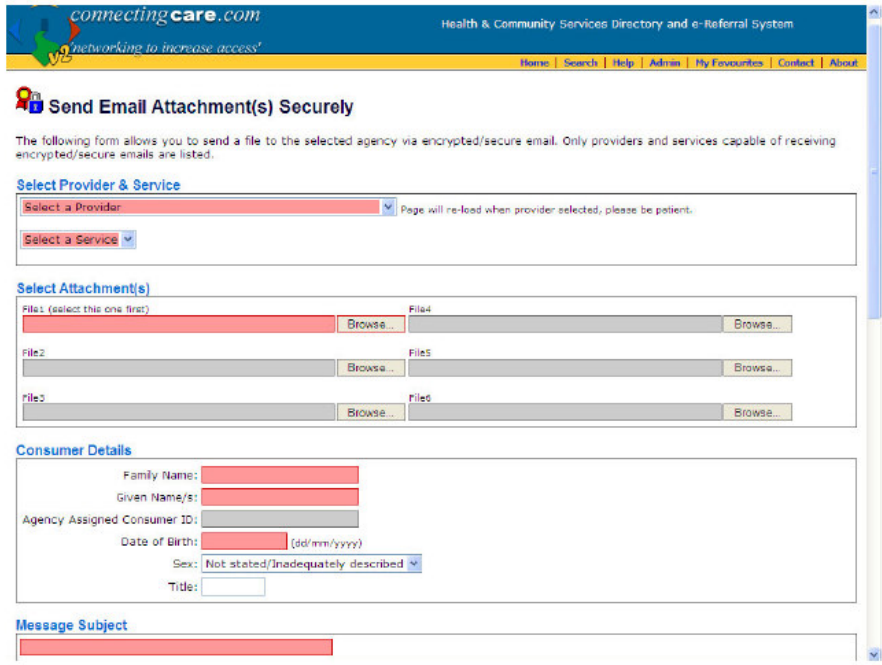
2. Select the PCP area where you want to send the attachment.



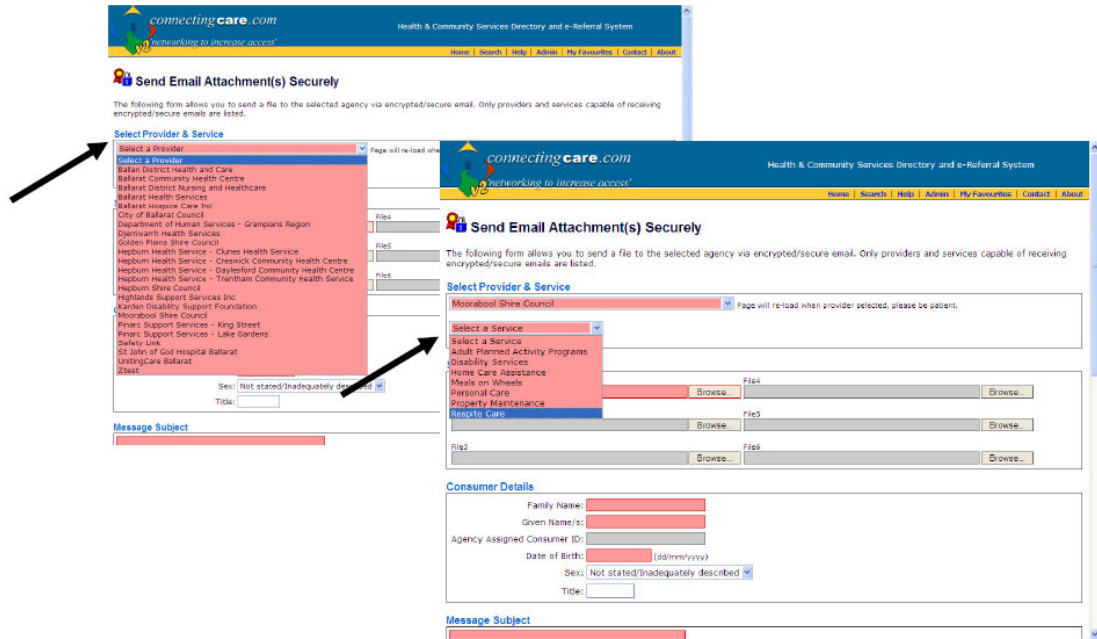
- Underneath the yellow box there is an icon with a spinning key with 'send files as attachment'. Click on this icon. (Note: the same icon also appears on the service pages of an agency's programs that are set up for e-referral)



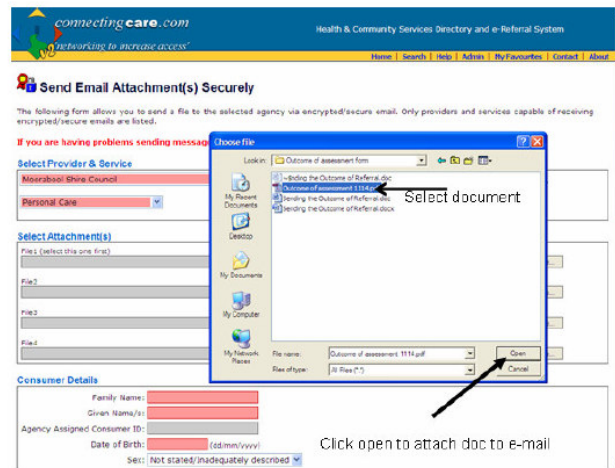
- This opens up the Secure Filele-mail application



5. Select the agency and the service you are referring to.



6. Browse to the folder where your document is, select & attach your referral. (Note additional documents can be attached to accompany the ORA document, e.g. a care plan or allied health service provider's report (up to seven individual documents or more if zipped, however some size limitations can apply).



## 7. Add

- a. consumer details, agency ID number etc
- b. Message subject - type: Outcome of Assessment **NOTE: The subject field (in pink) is a non-secure field; therefore there should be no client identifying information in this field.**
- c. An acknowledgement is requested within: (Select N/A)
- d. Consent - type: Yes
- e. Notes: This field is secure, you may make any client specific remarks if required, or leave blank.
- f. Request Referral Feedback (uncheck this box unless you require some feedback to your e-mail)
- g. Referral Specific Information select N/A
- h. Priority: Select routine (unless otherwise)
- i. Your details will be automatically entered by Connecting care

**Consumer Details**

Family Name:	Smith
Given Name/s:	John
Agency Assigned Consumer ID:	AD354
Date of Birth:	03/04/49 (dd/mm/yyyy)
Sex:	Male
Title:	Mr=

**Message Subject**

Outcome of assessment

This will appear as the message subject in the email. Eg. Referral for service XYZ  
**Do not include client specific information in this message subject!**

**Additional Information**

**An Acknowledgement is Requested Within:**

1 Working Day  
 2 Working Days  
 Not Applicable

**Consent:** (has the consumer given consent?)  
 Yes  
 No

**Request Referral Feedback**  
(If this attachment is a referral would you like to receive feedback on the referral?)

**Notes:** (including alerts and comments on risks, urgency and access issues)

**Referral Specific Information**

**Assessment Expected:**

Service Specific  Specialist  Comprehensive  N/A

**Priority**

This referral is:  Low (hold over during peak demand)  Routine (attend in date order (this may include the consumer being placed on a waiting list))  Urgent (cannot wait)  Renewal (ACAS) (For ACAS assessment)

**Your Details**

**Please enter your details:**

Name:	John Dixon
Phone:	03 5338 4772
Fax:	03 5339 8419
Email:	john.d@chpcp.org
Organisation:	Central Highlands Primary Care Partnership

Send Message

Please note that there will be a delay once you click Send due to the upload of the attachment(s) to the server. Wait until you receive notification that the email has been sent before clicking any more buttons or links.



8. Click send message. You will receive a confirmation that the message has been sent



**connectingcare.com** Health & Community Services Directory and e-Referral System  
networking to increase access!

Home | Search | Help | Admin | My Favourites | Contact

### Message Successfully Sent!

Your message was successfully sent.

**To:** Ztest  
**Service:** Test Service  
**Consumer ID:** 09-789  
**Date/Time:** 4/05/2009 4:25:52 PM  
**Attachment(s):**  
**Referral ID:** 47904

**Requesting Practitioner:** John Dixon (Tel: 03 5338 4772)

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At this point you have an option to initiate another e-mail (if necessary)

**Note:** Connectingcare generates a referral number (**Referral ID**) – this is a unique number attached to the message, and allows Connectingcare to track the message (but not the client attachment information) primarily for the purpose of statistics & quality control.

For more information on e-referral practice, consult the references below or contact your primary care partnership Service Co-ordination Advisor

#### References:

How-to-guide to e-referral for health professionals and community workers April 2009

Regional Connectingcare E-Referral Addendum to the Victorian Service Coordination Manual.

## 5. GRAMPIANS REGION SERVICE PROVIDER HOME SAFETY CHECKLIST

Click to insert  
your logo

### Grampians Region Service Provider Home Safety Checklist



Client Name.....DOB.....Client Record No.....

Contact Person (if Not Client):Name:.....Phone:.....

Identifying features of the house if isolated or difficult to find/identify (eg map reference, directions)	
Location of entrance door – (tick the box)	<input type="checkbox"/> Front <input type="checkbox"/> Side <input type="checkbox"/> Back <input type="checkbox"/> Other
Type of dwelling – (tick the box)	<input type="checkbox"/> House <input type="checkbox"/> Flat/Unit <input type="checkbox"/> Multi Level <input type="checkbox"/> Residential Facility <input type="checkbox"/> Rural

#### Section One - To be completed PRIOR to first home visit

**Suggested – Home visit risk assessment introductory statement** (Can be read out over the phone to explain why we need to do the risk assessment)  
This agency has a duty of care to make sure that all staff are safe at work – so it is routine for us to ask some questions before we visit you at home. I need to ask you about pets, firearms, smoking – we ask these questions of all clients.

OCCUPANTS	Yes	No	Unsure
Do you have religious or cultural needs our staff should be sensitive to?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Are there others who live at your premises? Please list on client file:	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Do you currently have a nominated authorised representative, Community Treatment order or similar?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Is anyone living at the premises known to be potentially aggressive or violent?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Are there any firearms at the property? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes are they appropriately secured?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
HAZARDS	Yes	No	Unsure
Are the clients or others living at the premises smokers? Explain smoking policy.	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Does any occupant have an infectious disease, eg chicken pox/shingles, influenza, gastro?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
ACCESS	Yes	No	Unsure
Are there any access problems, eg clear pathway, easy to open door/gate?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Are there any pets/animals on the premises? Explain the policy.	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Is there any difficulty with mobile phone coverage and/or a working land line?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>

#### Section Two - To be completed AT first home visit

OCCUPANTS	Yes	No	Unsure
Is there any observable evidence that client/other occupants are involved in substance abuse?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Is there any evidence that weapons (eg guns), are on the premises?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
HAZARDS	Yes	No	Unsure
Smoke detectors – are they installed and operational?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Is there adequate lighting – indoors/outdoors?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Basic amenities – is there access to running water and rubbish disposal?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Pressurised cylinders? <input type="checkbox"/> Yes <input type="checkbox"/> No Is it safely positioned away from naked flames?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Is there a biological hazard on the premises, eg body fluids, dressings?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
Is there evidence of immediate danger to the client or staff?	* <input type="checkbox"/>	<input type="checkbox"/>	* <input type="checkbox"/>
ACCESS	Yes	No	Unsure
Is entry to the premises free of impediment and visible from the street?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Is parking adequate on the street?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Are there two safe exit points - from the building and property in an emergency?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>
Are the premises free from clutter and safe for the worker to undertake their duties?	<input type="checkbox"/>	* <input type="checkbox"/>	* <input type="checkbox"/>

Section One Completed by (name):..... Signature:

Agency:.....Date.....

Click to insert signature scan or sign by hand

This checklist is designed to be completed by the first agency to make contact or visit, and forwarded with any Referrals – the information it contains was reflective of the situation at the date of contact – details may have since changed.

Click to insert your logo

**Grampians Region Agency Risk Report**



Client Name.....DOB.....Client Record No.....

NB When completing the Check List on Page One ensure that any boxes you tick which are marked with an asterisk are reported in the Agency Risk Report below.

OCCUPANTS - CONCERN	ACTION TAKEN - BY WHOM - REVIEW DATE
1. Date:	1.
HAZARD - CONCERN	ACTION TAKEN - BY WHOM - REVIEW DATE
1. Date:	1.
ACCESS - CONCERN	ACTION TAKEN - BY WHOM - REVIEW DATE
1. Date:	1.

ASSESSMENT HOME VISIT DECISION	YES	NO
Risk analysis indicates that it will be appropriate for just one staff member to attend the initial visit	<input type="checkbox"/>	<input type="checkbox"/>
Risk analysis indicates that it is appropriate for two staff members to attend the initial visit. NB All risks need to be addressed prior to initial visit – two staff attending does not necessarily reduce the risk.	<input type="checkbox"/>	<input type="checkbox"/>
Risk analysis indicates that the issues identified above need to be addressed before a staff member can complete the initial visit	<input type="checkbox"/>	<input type="checkbox"/>

Section Two Completed by (name):..... Signature:

Click to insert signature scan or sign by hand

Agency:..... Date:.....

Client/Carer Signature:..... Date:.....

Present at Assessment:..... Review date for monitoring action taken by client/carer:.....

- The Assessment Home Visit Decision above is not a directive or advice for other agencies – it is the opinion of the person completing it – each agency receiving a copy of this form is responsible for its own staff and any consequent decisions as to the risk of visiting this client in their home. The decision as to home visit safety can be amended following a change in client circumstances.
- This Service Provider Home Safety Checklist and Agency Risk Report was developed by the Ballarat Partnering Project (2008/9). The original Home Safety Checklist on which this work was based was developed under the auspice of the Central Highlands Primary Care Partnership, Service Coordination Sub-Committee.

SAVE AS



# INSTRUCTIONS FOR USING THE ELECTRONIC SERVICE PROVIDER HOME SAFETY CHECKLIST

## GRAMPIANS REGION SERVICE PROVIDER HOME SAFETY CHECKLIST



### INSTRUCTIONS FOR USING THE HOME SAFETY CHECK LIST ELECTRONICALLY

You will need Acrobat Reader 8 and above to be able to complete and save the form electronically. This version of Acrobat Reader is a free download. The form can also be saved and printed for your records or used as a hard copy.

#### To insert your logo:

- Left click “click to insert your logo” box. This will open into your computer files allowing you to choose a logo
- You must choose a logo in JPG format
- Double click on the chosen logo (or click the logo & then ‘select’)
- The logo will self size into the box on the form
- Remember to put your logo on both pages
- Save a blank form with your logo (then it can be given to staff ready to use with logo in place)

#### To use the electronic features:

- Click on the relevant place to put information and then just type – the character level is limited
- You can press the “tab key” to get from box to box (or click where you desire to type with the mouse)
- For tick boxes, put your cursor on the box and left click, you can left click to take the tick out again

On the agency risk report put your cursor in the white box next to where you want to start typing, when finished you can use the “tab key” to take you across to the next box and down to the next section

Save As – this button is at the bottom left of the form and allows you save to your own computer – this document can then be sent with an referral or printed for the client’s record. NB This document will not save through the normal File:save as on your computer tool bar.

**This Service Provider Home Safety Checklist and Agency Risk Report form is in PDF format and as such can be added to and altered by the receiving agency. To ensure that you maintain accurate client records and information within your agency, you must make a copy of the form and file it prior to forwarding the form to another agency.**

# PROTOCOL FOR IMPLEMENTING THE SERVICE PROVIDER HOME SAFETY CHECKLIST

## GRAMPIANS REGION SERVICE PROVIDER HOME SAFETY CHECKLIST



## Protocol for Implementation

This checklist is designed to advise employers of:

- Any identified risks in the staff workplace(s)
- Describe any action has been taken to resolve/reduce the risk; and,
- Act as evidence that the worksite has been screened for risk

The Occupational Health and Safety Act 2004 “requires employers to provide a workplace that is safe and without risks to health. A healthcare service organisation must, so far as is reasonably practicable, ensure the safety of both the worker and the client”<sup>1</sup>.

### Process for Completion of Tool

- At initial referral point the “intake” worker will complete the client Demographics and Section One – if there is no Intake Worker then Section One can be completed at the time the assessment visit is booked
- At Home Visit the assessment worker or OH&S worker will complete Section Two
- At both stages the Agency Risk Report must be completed if issues are identified.

As with all information collected relating to clients the consumer needs to understand the process for collecting and disclosing information AND all information collected must be relevant to the service requested or being provided<sup>2</sup>.

### Sharing of the Tool

This checklist is designed to be shared between the participants in the Partnering Project and made available to other organisations as requested:

- All referrals to another agency must be accompanied by a copy of the Service Provider Home Safety Check List and Agency Risk Report (where appropriate)
- The form will be made available electronically to all partnering agencies – this will allow it to be transmitted with the referral, by facsimile or post.

Client consent to the referral to another agency OR service by the initiating agency is paramount – this consent is inclusive of the sharing of the Service Provider Home Safety Check List and Agency Risk Report. It is always appropriate to advise the client of what information they are consenting to share.

**This Service Provider Home Safety Checklist and Agency Risk Report form is in PDF format and as such can be added to and altered by the receiving agency. To ensure that you maintain accurate client records and information within your agency, you must make a copy of the form and file it prior to forwarding the form to another agency.**

If your organisation has no specific policies, the following is a recommended process for improving staff/client safety:

<sup>1</sup> Working Safely in Visiting Health Services, 1<sup>st</sup> Edition, June 2006, WorkSafe, State Government Victoria

<sup>2</sup> Central Highlands Primary Care Partnership, Protocol for Home Hazard Service Provider Check List



#### Management Responsibilities:

Employees are not to provide home visits if:

- There is a history of aggressive behaviour, violence or sexual harassment
- Domestic violence has been perpetrated and the perpetrator is at the home or likely to return
- There is a risk of injury occurring to clients or staff
- Employees feel they may be at risk during the visit

#### Employee Considerations for Safe Home Visiting:

An employee should:

- Be aware of the nearest exit in a client's home
- Be aware of locks on doors and know how they work
- Check for lighting externally and ensure that clients leave the lights on for after dark visits
- Ensure car keys or personal keys are not left in a place accessible to clients or other household members

#### **Violent or Potentially Violent Situations**

- If an employee is either physically or verbally threatened by a client, carer or any other member of the household, they should take measures to protect themselves and leave the scene as soon as possible
- Summon the police if the situation warrants it. For example: in situations of domestic violence or if firearms are seen on the premises or the employee is being threatened

#### **If the employee feels threatened, the following action should be taken:**

- If in the car, ensure windows are closed and the doors are locked
- If it is considered unsafe to drive away, sound the horn long and loud and if appropriate ring the police (000) on your mobile phone
- If it is considered safe to drive away, proceed to the nearest Police Station
- Do not leave the car until it appears safe to do so

#### **All incidents – however trivial, should be:**

- Reported to the employee's Manager
- Documented in the client's file
- Reported on the Service Provider Home Safety Check List and Agency Risk Report

#### **References**

This Home Safety Check List and Agency Risk Report was developed as part of the Partnering Development for HACC Assessment in the City of Ballarat Project (2008-2009).

The Service Provider Home Safety Check List and Risk Report and protocol was developed using resource material provided by:

- Victorian Home Care Industry, Occupational Health and Safety Guide, October 2005
- Central Highlands Primary Care Partnership "Service Provider Home Hazard Checklist"
- WorkSafe Working Safely in Visiting Health Services, 1<sup>st</sup> Edition, June 2006
- WorkSafe Working Safely in Community Services, 1<sup>st</sup> Edition, October 2005
- Home Care & Personal Care, A guide to managing risk, Jardine Lloyd Thompson, 2004
- Health Safety & Welfare, For Home and Community Workers, Guidelines for Managing OHS&W – <http://www.safework.sa.gov.au>

- Home and Community Health Worker Handbook, Page 40, <http://search.worksafebc.com/search>
- Victorian Home Care Industry Occupational Health and Safety Guide, October 2005
- Home Care and Personal Care, A guide to managing occupational health and safety risks, [www.echelonaustralia.com.au](http://www.echelonaustralia.com.au)
- Western Health SACS, PAC and ACAS Pre Home Visit Risk Assessment Tool
- Stawell Regional Health, Home Visit Risk Assessment
- The Children's Hospital at Westmead

## 6. CENTRAL HIGHLANDS MEMORANDUM OF UNDERSTANDING

### ENDORSEMENTS

#### BALLARAT DISTRICT NURSING AND HEALTHCARE

##### CENTRAL HIGHLANDS – GRAMPIANS REGION HACC LIVING AT HOME ASSESSMENT SERVICES MEMORANDUM OF UNDERSTANDING 2010

This MOU outlines the assessment and referral process within and between HACC Assessment Services in the Central Highlands community.

On implementing this MOU, each organisation will:

- Operate within the framework of the MOU when undertaking Living at Home Assessments, referring clients to other organisations and to other HACC Assessment Services.
- Utilise the Grampians Region Service Provider Home Safety Checklist when sending referrals and the Outcome of Referral/Assessment form to provide feedback to referring agencies.
- Include the MOU as a component of the induction program for all new staff who will be involved in the provision of Living at Home Assessments.

##### HACC Living at Home Assessment Services guided by this MOU are:

Golden Plains Shire Council

Hepburn Shire Council

Moorabool Shire Council

Ballarat District Nursing and Healthcare

Ballarat City Council

##### Protocol Review

The MOU should be reviewed as required but within a time frame of three years from introduction (ie first review no later than 2013).

##### Protocol Endorsement

Endorsement of this interagency MOU must be by the HACC Assessment Service Chief Executive Officer or program manager.

Please complete and sign the following to signify your endorsement of the Central Highlands, HACC Living at Home Assessment Service MOU:

I represent my organisation in formally endorsing this MOU and its intent.

Name of Organisation: Ballarat District Nursing & Healthcare

Address: 1818 Sturt St Alfredton 3352

Name of Endorsee: Dianne Brayshaw

Position: Acting Director of Nursing

Signature: [Handwritten Signature]

Date: 25/02/2011

Please post the signed endorsement back to Robyn Fletcher, Community Care and Access, City of Ballarat. P.O.Box 655, Ballarat, 3353.

**CENTRAL HIGHLANDS – GRAMPIANS REGION  
HACC LIVING AT HOME ASSESSMENT SERVICES  
MEMORANDUM OF UNDERSTANDING 2010**

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**HACC Living at Home Assessment Services guided by this MOU are:**

Golden Plains Shire Council                      Hepburn Shire Council  
Moorabool Shire Council                      Ballarat District Nursing and Healthcare  
Ballarat City Council

**Protocol Review**

The MOU should be reviewed as required but within a time frame of three years from introduction (ie first review no later than 2013).

**Protocol Endorsement**

Endorsement of this interagency MOU must be by the HACC Assessment Service Chief Executive Officer or program manager.

Please complete and sign the following to signify your endorsement of the Central Highlands, HACC Living at Home Assessment Service MOU:


I represent my organisation in formally endorsing this MOU and its intent.

Name of Organisation: CITY OF BALLARAT

Address: ARMSTRONG ST NTH BALLARAT

Name of Endorsee: NEVILLE TWEY

Position: MANAGER COMMUNITY CARE & ACCESS

Signature: 

Date: 14/12/10

Please post the signed endorsement back to Robyn Fletcher, Community Care and Access, City of Ballarat. P.O.Box 655, Ballarat, 3353.

**CENTRAL HIGHLANDS – GRAMPIANS REGION**

**HACC LIVING AT HOME ASSESSMENT SERVICES  
MEMORANDUM OF UNDERSTANDING 2010**

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**HACC Living at Home Assessment Services guided by this MOU are:**

Golden Plains Shire Council	Hepburn Shire Council
Moorabool Shire Council	Ballarat District Nursing and Healthcare
Ballarat City Council	

**Protocol Review**

The MOU should be reviewed as required but within a time frame of three years from introduction (ie first review no later than 2013).

**Protocol Endorsement**

Endorsement of this interagency MOU must be by the HACC Assessment Service Chief Executive Officer or program manager.

Please complete and sign the following to signify your endorsement of the Central Highlands, HACC Living at Home Assessment Service MOU:

I represent my organisation in formally endorsing this MOU and its intent.

Name of Organisation: GOLDEN PLAINS SHIRE COUNCIL

Address: 2 POPE ST, BANNOCKBURN, 3331

Name of Endorsee: JILLIAN EVANS

Position: DIRECTOR COMMUNITY SERVICES

Signature: Jillian Evans

Date: 29 NOVEMBER 2010

Please post the signed endorsement back to Robyn Fletcher, Community Care and Access, City of Ballarat. P.O.Box 655, Ballarat, 3353.



## HEPBURN SHIRE COUNCIL

### CENTRAL HIGHLANDS – GRAMPIANS REGION

#### HACC LIVING AT HOME ASSESSMENT SERVICES MEMORANDUM OF UNDERSTANDING 2010

This MOU outlines the assessment and referral process within and between HACC Assessment Services in the Central Highlands community.

On implementing this MOU, each organisation will:

- Operate within the framework of the MOU when undertaking Living at Home Assessments, referring clients to other organisations and to other HACC Assessment Services.
- Utilise the Grampians Region Service Provider Home Safety Checklist when sending referrals and the Outcome of Referral/Assessment form to provide feedback to referring agencies.
- Include the MOU as a component of the induction program for all new staff who will be involved in the provision of Living at Home Assessments.

#### HACC Living at Home Assessment Services guided by this MOU are:

Golden Plains Shire Council

Hepburn Shire Council

Moorabool Shire Council

Ballarat District Nursing and Healthcare

Ballarat City Council

#### Protocol Review

The MOU should be reviewed as required but within a time frame of three years from introduction (ie first review no later than 2013).

#### Protocol Endorsement

Endorsement of this interagency MOU must be by the HACC Assessment Service Chief Executive Officer or program manager.

Please complete and sign the following to signify your endorsement of the Central Highlands, HACC Living at Home Assessment Service MOU:

I represent my organisation in formally endorsing this MOU and its intent.

Name of Organisation: Hepburn Shire Council

Address: 76 Vincent St Daylesford

Name of Endorsee: Dr Martin Whelan

Position: General Manager Community Development

Signature: [Handwritten Signature]

Date: 04/02/2011

Please post the signed endorsement back to Robyn Fletcher, Community Care and Access, City of Ballarat. P.O.Box 655, Ballarat, 3353.



**CENTRAL HIGHLANDS – GRAMPIANS REGION  
HACC LIVING AT HOME ASSESSMENT SERVICES  
MEMORANDUM OF UNDERSTANDING 2010**

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**HACC Living at Home Assessment Services guided by this MOU are:**

Golden Plains Shire Council                      Hepburn Shire Council  
Moorabool Shire Council                      Ballarat District Nursing and Healthcare  
Ballarat City Council

**Protocol Review**

The MOU should be reviewed as required but within a time frame of three years from introduction (ie first review no later than 2013).

**Protocol Endorsement**

Endorsement of this interagency MOU must be by the HACC Assessment Service Chief Executive Officer or program manager.

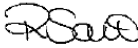
Please complete and sign the following to signify your endorsement of the Central Highlands, HACC Living at Home Assessment Service MOU:

I represent my organisation in formally endorsing this MOU and its intent.

Name of Organisation: Moorabool Shire Council.

Address: PO.Box 18 Ballan. 3342

Name of Endorsee: Robyn Salt  
Position: Aged and Disability Services

Signature: 

Date: 16/12/2010

Please post the signed endorsement back to Robyn Fletcher, Community Care and Access, City of Ballarat. P.O.Box 655, Ballarat, 3353.