National Screening and Assessment Form User Guide

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1   Acknowledgements

The Department of Social Services would like to acknowledge the following organisations and participants for their involvement in the development and finalisation of the National Screening and Assessment Form and their contribution to the information included in the National Screening and Assessment Form User Guide:

- Assessor User Group which had representatives from Access Points, HACC assessors and service providers, and Aged Care Assessment Team members
- National Aged Care Alliance Gateway Advisory Group and assessment sub-group
- Gateway Consultation Forum
- Centre for Health Service Development, University of Wollongong, for the development, validation and field trials of the Assessment Framework and Tool for Aged Care
- Aged Care Assessment Expert Clinical Reference Group supporting the development of the Assessment Framework and Tool for Aged Care.

The Department of Social Services would also like to acknowledge state and territory governments, representative organisations and other Australian Government departments including the Department of Health, Department of Human Services and Attorney-General's Department for the materials provided to the development of the NSAF and the NSAF User Guide.

1.1   Feedback mechanisms

As the assessment capability matures, feedback is welcomed to allow for continuous improvement. It is through this feedback that the Department can continue to make changes to improve the screening and assessment process and the NSAF. Should you have any feedback on this NSAF User Guide, please email Assessment.Reform@dss.gov.au

2 Overview

2.1 Purpose of this User Guide

The National Screening and Assessment Form User Guide (NSAF User Guide) provides detailed information on the principles, inputs, processes and outputs that underpin the use of the National Screening and Assessment Form (NSAF). It provides guidance for:

- My Aged Care contact centre staff (contact centre staff), to conduct screening
- My Aged Care Regional Assessment Service (RAS), to conduct face-to-face home support assessment
- Aged Care Assessment Teams (ACATs), to conduct face-to-face comprehensive assessment.

It will also provide:

- An outline of how to conduct the screening and assessment process as part of My Aged Care, including the use of pre-populated information from previous screening and assessment events
- Helpful hints and prompts to gather appropriate information to be entered into the My Aged Care system.

2.2 My Aged Care

The My Aged Care vision is to 'make it easier for older people, their families, and carers to access information on ageing and aged care, have their needs assessed and be supported to locate and access services available to them.'

My Aged Care was introduced on 1 July 2013 and consists of the My Aged Care contact centre (1800 200 422) and website (myagedcare.gov.au). My Aged Care currently provides:

- Information about aged care to consumers, family members and carers
- Online service finders that provide information on aged care service providers and assessors
- Online fee estimators for pricing on Home Care Packages and aged care homes.

After July 2015, people seeking access to aged care services for the first time will need to contact the My Aged Care contact centre to discuss their aged care needs and have a client record created. My Aged Care client interactions are described in the diagram on page 3.

Clients receiving services prior to July 2015 do not need to register with My Aged Care unless their needs and/or circumstances change.

My Aged Care client interactions

The following diagram describes the interactions people have with My Aged Care.

People seeking access to aged care information and services

My Aged Care contact centre
Phone 1800 200 422
Operates 8am–8pm weekdays and 10am–2pm Saturdays.

My Aged Care contact centre staff

Information

My Aged Care provides information about aged care services (including non-Commonwealth funded services) and how they can be accessed. This information is available from the My Aged Care contact centre and website.
People can use the website to:

- Search for services in the service finders
- Understand what fees they may be asked to pay using the fee estimators

Website
www.myagedcare.gov.au

Client Registration and Screening

Contact centre staff use the My Aged Care system to:

- Complete registration, which creates a client record
- Conduct screening to understand a client's needs using the National Screening and Assessment Form
- Create an action plan as an outcome of screening
- Refer clients for assessment
- Refer clients for Commonwealth Home Support Programme service(s)
- Manage inbound referrals
- Provide information about non-Commonwealth funded services

My Aged Care client portal
Allows clients to view and access their client record.

Client Record

Home Support Assessment (RAS)

Assessment

Assessments are conducted by the My Aged Care Regional Assessment Service (RAS) and Aged Care Assessment Teams (ACATs). Assessors use the assessor portal to:

- Accept/reject referrals for assessment
- Access the National Screening and Assessment Form to undertake assessment
- Review the client record before the assessment, and update the client record afterwards (with recommendations and the support plan)
- Issue referrals for Commonwealth funded services
- Provide information about non-Commonwealth funded services

My Aged Care assessor portal

Assessors

Comprehensive Assessment (ACATs)

Commonwealth Home Support Programme Providers

Services

Commonwealth funded service providers will use the provider portal to:

- Maintain information about the services they provide (including availability)
- Accept/reject/waitlist referrals for service(s)
- Review the client record before delivering services, and update the client record (with service delivery and care planning information)
- Request a new assessment if the client's needs have changed

My Aged Care provider portal

Service Providers

Home Care Package, Transition Care and Residential Care Providers

2.3 Changes to My Aged Care in 2015

My Aged Care will be expanded in 2015. The table below details what is being introduced, and why it is being introduced.

What is being introduced	Why it is being introduced
Central client record	To facilitate the collection and sharing of client information.
My Aged Care RAS	To conduct face-to-face assessments independent of service provision for clients seeking to access CHSP services.
National Screening and Assessment Form (NSAF)	To ensure a nationally consistent and holistic screening and assessment process. The NSAF will be used by contact centre staff, the RAS and existing ACATs.
Web-based portals for: • clients • assessors • service providers	Client portal – to view their client record and update personal details Assessor portal – to manage referrals, use the NSAF and update the client record Provider portal – to manage service information, referrals and update the client record.
Service providers will self-manage information about the services they deliver	This information will be presented on the service finders via My Aged Care, and will support accurate referral of clients to services.
Enhanced service finders that include information about non-Commonwealth funded services	To enable the provision of information about non-Commonwealth funded aged care services to clients and the public.

These changes will result in:

- A consistent, streamlined and holistic assessment of clients
- Better access to accurate client and service information (for clients, representatives, carers and family members, service providers and assessors)
- Appropriate and timely referrals for assessment and services.

3   National Assessment Framework

The purpose of the National Assessment Framework is to ensure a nationally consistent approach to assessing people's aged care needs and eligibility for government-funded services. The National Assessment Framework provides assurance that the aged care assessment workforce, funded by the Commonwealth Government to conduct the processes involved in assessing a person's aged care needs, is supported appropriately, and that reporting requirements by and for organisations and government are enabled. A governance structure will be in place to support the implementation and delivery of the National Assessment Framework.
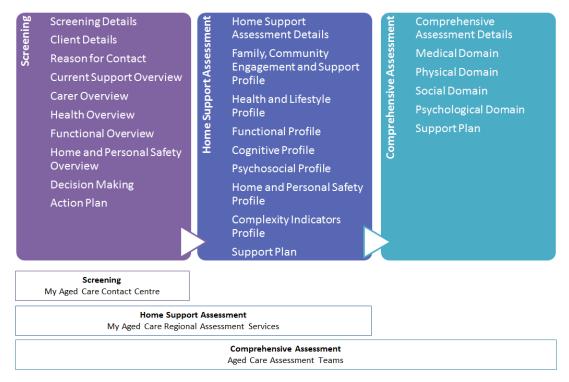
The National Assessment Framework includes the following components:

Overview – National Assessment Framework	
Workforce	Contact centre staff in the My Aged Care contact centre
	My Aged Care Regional Assessment Service
	Aged Care Assessment Teams
Funding	Commonwealth funding to operate the Workforce
Processes	Nationally consistent assessments
	Complaints
	Compliance
	Quality Assurance
Support	ICT platform that operationalises My Aged Care, including the Assessor Portal
	User Guides (NSAF User Guide, Assessor Portal User Guide, Data Dictionary)
	National Training Strategy
	Departmental Administration
Reporting	Mandatory reporting
	Business reporting
	Organisation reporting
Governance	Legislation
	The *Aged Care Act 1997*
	Workforce contracts and agreements
	Internal governance within the Department of Social Services (the Department) focussing on operational control, policy, clinical guidance and engagement with other government agencies
	External governance including with consumers, stakeholders and peak bodies
	Engagement with delivery partners

4   National Screening and Assessment Form

The NSAF has been designed to support the collection of information for the screening and assessment processes conducted under My Aged Care. It has been developed by the Department of Social Services based on existing best practice assessment processes from around Australia, and through significant consultation with stakeholders, particularly the Assessor User Group (made up of representatives from Access Points, Home and Community Care assessors and service providers and ACATs).

The NSAF includes the questions to be asked as part of screening, home support assessment and comprehensive assessment. It ensures that questions are appropriate to each level of assessment; that there is no duplication which would result in the client having to repeat their story; and that the appropriate client pathway can be facilitated through the completion of an action plan or support plan. It also includes the assessment requirements for delegate approval for services under the *Aged Care Act 1997*.

Screening	Home Support Assessment	Comprehensive Assessment
Screening Details	Home Support Assessment Details	Comprehensive Assessment Details
Client Details	Family, Community Engagement and Support Profile	Medical Domain
Reason for Contact		Physical Domain
Current Support Overview	Health and Lifestyle Profile	Social Domain
Carer Overview	Functional Profile	Psychological Domain
Health Overview	Cognitive Profile	Support Plan
Functional Overview	Psychosocial Profile	
Home and Personal Safety Overview	Home and Personal Safety Profile	
Decision Making	Complexity Indicators Profile	
Action Plan	Support Plan	

Screening My Aged Care Contact Centre	
Home Support Assessment My Aged Care Regional Assessment Services	
Comprehensive Assessment Aged Care Assessment Teams	

Supplementary Assessment Tools are included as part of the NSAF and may be used by an assessor to inform a holistic assessment of a client's needs. The use of these clinically-validated assessment tools is not mandatory, but should be used if a need is identified that requires a greater level of assessment. An assessor may also choose to use other clinically-validated tools at their discretion, but should record within the NSAF the name of the assessment tool used, the result of the assessment and also attach the assessment to the client's record.

The NSAF also includes a set of decision support rules that assists the RAS and ACAT to make recommendations for the type of support a client requires. There are five types of decision support rules:

- Pathway and eligibility (e.g. this client should be referred for comprehensive assessment)
- Priority (e.g. access to assessment or service is a high priority)
- Recommended actions (e.g. the client should visit a GP)
- Complexity indicators (e.g. the client is living in inadequate housing or with insecure housing or is already homeless)
- Needs identification (e.g. behavioural concerns)

It is important to note that the NSAF is not a decision-making tool nor is it designed to recommend particular service types a client should access. This will be the role of a trained assessor who, when developing the support plan with a client, considers their needs holistically, and recommends support most appropriate to their needs and circumstances. This may include referral to Commonwealth-funded services or provision of information about non-Commonwealth funded services the client may wish to approach.

5 A nationally consistent screening and assessment process

The national screening and assessment process has three components:

- Screening conducted over-the-phone by My Aged Care contact centre staff.

  - By asking a broad and shallow set of questions, contact centre staff will be able to facilitate the appropriate client pathway – to home support assessment, comprehensive assessment and/or direct to Commonwealth Home Support Programme services.

- Home support assessment conducted face-to-face by the RAS.

  - This holistic assessment will determine eligibility for Commonwealth Home Support Programme services and will result in the development of a goal-oriented support plan. This will include the consideration of both formal and informal services that are most appropriate to provide the client with support.

- Comprehensive assessment conducted face-to-face by Aged Care Assessment Teams (ACATs).

  - This holistic assessment will include the development of a goal-oriented support plan and will determine eligibility for services under the *Aged Care Act 1997*. This will include the consideration of both formal and informal services that are most appropriate to provide the client with support.

5.1 Screening and assessment principles

The following overarching principles form the basis of conducting screening and assessment using the NSAF.

5.1.1 Holistic assessment of client need

The screening and assessment process provides the opportunity for contact centre staff and assessors to understand a client's needs holistically. The NSAF facilitates the collection of information on:

- The client's current level of support (formal and informal) and engagement

- Carer availability and sustainability

- Health concerns and priorities

- Functional status

- Psychosocial and psychological concerns

- Home and personal safety considerations

- Decision making capabilities.

It also identifies any complexities a client may have that indicate a level of vulnerability.

It is important that clients receive an assessment that is relevant to their needs and that a client is not under-assessed or over-assessed. While the NSAF provides the ability to collect information on a range of considerations (such as alcohol

consumption, legal concerns etc.), information should only be collected if the client or assessor identifies this as an area of concern.

Just as important, if a client's needs or areas of concern are identified beyond the scope of the questions asked in the NSAF, this information should be included so that it can form part of the consideration for support, service provision, or further assessment.

The NSAF includes Supplementary Assessment Tools that may be used by an assessor to inform a holistic assessment of a client's needs. The use of these clinically-validated assessment tools is not mandatory, but should be used if a need is identified that requires a greater level of assessment. An assessor may also choose to use other clinically-validated tools at their discretion, but should record within the NSAF the name of the assessment tool used, the result of the assessment and also attach the assessment to the client's record.

5.1.2 Flow of information from screening and assessment events

The NSAF has been designed so that appropriate questions are included at each level of screening and assessment, and that this information flows on to the next level of assessment.

It is recognised that the type of information gathered over-the-phone from the client may be different to the information a client provides during a face-to-face assessment; what an assessor is able to observe, and the information that can be gained from another party, such as the client's carer. This is important information to know.

A home support assessment or comprehensive assessment will build on the information collected at screening and an assessor will update the information provided as appropriate. This will allow an assessor to understand what the client's functional ability and areas of concern were at the point of screening, identify how the client's needs have changed between screening and assessment events and then provide a sound basis to further investigate areas of concern during assessment.

If a client requires a further level of assessment beyond what is currently being undertaken, contact centre staff or assessors should attempt to gather as much information as the client is comfortable to provide, in order to support the next level of assessment.

The following options should be considered when reviewing preceding screening and assessment questions:

1. Verify that the information collected is still accurate;

2. Update the information if it has changed; or

3. Complete the information if it was not addressed at screening or at home support assessment.

5.1.3   Provision of support in line with the client's goals

It is important to note that the NSAF has not been developed or designed to equate to a service response, rather it is the role of the trained assessor to be able to make recommendations for support in line with the client's needs and concerns, as well as their goals and aspirations.

This is achieved through the development of the support plan, where a conversation between the client and assessor identifies what is most important to the client, the client's current strengths and abilities, as well as their areas of difficulty. It asks clients to consider how satisfied they are with their current level of independence, and what they hope will change if they are able to receive support. The support plan also identifies any considerations that would be important to record or that could affect service provision.

The support plan asks the client to identify what they would like to improve (their area of concern), what they would like to achieve, their motivation to achieve each goal, and the agreed action to be taken to meet their goals. This may be a combination of client-initiated solutions, support received through Commonwealth funded services, or support provided through other services/organisations/ community groups.

5.1.4   Promotion of consumer direction

Consumer direction is a core component of the delivery of Commonwealth Home Support Programme services and home care, and this approach should be encouraged throughout the screening and assessment process.

In partnership with a wellness approach, consumer direction under the Commonwealth Home Support Programme will drive a model of service delivery that focuses on a client's life goals and strengths. It will empower individuals to take charge of, and participate in, informed decision-making about the care and services they receive. Clients will:

- Have access to detailed information on aged care options provided through My Aged Care
- Actively participate in assessment of their needs through a two-way conversation with My Aged Care assessors
- Identify any special needs, life goals, strengths, service delivery preferences
- Have their carer's needs recognised and assessed with assessors from My Aged Care
- Have access to free, independent and confidential advocacy services
- Have options on how to select their preferred grant recipient (if they choose to) from information available through My Aged Care
- Have access to client feedback mechanisms including the Aged Care Complaints Scheme.

To enable consumer direction, contact centre staff and assessors should:

- Ensure opportunities for client choice and control are provided for each client, their carer's and families, in line with their needs; and
- Invite clients to identify their goals, strengths and service delivery preferences and where possible honour that request.

5.1.5 Awareness of cultural and/or religious values or beliefs, gender identity or sexual preferences

A client's cultural and/or religious values and beliefs; gender identity or sexual preferences or history of discrimination; or history of experiences such as institutionalisation is an important consideration for contact centre staff or assessors as it may influence the way a client interacts during a screening or assessment event. It may also influence the type of service a client may wish to receive.

These questions are included in the action plan and support plan as a way of recording this information. It is important that contact centre staff or assessors asks these questions in an appropriate manner, acknowledging that these may be sensitive questions for a client, and respecting that a client may not wish to disclose this information. The contact centre staff or assessor should assure the client that this information will only be used for purposes of providing appropriate service pathways and support.

5.1.6 Consent to Screening and Assessment

Gaining of client consent is required at multiple points of the screening and assessment process:

- For the screening or assessment event to take place
- For the collection and recording of information pertaining to the screening or assessment
- For the sharing of screening or assessment information with people involved in the provision of support including representatives, assessors and service providers.

The client should be assured that the information collected and recorded on the client record is secure and only used for the provision of support. The My Aged Care system complies with the requirements of the *Privacy Act 1988* and the *Aged Care Act 1997*.

5.1.7 Interaction through the My Aged Care system

The My Aged Care system has been designed and developed to support the functionality contact centre staff and assessors require to undertake screening and assessment and facilitate referrals. Assessors should follow the instructions provided in the My Aged Care Assessor Portal User Guide to ensure information is correctly recorded in My Aged Care. This will ensure the system is correctly utilised and expected results can be achieved for all relevant users – clients, assessors and service providers.

5.2 Screening

5.2.1 Overview

My Aged Care contact centre staff will ask a series of questions to determine the assessment and/or care needs of the client.

During this conversation contact centre staff will establish an initial indication of the client's care needs. This includes information about the reason for contacting My Aged Care, an overview of the client's current support, carer status, functional status, health status, and home and personal safety.

As part of the screening process, an action plan, which is an agreed set of actions to be undertaken by the My Aged Care contact centre (referral to service provider, further assessment, or other services), is completed. For some people, this may lead directly to referral for basic services. For others with more complex needs, the process will lead to a referral for a face-to-face assessment of care needs.

The screening process is supported by the NSAF. Information gathered from the NSAF is integrated into the My Aged Care client record for sharing with the relevant contact centre staff, assessors and service providers.

Consent for screening needs to be obtained by the My Aged Care contact centre prior to referring a client to an assessment organisation for a face-to-face assessment or referring a client to services.

5.2.2 Principles of Screening

The following principles form the basis of screening using the NSAF. It is important to acknowledge when a client, their carer and/or their representative contact My Aged Care, as it may be their first contact with aged care services. The initiation of this contact could be coupled with a range of emotions about their changing circumstances, request for help and uncertainty about their future. The My Aged Care screening may be the first time that a client's information is collected.

5.2.2.1 Recognising client's needs throughout the contact

This may be the first contact a client, carer or representative has with My Aged Care. A contact centre staff should approach the phone call with a personable, warm and welcoming manner. This reassures the caller and assists them to feel at ease during the conversation.

Building rapport with the caller can be achieved by establishing how they would like to be addressed (such as by title, first name, preferred name) and maintaining a professional but personable tone of voice.

Listening and responding to non-visual feedback, for example, hearing the callers concerns and listening to the emotion and tone behind a callers words are important and can guide how you respond to the information presented as well as establishing trust.

Identifying the client's preferred communication style is necessary and may require the use of the NRS for those who have hearing difficulties or TIS for those who have English as a second language or do not speak English.

For callers who have communication difficulties, it is important to implement strategies to facilitate these communication difficulties. For example, ask the client to repeat themselves; ask closed questions to elicit more specific responses and increase your chance of the caller understanding, as well as you understanding what they are saying; and give the caller time to process and think about the answer to your question.

5.2.2.2 Client-led interaction

Screening should be approached as a client or carer led conversation rather than a series of questions that need to be answered. The contact centre staff should have the ability to fit with the caller's flow, rather than trying to fit the caller into a set process. The contact centre staff needs to be able to listen to the tone of the conversation and what may lie behind the words of the caller taking into account their needs and preferences. A contact centre staff should collect enough information from the client that they are willing to provide.

5.2.2.3 Setting expectations

When it is identified that the client is calling My Aged Care seeking assistance, the client should be made aware that in order to find out how to help them, Screening will be undertaken and that it may take some time to complete.

It is important to check with the client and/or their carer/representative that they are able to have a conversation and proceed with Screening. Limit any environmental factors that may cause distraction (at either end). For example, ask the client to turn their TV or radio down.

The client should be made aware that the information collected as part of the screening process is needs focused and is used to determine the client's eligibility for assessment and basic services. They should be made aware that the information that is collected will inform a home support assessment and/or comprehensive assessment.

5.2.2.4 Communicating next steps

Summarising and call wrap-up are important steps once there is enough information to finalise the screening in order to bring it to a timely end. For example, thanking the caller for providing the information can signify to the caller that the conversation is about to end and focusing on summarizing the phone conversation. The summary may include discussion about the action plan and match and refer for assessment and/or referral direct to service.

5.3 Home Support Assessment

5.3.1 Overview

Home support assessment is conducted face-to-face by the RAS. This holistic assessment will include the development of a goal-oriented support plan and consideration of both formal and informal services that are most appropriate to provide the client with support. As a result of home support assessment, an eligible client may be referred to CHSP services.

Home support assessment builds on the information collected in registration and screening, collecting a further level of detail that is suitable to ask or be observed in a face-to-face context. This includes collecting information on the client's:

- Family, community engagement and support;
- Health and lifestyle;
- Level of function;
- Cognitive capacity;
- Psychosocial circumstances;
- Home and personal safety;
- Level of complexity and risk of vulnerability; and
- Goals, motivations and preferences.

The NSAF is used to guide the collection of this information as part of the assessment process. It will assist the development of the support plan and the recommendation of services to meet the client's needs.

5.3.2 Principles of Home Support Assessment

It is important that assessors maintain professionalism in all interactions they have, both with clients and when recording information on the Client Record. An assessment is simply the best understanding available based on what can reasonably be known at a point in time. Assessors should:

- Utilise information collected at screening
- Conduct the assessment with an open mind;
- Withhold from having preconceived ideas about a client's capability or the service pathways they may require;
- Respect the client's personal values and beliefs, health and lifestyle preferences, goals and privacy;
- Impart knowledge to ensure the client is making informed decisions;
- Record assessment information in an appropriate, sensitive manner.

5.3.2.1 Preparation for assessment

When scheduling an assessment with the client, an assessor should confirm the client's contact details and address/location of where the assessment is to take place. The assessor should enquire if anyone else will be present at the assessment and whether the client is comfortable with the arrangement. An assessor may also ask questions pertaining to work, health and safety in accordance with local policy and procedures.

Prior to the assessment, an assessor should review relevant information pertaining to the client. This includes the client's details, information collected during screening, and any other referral information provided. An assessor may wish to talk to people who provide the client with support (following client consent). An assessor should organise any assessment needs such as an interpreter, Aboriginal Liaison Officer or advocate.

An assessor should also be aware of the client's willingness to participate in an assessment; their language abilities and aspects of cultural importance, including any cultural practices that may need to be observed.

5.3.2.2 Client-centred approach to assessment

A client-centred approach to assessment will enable the best outcomes to be achieved for the client. It involves:

- Conducting an assessment 'with' the client – taking into consideration the client's needs, values, goals and choices, and not just the issues they present with;
- Building a client's confidence of their own abilities and acknowledgement of their areas of difficulty;
- Empowering the client to make decisions about the type of support they wish to receive; and
- Generating a support plan that reflects the client's goals and the type of support they wish to receive.

5.3.2.3 Assessor observations

Assessor observations are an essential component of assessment. Observations can verify or contradict information that has been obtained from informal and formal reports. They can help the assessor communicate with the client about their concerns and possible solutions in a practical way. Observations can be opportunistic, for example noticing how the person moves about the home, their facial expressions, the interpersonal dynamics between the client and others present. Observations can also be more overt and intentional, for example asking the person to demonstrate how they transfer, manage the stairs, open the medicine bottle etc.

5.3.2.4 Importance of developing a support plan in line with the client's goals

Goal setting is a key component of the assessment process and is facilitated through the development of the support plan. Asking clients to think about what their goals are allows an assessor to understand where the client's priorities may be. These may be priorities in relation to support, or other goals the client may have in mind, such as leading a healthy and active lifestyle or reconnecting with the community. The goals outlined in the support plan do not have to be actioned through service provision, rather it is encouraged that clients and assessors think more broadly about ways to address the client's goals, through formal and informal services. It is also important that the support plan is considered as an ongoing document that can be updated as needs change.

5.4 Comprehensive Assessment

5.4.1 Overview

A comprehensive assessment (conducted by ACATs) builds on the information collected at screening and home support assessment (if applicable), and is undertaken face-to-face to determine a client's eligibility for care types under the *Aged Care Act 1997*. During the assessment, the assessor will assess the client's physical, medical, psychological and social needs. The assessor and client will work together to establish a support plan that reflects the client's strengths and abilities, areas of difficulty, and the support that will best meet their needs and goals, including appropriate reablement pathways.

Where a care type under the *Aged Care Act 1997* is identified as the most appropriate type of support to meet the client's needs, and the client meets eligibility criteria, the assessor will make a recommendation for approval by a Delegate of the Secretary. A client may be approved for a home care package, residential care, residential respite care or transition care. Clients may also be referred to CHSP services where appropriate and/or recommended to access informal services that are most appropriate to provide the client with support.

The NSAF is used to guide the collection of this information as part of the assessment process. It will assist the development of the support plan and the recommendation of services to meet the client's needs.

5.4.2 Principles of Comprehensive Assessment

5.4.2.1 Information gathering

Comprehensive assessment is a critical information-gathering process, without which effective decisions about health-promoting interventions cannot be made or the monitoring of changes in health status cannot be undertaken. It helps to identify the care needs of a select group of generally frail, older people and informs the development and implementation of individualised goals leading to a support plan. This support plan should include short and long term goals with a wellness and reablement focus.

An assessor should review any information collected prior to the face-to-face visit. This activity will help gain valuable information about what may have changed for the client since screening and or home support assessment and why they are seeking support through a Home Care Package or Residential facilities.

The assessment process should include data collection, documentation and evaluation of the client's health status and responses to health problems and intervention. All documentation should be objective, accurate, clear, concise, specific and current.

5.4.2.2 Assessment according to domains

To be approved for any type of Australian government-subsidised residential, Home Care Package or flexible aged care services, the *Aged Care Act 1997* (the Act) prescribes that a person must be assessed as having physical, medical, social or psychological needs that require the provision of care. In addition, the Aged Care Principles (the Principles) state that a person must have "a condition of frailty or disability requiring at least low level continuing personal care" and be "incapable of living in the community without support".

Comprehensive assessment focuses on the four domains with subsets of these domains known as dimensions. The extent to which each dimension of each domain is assessed will vary according to the client and their needs.

- A domain is a broad area of health and well-being covering social, medical, physical and psychological functioning.
- A dimension is a subset of a domain, such as 'depression' or 'dementia' in the case of behavioural and psychological functioning, or such as 'mobility' or 'continence' in the case of physical functioning.

5.4.2.3 Multi-dimensional approach to assessment

A comprehensive assessment is multi-dimensional. In order to fully assess a client's current needs and potential to remain independent, an assessor should consider long and short term service provision. This approach promotes a wellness and reablement focus. The assessor will work with clients who require supports to rebuild their confidence, support the development of daily living skills and promote community access and integration[1]. This philosophy treats assessment as dynamic and not static and supports clients to increase their confidence and independence to maximise choice and quality of life.

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[1] Department of Health, NHS North East. Reablement: a guide for frontline staff,2009

6 NSAF and Client Record – Items and guidance

6.1 Overview

The following sections of the NSAF User Guide provide guidance to the My Aged Care contact centre, home support assessors and comprehensive assessors on how to complete the questions and information required as part of screening, home support assessment and comprehensive assessment. It also includes guidance on the type of information that can be collected as part of the client record.

Due to the integrated nature of the NSAF, the order that questions present in may be different to how the My Aged Care contact centre, home support assessors and comprehensive assessors complete the screening and assessment process. The Key below has been provided to assist in further understanding the tables.

6.2 Key

The sections below are separated into tables relating to the area of the NSAF or client record that information can be collected as part of. User Guide information will be relevant depending on the level of screening or assessment information required to be collected. For example, information relating to Domains is only relevant to comprehensive assessors.

The sections take on the following format:

Column	Context
Item	This relates to the question or information that is collected as part of the NSAF or client record. This enables contact centre staff or assessors to search the document (CTRL+F) for the specific piece of information they require guidance on.
	The item is also categorised into:
	Assessor recorded: This indicates that the question or information is to be supplied by the contact centre staff or assessor and is not asked of the client.
	Mandatory: This indicates that the question or information is required to be completed by the contact centre staff member or assessor.
Level	This relates to the level of screening and/or assessment that the item and guidance applies to. All fields relating to the client record related to the My Aged Care contact centre, RAS and ACAT as it is expected that this information is verified/completed when necessary.
	The level is categorised into:
	All: This indicates that the item and guidance applies to screening, home support assessment and comprehensive assessment.
	CC: This indicates that the item and guidance applies to screening to be conducted by the My Aged Care contact centre.
	RAS: This indicates that the item and guidance applies to home support assessment to be completed by the RAS.

Column	Context
	ACAT: This indicates that the item and guidance applies to comprehensive assessment to be completed by the ACAT. In some instances, a different type or level of information per item will be required to be collected. This will be identified by the item and guidance being split per relevant level.
Guidance	This provides information relating to the item. Information may include: • The purpose of the question • The response options for the item • The type of information to be recorded in free text fields • Any hints/tips relating to the item. Where there are related questions to the item, or information relating to response options, they will be indicated in **bold**.

7 Client Record – Client Details

7.1 Overview

The collection of accurate client details is extremely important for My Aged Care and the client. It will allow for the establishment of a client record and the identification and verification of clients as they progress through My Aged Care. The collection of client details might occur over several screening and assessment events, and may also need to be updated as the client's circumstances change.

7.2 Personal information

Item	Guidance
Title **Mandatory**	A name title is a prefix to a person's name. Recording a client's correct title is important particularly for written correspondence. Titles include Mr, Mrs, Miss, Ms, Dr, Captain, Chaplain, Father, Lieutenant, Major, Master, Pastor, Prof., Professor, Reverend, Reverend Canon, Reverend Dr, Sister, Other and Not Specified.
First Name **Mandatory**	The name given to a person which is their identifying name within the family group or the name by which the person is uniquely socially identified.
Middle Name	A secondary name given in addition to the first name.
Last Name **Mandatory**	The name a person has in common with other members of their family, as distinguished from their first name.
Preferred Name	The name a person would prefer to be referred to when interacting with My Aged Care.
Date of Birth **Mandatory**	**Date of Birth:** The date of birth of the client. **Date of Birth Estimated:** Whether or not the person's date of birth has been estimated **Age:** The age of the client in years. This will be generated by the system if the client's date of birth is known. If the

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
	client's date of birth is not known but the client's age is known, it should be entered.
Gender Mandatory	Individuals may identify and be recognised within the community as a gender other than the sex they were assigned at birth, as intersex, or as an indeterminate sex and/or gender, and this should be reflected in their personal records. Contact centre staff and assessors should refrain from making assumptions about a person's sex and/or gender identity based on indicators such as their name, voice or appearance. The responsibility of the contact centre staff and assessors is to provide opportunities for people to identify as they prefer, whilst being aware of the potential sensitivity of categorising-type questions. Options include male; female; indeterminate, intersex, unspecified and not specified. More information on the Australian Government Guidelines on the Recognition of Sex and Gender can be found at: http://www.ag.gov.au/Publications/Pages/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.aspx
Country of Birth Mandatory	This is the country in which the client is born. Combined with preferred language, this allows contact centre staff and assessors to potentially identify clients from culturally and linguistically diverse backgrounds. Contact centre staff and assessors should be aware of past history and current issues relating to a client's Country of Birth that may influence a client's participation with My Aged Care.
Ethnicity Mandatory	This is the ethnicity the client relates with. It may be different to the ethnicity associated with their Country of Birth or the preferred language. Not stated or not stated/unknown should be selected if the client or their representative is uncertain or unable to communicate the client's ethnicity.
Aboriginal and/or Torres Strait Islander Status Mandatory	This is whether the client identifies as being of Aboriginal and/or Torres Strait Islander descent. Aboriginal and/or Torres Strait Islanders are likely to experience significant health disadvantage that may impact on their need for and use of health and community services. Aboriginal and/or Torres Strait Islanders also have a lower life expectancy, which may lead them to requiring screening or assessment at an earlier age. A client who identifies as being Aboriginal and/or Torres Strait Islander is eligible to receive CHSP services from the age of 50.

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Item	Guidance
	Options include No – Neither, Yes – Aboriginal, Yes – Torres Strait Islander, Yes – Both or Not stated/inadequately described.
Veteran or War Widow/Widower	When screening or assessing a veteran or war widow/widower, it is important to be sensitive to their experiences.
	Veterans or war widow/widowers who hold a gold card or a white card may be eligible to receive home care services through the Department of Veterans' Affairs (DVA). They are also able to receive services through the CHSP and services under the Aged Care Act 1997.
	A contact centre staff or assessor should confirm with the veteran or war widow/widower whether they are aware of the services they may be eligible for through DVA, and either transfer or provide information to the client about DVA services, or continue the screening or assessment process for services delivered by the CHSP or for services under Aged Care Act 1997.
DVA Entitlement	There are several types of DVA entitlement:
	Gold Card: Enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.
	It should be noted that a number of gold card holders don't have a Medicare card.
	White Card: Enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post-traumatic stress disorder and, for Vietnam Veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.
	White card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health providers with whom DVA has arrangements.
	A white card is also used by eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian Government for the treatment of the conditions that those countries accept as war related.
	Orange Card or other DVA entitlement: The orange card enables the holder to access the range of pharmaceutical

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
	items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services. More information on DVA services and entitlements can be found at: http://www.dva.gov.au/health-and-wellbeing/veterans%E2%80%99-health-cards
Marital Status Mandatory	This field is to record a client's marital status. This can give contact centre staff and assessors valuable information regarding the client's current or previous relationships, whether support is available, and whether the client might have experienced a significant or stressful event recently that may contribute to their current presentation. Options include never married, married (registered or de facto), widowed, divorced, separated or unable to determine.
Lives with Mandatory	This is whether the client lives alone, or with other related or unrelated persons. This gives an indication of the client's current accommodation arrangements and available supports, level of engagement and community support, and psychosocial concerns such as social isolation. It is also important when considering the client's home and personal safety and financial situation. Options include lives alone, with partner, with family, with friends, with others, not specified or not applicable.
Type of Accommodation Mandatory	This is the setting in which the person usually lives. The relationship between housing and the care needs of older people is an area of considerable policy importance. Recent reviews have identified insecure housing as a risk factor in premature entry into residential care among frail older people and the possibility that it may be associated with more limited access to community-based services. Options include private residence (client owns/is purchasing, related person owns/is purchasing, private rental, public rental or community housing); independent living within a retirement village; boarding house/rooming house/private hotel; short term crisis, emergency or transitional accommodation; supported community accommodation; residential aged care service; hospital; other institutional care; public place/temporary shelter; other community; indigenous community/settlement or not stated/inadequately supplied. Further information is available at Appendix A.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

7.3 Identity information

Item	Guidance
Medicare number	A Medicare Card Number will enable My Aged Care to verify the identity of the client with the Department of Human Services. **Medicare Card number:** The client's Medicare Card number. **Individual reference number (IRN):** The client's individual reference number displayed on their Medicare Card. This number can be found next to the client's name on their Medicare Card.
DVA Card number	A client with a DVA Card may not necessarily have a Medicare Card (particularly those with a gold card). **DVA card number:** Should be recorded if the client has a DVA card. All veteran or war widow/widower clients are issued with a DVA File Number. 1st character is the State Code; next 7 characters are the file number; made up of: war code + numeric digits. The DVA card number is the digitised version of the file number.
Centrelink Customer Reference number	In the case where a Medicare card number cannot be collected from the client, a client's Centrelink Customer Reference number (if applicable) will assist in identifying the client with any existing records.
Aged Care Management Payment System (ACMPS) number	In the case where a Medicare card number cannot be collected from the client, a client's ACMPS ID (if applicable) will assist in identifying the client with any existing records. This will be relevant for client's who have an approval for a home care package and the number can be found on correspondence they have received from DHS.
System for the Payment of Aged Residential Care (SPARC) number	In the case where a Medicare card number cannot be collected from the client, a client's SPARC ID (if applicable) will assist in identifying the client with any existing records. This will be relevant for client's who have an approval for residential care and the number can be found on correspondence they have received from DHS. It is also available via the Aged Care Online Payment system.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

7.4 Communication needs

Item	Guidance
Preferred Language Mandatory	This is the main language the client speaks when at home and the language in which they are most comfortable to communicate by. Combined with Country of Birth, this allows contact centre staff to potentially identify clients from culturally and linguistically diverse backgrounds. The answer to this question should help inform the type of interpreting service a client may require during screening or assessment.
Requires help to communicate	This question is asked of the client to understand whether they perceive any barriers in communicating. This includes communicating over-the-phone and face-to-face. If the client requires help to communicate, confirm whether they use aids to assist with inter-personal interaction such as telephone attachments, writing aids, speaking aids, hearing aids, reading aids or interpreters. This includes the use of the National Relay Service (NRS) or Translating and Interpreter Service (TIS). Should a contact centre staff or assessor notice a barrier in communication that is not identified by the client, this should also be recorded to enable communication assistance and awareness for others involved in the client's support. Examples of communication difficulties that might be identified include: **Language**: The client has difficulty understanding and/or getting their message across using their first language. **Hearing**: The client has difficulty hearing questions, particularly when repeated. **Speech**: The client has difficulty in being clearly understood (including stuttering, broken, and/or mumbled speech). **Cognitive**: The client has difficulty recalling, understanding, responding to or providing basic information even when prompted/guided. **Other – Specify**: The client has any other communication difficulties identified such as erratic or incoherent conversation and behaviour, hysteria, or emotional responses that inhibit the ability to collect information.
NRS Required	When communication difficulties have been identified, the contact centre staff or assessor should have a conversation with the client, their representative or the referrer about using the NRS for those who have hearing. Should the client agree, the contact centre staff should facilitate access to NRS as appropriate. If the client does not wish to access

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
	NRS, the contact centre staff should assess if it is possible to continue with Screening, or whether a face-to-face assessment is more appropriate for the client.
TIS Required	When communication difficulties have been identified, the contact centre staff or assessor should have a conversation with the client, their representative or the referrer about using the TIS for those who have English as a second language or do not speak English. Should the client agree, the contact centre staff should record the language provided and facilitate access to TIS as appropriate. If the client does not wish to access TIS, the contact centre staff should assess if it is possible to continue with Screening, or whether a face-to-face assessment is more appropriate for the client.

7.5 Payment details

Item	Guidance
Government Pensions/ Benefits	This is to record whether the client is in receipt of a full or part government pension or benefit. This information is collected to give an indication of a client's financial position and to inform service providers as it may influence the types of fees clients are charged.
	Age pension: Provides income support and access to a range of concessions for eligible older Australians. Eligibility is based on being aged 65 years or over, and meeting an income and assets test.
	More information is available at: http://www.humanservices.gov.au/customer/services/centrelink/age-pension
	Veterans' Affairs pension: There are a range of pensions available through the Department of Veterans' Affairs, including disability pension, service pension, war widows pension and orphans pension, income support supplement, special rate disability pension and age pension.
	More information is available at:

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Item	Guidance
	http://www.dva.gov.au/pensions_and_compensation/pensions_and_rates/Pages/index.aspx
	Disability support pension: Provides financial support for people who have a physical, intellectual, or psychiatric condition that stops them from working or who are permanently blind.
	More information is available at: http://www.humanservices.gov.au/customer/services/centrelink/disability-support-pension
	Carer payment: An income support payment for people who personally provide constant care in the home of someone with a severe disability, illness, or who is frail aged.
	More information is available at: http://www.humanservices.gov.au/customer/services/centrelink/carer-payment
	Carer allowance: A supplementary payment for carers who provide additional daily care and attention for someone with a disability or medical condition, or who is frail aged.
	More information is available at http://www.humanservices.gov.au/customer/services/centrelink/carer-allowance
	Unemployment related benefits: These include benefits such as the Newstart Allowance which provides financial help when looking for work and Youth Allowance which provides financial help for people aged 16 to 24 who are studying full-time, undertaking a full-time Australian Apprenticeship, training, looking for work, or sick.
	More information is available at: http://www.humanservices.gov.au/customer/services/centrelink/newstart-allowance http://www.humanservices.gov.au/customer/services/centrelink/youth-allowance
	Other Government pension or benefit: Any other form of Australian Government support which is not listed.
Payment type	**Full pension/Part pension:** With the exception of a carer allowance, the government pension or benefit can be recorded as a full pension or a part pension.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

7.6 Health insurance

Item	Guidance
Private Health Insurance	This is for clients who have private health insurance. Clients in this category may be able to access services such as allied health through their private health insurance.
	Hospital cover: Hospital policies cover the cost of in-hospital treatment by the doctor and hospital costs such as accommodation and theatre fees. Generally, medical services listed under the Medical Benefits Schedule are covered by private health insurance.
	General treatment cover: General treatment policies (also known as ancillary or extras cover) provide benefits for non-medical health services, such as physiotherapy, dental and optical treatment. General treatment policies may be offered separately or combined with hospital cover.
	More information is available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-whatisPHI

7.7 Address details

Item	Guidance
Address purpose	Whether the address is relating to a home, postal, business or service delivery address.
Address type	Whether the address is a postal address or street address.
Address	The correct categorisation of address type is important as it will determine how My Aged Care assessors and service providers communicate and deliver services to the client.
	Unit/Shop/Flat/Suite: The unit type (flat, office, suite, shop); the floor type (level, basement, floor); the street start number and street end number.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
	Street Address/PO Box: The street number, the name of the street, and the type of street (such as street, road, avenue, circuit). It may also include a street type suffix (such as west, north).
	Suburb/Town: The suburb, town or locality in which the address is located.
	State/Territory: The state or territory in which the address is located.
	Postcode: The postal code of the geographic location of the address.
	Country: The country in which the address is located.
No fixed address	This field should be selected by the contact centre if the client indicates that they have no fixed address. That is, the client is homeless (without an acceptable roof over their head), moving between various forms of temporary accommodation, constrained to living permanently in single rooms in private boarding houses, or housed without conditions of home (such as safety, security or adequate standards).

7.8 Contact details

Item	Guidance
Preferred correspondence method	This records whether the client prefers to receive correspondence by email, fax or post, or whether they would prefer information to be sent to a representative.
Preferred contact number	The client's preferred contact telephone number. This may be a home number, mobile number, business number or other type of number.
Phone – Home	This is the most appropriate home phone number to contact the client on. Should the phone number belong to another individual, note the name of the person and the relationship they have with the client.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
Phone – Mobile	This is the most appropriate mobile phone number to contact the client on. Should the phone number belong to another individual, note the name of the person and the relationship they have with the client.
Phone – Business	This is the most appropriate business phone number to contact the client on. Should the phone number belong to another individual, note the name of the person and the relationship they have with the client.
Phone – Other	This is a different phone number the client can be contacted on. Should the phone number belong to another individual, note the name of the person and the relationship they have with the client.
Fax	A fax number that the client can be contacted on. Should the fax number belong to another individual the name of the contact and their relationship to the client should be recorded. In this instance, how correspondence is addressed in the fax should be discussed with the client (e.g. for the attention of [client name]).
Email	An email address the client can be contacted by. Should the email address belong to another individual the name of the contact and their relationship to the client should be recorded. In this instance, how correspondence is addressed in an email should be discussed with the client (e.g. for the attention of [client name]).
Preferred callback day	This identifies the day on which a client may prefer to be contacted. Options include Monday, Tuesday, Wednesday, Thursday, Friday and Saturday.
Preferred callback time	This identifies the time of day on which a client may prefer to be contacted. Options include morning, afternoon and evening.

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8 Client Record – Representative Details

8.1 Overview

A client may have many people in their lives which provide them with a level of support. By recording these relationships in My Aged Care, it allows the contact centre and assessors to understand to the type of support the person provides (e.g. decision making capabilities), and provides the contact details for the person for when it is relevant to contact them (noting client consent).

8.2 Representatives and other contacts

Item	Guidance
Role	People who provide the client with support can be categorised as:
	Representative (regular): Regular representatives are nominated by the client. This consent can be given verbally, in writing or in any other way that communicates the authority to act on behalf of the client. For the most part, regular representatives are able to give and receive information about the client to the extent of the clients' consent.
	Representative (authorised): Authorised representatives are generally able to act for a client based on provisions within federal, state or territory law. Instruments that are likely to be seen within the My Aged Care system include: power of attorney (lapses if the client loses capacity); enduring power of attorney or instrument of enduring guardianship or medical power of attorney based on state and territory law and can cover financial and health related decisions; appointment of a guardian by a tribunal or board; appointment by a tribunal, board or court as an administrator; and authorisation by a statute to make decisions on behalf of an individual.
	Carer: Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged. The relationship between a client and a carer may be identified during the screening and assessment process, when asking the client about whether they have someone helping them out, such as a family member or friend.
	Emergency contact: The client's chosen person who should be contacted if there is an emergency. The person(s) may or may not be the client's carer or representative.
	GP: The client's general practitioner. This information may be included on an inbound referral.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Guidance
	Support person: A person who provides the client with support, but would not be considered a carer (e.g. a neighbour or contact person).
Relationship	This is the relationship between the representative/other contact and the client. Options include child, parent, neighbour, friend, other.
Scope of representation	Where the person is a representative, the scope of their representation is collected. Options include financial, care, or financial and care.
Lives with	This is to record whether the representative/other contact lives with the client.
Start date	This is the start date by which the representative/other contact are enacted (e.g. where a guardian is appointed, it will only be for a specified period of time).
End date	This is the end date by which the representative/other contact ceases being a representative/other contact for the client (e.g. where a guardian is appointed, it will only be for a specified period of time).

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

9   NSAF – Event Details

These questions relate to the screening and assessment process. It includes referral information, relevant dates associated with the screening or assessment process and the participants involved in the screening or assessment event. It also includes the ability to record notes that summarises the screening or assessment event.

9.1   Referral information

Item	Level	Guidance
Source of referral **Assessor recorded**	CC	This refers to who has initiated contact with My Aged Care. When an inbound call and/or referral are received, it is necessary to state the source of the referral. Should you need to further specify the source of referral, enter relevant information in 'specify', without duplicating information collected in Referrer Details. Options include Self; Family, significant other, friend; GP/Medical Practitioner (Community Based); CHSP service provider; Aged Care Assessment Team; Community nursing or health service; Hospital; Psychiatric/Mental health service or facility; Extended care/Rehabilitation facility; Palliative care facility/Hospice; Residential aged care facility; Aboriginal health service; Other medical/health service; Other community based service; Law enforcement agency; Aged Care Gateway; Other; and Not stated/inadequately described.
Referrer details **Assessor recorded**	CC	This is the contact information of the referrer specified in 'source of referral'. This information will generally be provided as part of an inbound referral. It does not need to be collected is the source of referral is 'Self'. **Name:** The title, first name and last name of the person who provided referral information. **Organisation:** The name of the organisation the referrer is associated with (if applicable). **Address Type:** The type of address listed under 'address details'. Options include home, postal, service delivery, other. **Address Details:** The address details associated with the referrer and/or their organisation. Address details include street number, street address, State/Territory, postcode and country.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		Contact Number: The contact number for the referrer. This can be a home, mobile or business number.
Reason for referral Assessor recorded	CC	This is the reason the referrer is referring the client to My Aged Care. It should include information about the trigger or situation that has led to them contacting My Aged Care. If the referral is received via an inbound call from a hospital it may be useful to collect information on when the client was admitted, the reason for their admission, their estimated discharge date and if the client will be discharged with any interim hospital services. If the referral is received from a service provider it may be useful to understand what changes have occurred to the client's medical, physical, social or caring arrangements that have prompted the referral.
Date the referral is received Assessor recorded	CC	This is the date on which the inbound referral is received.

9.2 Previous assessment information

Item	Level	Guidance
Has the client previously participated in Assessor recorded	CC	This refers to whether the client has previously participated in screening or assessment. Should the client have already accessed My Aged Care screening and assessment services, this information will be available on the client record. If no details exist on the client record, confirm with client if there has been any previous assessment events and if so, request details of prior assessment information, eligibility and approval. This includes: **Screening**: If the client has participated in screening through the My Aged Care contact centre. If screening has occurred on or after 1 July 2015, this will be present on the Client Record.

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		Home Support Assessment: If the client has had a home support assessment through RAS. If home support assessment has occurred on or after 1 July 2015, this will be present on the client record.
		Comprehensive Assessment: If the client has had a comprehensive assessment through an ACAT. From 1 July 2015, a client's aged care approvals will be available on the client's record.
		Other Assessment: Should be selected if the client has previously had a level of assessment. Specify the type of assessment the client has participated in, such as a HACC assessment, assessment by a health professional, memory assessment, continence assessment, mobility assessment, home safety assessment etc. Where possible, record when assessment occurred and who it was conducted by.

9.3 Event information

Item	Level	Guidance
Date of event Mandatory Assessor recorded	CC	This is the date that screening is undertaken. In most instances, it will be the current date.
	RAS	This is the date of first face-to-face contact with the client for the purposes of conducting home support assessment. In most instances, it will be the current date.
	ACAT	This is the date of first face-to-face contact with the client for the purposes of conducting comprehensive assessment. In most instances, it will be the current date.
Date of first intervention of a clinical nature Mandatory Assessor recorded	ACAT	This is the first date that contact of a clinical nature (i.e. non-administrative) is made between an Assessor and the person, their carer, a service provider or a clinician in response to the person's referral for a comprehensive assessment. The first clinical intervention by an ACAT may involve direct face-to-face contact with the client. In this case, the first intervention date will be the same as the first face-to-face contact date. However, at times, an ACAT may take significant action in response to information available at referral before face-to-face contact with the client (e.g. organising emergency respite care, or developing an interim support plan).

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		Date: Record the date of the first intervention of a clinical nature.
		Outcome: Record the outcome of the first intervention of a clinical nature.
Are there other participants who have been consulted prior to the assessment? Assessor recorded	RAS ACAT	This question refers to the person(s) that have been consulted prior to the home support or comprehensive assessment. This may include person(s) that have a role in providing the client with support, such as the client's representative, family, carer(s), existing service provider or GP. The person(s) name should be recorded, and if they aren't already established as a representative of the client, their relationship to the client and their contact details recorded. It is important that consent is gained to undertake this activity.
Setting Mandatory Assessor recorded	RAS ACAT	This question refers to the location of first face-to-face contact with the client for the purposes of home support assessment or comprehensive assessment. Information about the setting of the first face-to-face contact describes the environmental context in which the assessment has occurred. This information has been identified as a factor in the recommended long-term care setting for the client. Options include: **In the client's home:** The location the client has nominated as their usual place of residence. This should match the information provided in 'Address details'. **In the carer's home:** Where the carer of the client lives. This is the residence recorded on the representative record. An assessor should add carer contact and address details to the representative record if not already available. **Other community setting:** All other community settings, such as private homes, outpatient clinics, retirement villages, independent living units, supported residential services/facilities (Victoria and South Australia only) and supported accommodation settings in the community. **In hospital:** For clients in hospital (public or private). **Other hospital inpatient setting:** Hospital settings other than acute care, in which the person is an admitted patent receiving overnight care, admitted patients in extended care or rehabilitation facilities or other non-acute

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Item	Level	Guidance
		wards/beds in hospital.
		Residential aged care service: For clients in a government-funded residential aged care service, multipurpose service or multipurpose centres and Indigenous flexible pilots, regardless of the level of care received by the person or whether the client is a permanent or respite resident.
Informational primarily being collected from Mandatory Assessor recorded	All	This refers to the primary person or organisation providing information at the time of the screening or assessment event. In most instances, it will be the client. Other options include the client's carer, the client's representative, the client's GP, a service provider, healthcare provider or other information. In instances that information is not provided by the client, it is necessary to document the name of the person(s) providing the information and the organisation that they work for. It is important to have consent from the client for information to be provided on their behalf. If not already, consider whether they should be established as a representative for the client.
Are there other participants involved in the assessment? Assessor recorded	All	This refers to other people that are informing the screening or assessment event, other than that identified in 'information primarily being collected from'. Where someone else is involved in the screening or assessment event, specify their name, relationship to the client and contact details. If not already, consider whether they should be established as a representative for the client.

9.4 Event completion information

Item	Level	Guidance
Event completion	All	This refers to the completion of the screening or assessment event.

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Assessor recorded		If unable to complete the screening or assessment event, record the reason why it could not be completed. Examples may include the client was admitted to hospital; they moved location; they passed away or changed their mind. Record any follow up actions that are required to be undertaken.
End date Assessor recorded	All	This if the date that the screening or assessment event was completed.
Assessment summary Assessor recorded	All	This is a summary of information pertaining to the screening or assessment event. It may describe key characteristics about the client and their current situation, any matters of concern and the key outcomes as per the action plan or support plan. You may wish to provide or record this summary information using the SBAR model. There are four common elements to this model and it offers a simple way to communicate. S – Situation: briefly describe the situation. Give a succinct overview. B – Background: briefly describe what precipitated the referral for assessment. A – Assessment: summarise the facts and the outcomes from the assessment including the client's goals. R – Recommendation: what are the services that are being recommended, are these are short or long term focussed goals, incorporating information relevant to the client support plan. For example, Mrs Smith presented with needs A, B and C. She was particularly concerned about D and E. Her goals include X and Y. Mrs Smith has been referred for Z.
Comments/Further information Assessor recorded	All	This section allows you to document any additional general comments and information as provided during the screening or assessment event regarding Event Details. This may include: • Information about why you have been unable to determine a response to a question in this section. • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere.

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10 NSAF – Reason for Contact

These questions relate to the reason why contact has been made with the My Aged Care. This includes information about the circumstances that prompted contact, concerns about the client has with their current situation and how they have been managing to date.

Item	Level	Guidance
How may I help you today? Mandatory	All	This records the reason why the person is contacting My Aged Care. This may be a change in circumstance for the client, an increase in care needs, or due to a recent event. In some instances, the caller may not actually know what they are calling My Aged Care for or how they can be assisted. If this is the case, it is still important to document the caller's response. Document the details as provided by the client. It may be necessary at this point to inform the client of the My Aged Care role and screening and assessment process and that the information collected will help determine the next steps.
Key circumstances triggering contact Mandatory Assessor recorded	All	This categorises the main reasons for seeking assistance and should include information about the situation or trigger that has led to them contacting My Aged Care. Complete the question based on information available, your judgement based on the conversation with the client, information on the inbound referral and/or information provided by another source such as a representative, carer or friend. Options include: **Hospital discharge**: If the client has had a recent hospitalisation. If hospitalisation is mentioned, consider 'Have you been discharged from hospital in the past 3 months?' Other information provided on this topic that may inform this question includes the date that the client was admitted to hospital, the reason for the admission, the estimated discharge date and support and care that is being organised following their discharge. It is important to understand what care and support is being organised for discharge and whether it will be provided by private providers, informal care or other non-aged care funded programmes. Information about the care and supports in place should be documented in 'Are you currently receiving support or assistance from any of the following programs' and 'Have you been discharged from hospital in the past 3 months?' and 'Aids and equipment in place post discharge'. **Fall(s)**: If the client has had a fall. If fall(s) are mentioned, enter information in 'Falls'. Other appropriate

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		information about falls that may inform this question includes how many falls the client has had, when they occurred, at what time of day they occurred and the location of the fall(s). It is important to also gather information about the impact of the fall and whether the client needed medical attention such as an ambulance, admission to hospital or whether they advised their GP of the fall(s).
		Medical condition(s): If the client has medical conditions that are impacting on their ability to undertake day-to-day tasks. More information about medical conditions should be entered in 'Do you have any health conditions, mental health conditions or disabilities?'. It is important to note that the medical conditions affecting the client may be newly diagnosed or may be an exacerbation of an existing medical condition thus triggering contact for assistance. In some instances, the client will have multiple medical conditions.
		Change in cognitive status: If the client or their carer mentions that the client has experienced a change in their memory and cognition. This can include declining memory, short-term memory, poor memory, safety concerns with being left alone or using cooking appliances, forgetting to take medication or taking the wrong medication, getting lost in familiar environments and concerns about safety when driving. Other information that may inform this question includes whether the client has a new or existing diagnosis of dementia and how long the changes in cognition have been evident. Additional information about cognition should be entered in 'Does the client have any memory problems or get confused'. In most instances, a carer or referrer will express their concerns about a client's changed cognitive status. A client may also be aware of changes to their cognition and/or memory therefore prompting them to contact for assistance before it deteriorates further.
		Change in care needs: If the client needs more (or less) assistance to complete everyday tasks. If this is mentioned, the 'Functional Overview' will capture the client's abilities and difficulties, who/what they receive assistance from and whether assistance is required to fulfil the need.
		If the referral is from a carer, it is important to note the changed circumstances that have prompted the referral. This can include the carer no longer being able to provide the care they have been providing due to the client needing more or less assistance with everyday tasks.
		If the referral is from a service provider, it is important to note the changed circumstances that have prompted the referral. This can include the service provider no longer being able to provide the care they have been

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		providing due to the client needing more or less assistance than they are currently funded to provide.
		Concern about increasing frailty: If the client or carer mentions that they are not able to do the everyday things that they normally do, are concerned about getting older, have concerns about their worsening health and mobility. Specific concerns may be captured in the 'Health Overview'.
		Carer burden/issues: If the client has a carer that is stressed, tired or unwell, is having difficulty assisting with specific tasks (such as lifting or managing medicines) and is not coping or has other commitments impacting on their caring role. If this is mentioned, complete the 'Carer Overview'.
		Change in caring arrangements: If the client has a co-resident, non-resident carer or an informal support network that is unable to continue providing regular care and support. This may be as a result of the carer/support person passing away, being hospitalised or becoming unwell, moving out of the client's home or moving away from the client. If this is mentioned, complete the 'Carer Overview'.
		Change in living arrangements: If the client has relocated to new accommodation (by choice or forced relocation), is homeless, has a co-resident carer that moves out of their home or a carer/support person moves into their home.
		Sudden change in circumstance: If there has been an unexpected change in the client's circumstances. Include details such as environmental disasters (i.e. flooding, fire, storms or cyclones) that have an impact on the client's living arrangements. Other sudden changes can include financial hardship, homelessness or a carer passing away.
		Risk of vulnerability: If the client has a level of vulnerability, such as belonging to an at-risk group, Include details of the type of vulnerability as identified by the client. Should a client choose not to disclose information about their situation or lifestyle, this choice should be respected.
		Other: For any responses that are not defined in this guidance. Include relevant information if this response is chosen.
What is concerning you most about	All	This refers to what is of most concern to the client. The answer will possibly relate to the client's reason for contact. If the client has provided you with more than one concern, the answer to this question may well clarify

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your current situation?		which of the triggers is of most importance. Alternately, if a client raises a new issue as a concern, you may need to revise the key circumstances triggering contact.
		If the referrer is a service provider, they will express their concerns about the client's current situation. The client and the carer or referrer may have differing views about what is of most concern to them. Aim to obtain a balanced and as objective an account of the issue for the client as possible.
		As much as the carer may have the client's best interest at heart, it is often more difficult for a carer to remain objective around the client's needs. It will rely on your judgement to determine if they need to prompt further to find out about the client's main concern.
How have you been managing with this up until now?	All	This question asks how the client has been managing with the current issue up until their contact with My Aged Care. It relates to the answer(s) that you obtained from the previous question about what is of most concern to the client.
		As above, ensure the answer represents the scenario as it relates to the client and not a subjective or biased view from a representative, carer, service provider or healthcare professional.
Comments/Further information	All	This section allows you to document any additional general comments and information regarding their reason for contact.
		Types of comments or information that could be included here:
		• Information about why you have been unable to determine a response to a question in this section • Information that you have obtained that is unable to be documented elsewhere • Background information that has led to the circumstance triggering contact.

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11 Social Domain

The assessment of a client's social needs gauges their social isolation or loneliness and typically measures their perceived support received by family, friends and neighbours[2].

The assessor should consider the following dimensions of this domain:

- Existing social support networks
- Key relationships
- Current levels of support
- Feelings of loneliness
- Family issues (composition, history, dynamics, coping patterns, interactions)
- Care support arrangements (level of support, nature of support, coping capacity, support for the carer, role of significant others)
- Existing service providers (health, welfare, volunteer)
- Social, cultural, religious affiliations
- Transport access
- Financial status
- Levels of social interactions and isolation
- Companion animals.

11.1 Current Support

These questions relate to the formal services and supports currently in place, including whether the client has a support plan in place and the details about the formal services and supports.

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[2] National Aged Care Assessment Training – Assessor Module

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Item	Level	Guidance
Does the client currently have a support plan in place? Mandatory Assessor recorded	All	This question asks whether the client has a My Aged Care support plan in place. If a client has a support plan in place or one is under development, this can be viewed on the client record. If a client has a support plan in place or if it is in the process of being developed, include necessary information about the support plan, such as when the plan was developed and who it was developed by. If a support plan is currently being developed, include the date that the plan development commenced, and who it is being developed by. It is not mandatory to specify information about the support plan as relevant information should be available on the client record.
Are you currently receiving support? Mandatory	ACAT	This question asks whether client is currently receiving the help or supervision of another individual at the time of their comprehensive assessment and whether this help is from formal agencies or informal (i.e. family members, friends, or neighbours) persons. When recording whether a client is receiving support formally or informally it is important to understand the guiding descriptions for the Activities of Daily Living (ADL) and the Instrumental Activities of Daily Living (IADL) when answering this question. More than one activity can be recorded against each of the ADL/IADLs. The person's current use of assistance with activities should be reported in relation to their usual accommodation setting. If the person's accommodation arrangements at the time of comprehensive assessment are believed to be temporary, the information recorded here should reflect the person's usual living situation. This includes situations where the person is in hospital or another form of institutional or residential based care that is temporary in nature, as well as staying with family members or friends when this is believed to be a temporary arrangement. **Self-care:** Assistance or supervision of another person with daily self-care tasks such as eating, showering/bathing, dressing, toileting and managing incontinence. The independent use of aids and equipment should not be recorded against this option. **Movement activities:** Assistance or supervision of another person with activities such as maintaining or

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		changing body position, carrying, moving and manipulating objects, getting in or out of bed or a chair. The independent use of aids and equipment should not be recorded against this option. **Moving around places at or away from home:** Assistance or supervision of another person with walking and related activities, either around the home or away from home (excludes needing assistance with transportation). The independent use of aids and equipment should not be recorded against this option. **Communication:** Assistance or supervision of another person with understanding others, making oneself understood by others. The independent use of aids and equipment, e.g. hearing aids, speech aids, and assistance from interpreters should not be recorded against this option. **Health care tasks:** Assistance or supervision of another person with taking medication or administering injections, dressing wounds, using medical machinery, manipulating muscles or limbs, taking care of feet (when received from formal services, this type of assistance includes home nursing and allied health care, such as physiotherapy and podiatry and therapeutic services provided at Day Therapy Centres). **Transport:** Assistance or supervision of another person with using public transport, getting to and from places away from home, and driving. **Activities involved in social and community participation:** Assistance or supervision of another person with shopping, banking, participating in recreational, cultural or religious activities, attending day centres, managing finances and writing letters. **Domestic assistance:** Assistance or supervision of another person with household chores such as washing, ironing, cleaning and formal linen services. **Meals:** Assistance or supervision of another person with meals, including the delivery of prepared meals, help with meal preparation and managing basic nutrition. **Home maintenance:** Assistance or supervision of another person with the basic maintenance and repair of the person's home, garden or yard to keep their home in a safe and habitable condition, for example, changing light bulbs and basic gardening. **Other:** Assistance or supervision of another person with any other tasks or activities of daily living.

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		Not applicable: Should only be recorded for people who were permanent residents of residential aged care services, hospitals or other institutional settings at the time of assessment.
		None: Should be recorded when the assistance or supervision of another individual is not used by the person.
		Unable to determine: Should be recorded when the use of assistance or supervision of another person with tasks or activities by a person cannot be identified for any reason.
Are you currently receiving support or assistance from any of the following programs (if known)?	All	This question asks whether the client receives formal assistance or support on a regular basis. Formal assistance or support is provided via a service that is paid for and includes both government-subsidised and/or private services. Ask the client/carer if they are receiving any formal services and/or support to assist them with the management of their day-to-day tasks. If the client is in receipt of formal services/support, record what service they are receiving and where they get the assistance from. Clients and/or their carers may not know the name or type of assistance they are receiving and may require a verbal prompt or example to help them identify the specific service they are in receipt of. The following is a list of programmes that are available to clients. Multiple responses may be appropriate: Home and Community Care (e.g. meals on wheels, transport); Day Therapy Centre; National Respite for Carers Program; Assistance with Care and Housing for the Aged; Home Care Level 1 or 2; Home Care Level 3 or 4; Transition Care; Veterans' Home Care; and other. In this instance, specify if a client is in receipt of private services, services via a volunteer organisation, or services via their local hospital/local health district [e.g. post discharge services or a hospital avoidance program]). Where support is being provided, record how long the support(s) have been in place, when they ended or when they are due to end.
Are you currently receiving respite in an aged care	All	This question asks whether the client is currently receiving respite in an aged care facility. Respite care in an aged care facility is to give the carer a break from their usual caring role and/or to give the client a break from their usual place of residence.

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facility?		Contact with My Aged Care may be because the client is seeking respite; seeking a respite extension; wants to move into permanent care and only has approval for respite care; or wants to return home from respite with community aged care services. The caller may also offer information about how long the client is planning to remain in respite.
		If the client is receiving respite care in an aged care facility. Record when the client commenced respite, the name and the address of the facility (if known). These details may already be on the Client Record.
Has the client or their carer used residential or community based respite care in the last 12 months?	ACAT	This question asks whether the client or their carer has used residential based respite care in the last 12 months. In conjunction with information about carer availability, this information helps to identify the extent to which carers have received assistance in their caring role. Carers play a critical role in maintaining frail older people in the community and assist in preventing permanent admission to residential facilities.
		The following information is a guide of the types of respite care used by client's:
		Not applicable: Should be selected for people who were permanent residents of residential aged care services, multi-purpose services (or multi-purpose centres), hospitals or other institutional settings at the time of assessment.
		Residential: If the client has received short-term, alternative care provided in a residential aged care service or dedicated respite facility, or on a short-term residential basis in a multipurpose service (or multipurpose centre). This may be relevant to people with or without carers.
		Non-residential: Refers to assistance for a carer by the provision of a substitute carer from formal services who provides supervision and assistance to the client in the carer's absence in a non-institutional setting. This category is only relevant to clients with carers. Attendance at a day centre should only be included where the primary purpose of attendance is respite for the carer.
		None: If the client or their carer has not used residential based respite care in the last 12 months.
		Unable to determine: If you are unable to determine if the client has had residential based respite care in the last 12 months.

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Comments/Further information	All	This section allows you to document any additional general comments and information relating to the client's current supports that have been unable to be recorded. Types of comments or information that could be included here: • Information about why you have been unable to determine a response to a question in this section • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere • The service(s) or service type(s) that the client receives from the program (e.g. domestic assistance, meals on wheels, transport) and the name and contact details for the service provider.

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11.2 Carer

The Carer Overview relates to carer relationships as well as family and support networks such as friends and significant others who are involved at some level in caring for and supporting the client in their life. Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged. The Carer Overview is used to identify carers, the level of support they provide to the client; the sustainability of the caring relationship, and whether any support is needed.

It aims to assist in the identification of carers who would benefit from an assessment of their needs and circumstances as distinct to that of the client. It is important to recognise that a person:

- Who provides support to another person may not consider themselves to be their carer
- Who receives support from a person may not consider the person to be their carer
- Providing care to another may or may not receive a carer payment or carer allowance
- Providing care may challenge or question why information about them is being collected.

In the event there are questions that have been unable to be answered at screening, where appropriate, ask the remaining questions in a way that is not influenced by the people present at the assessment. For example, a client may not wish to answer certain questions such as current support or personal safety questions in front of the carer, and the identified person(s) may not wish to answer questions relating to how they are coping with the caring arrangement in front of the client. The person(s) the client is supporting may be present at the home support assessment. It is important to ask questions of the client that is based on their own needs, as well as their needs relating to looking after another person(s) (Client as a Carer Overview).

Contact centre staff and assessors need to be cognisant of the carer and their potential needs when conducting screening and assessment. It is important to recognise that the needs and wellbeing of carers will vary significantly as each caring situation is unique. The *Carer Recognition Act 2010* aims to increase recognition and awareness of the social and economic contribution that carers make to Australia's society. It includes a Statement for Australia's Carers, which sets out 10 principles about how carers should be treated and considered.

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11.2.1 Guidelines for completing the Carer Overview

The Carer Overview is completed depending on who is informing the screening or assessment process. It is important to remember that a carer can be any person who provides the client with help or assistance and does not need to be formally recognised as their carer. It is also important to note that the client and their carer may not recognise the relationship as a carer/care recipient relationship.

- If the client is informing the screening or assessment process and has a carer, complete Carer Overview – Client Perspective
- If the client's carer is informing the screening or assessment process, complete Carer Overview – Carer Perspective
- If the client and the carer are informing the screening or assessment process, complete both Carer Overview – Client Perspective and Carer Overview – Carer Perspective
- If the client is caring for another person, complete Client as a Carer Overview

Item	Level	Guidance
Is anyone helping you at the moment, such as a family member or friend? Mandatory	All	This question asks if informal assistance is received from a carer, family member(s), friend(s) and/or neighbour(s) not associated with a service provider or paid service. A client may identify that they have more than one family member or friend that helps them on a regular basis. Should a client indicate that they have somebody that supports them; the person should be established as a representative, carer or support person to the client. If a client identifies that they have more than one carer, family member or friend helping them on a regular basis, ask the client to identify the main (or primary) person who provides this support. Information about additional support persons can be captured in the 'Are there other people that help you?'
Are there other people that help you? Mandatory	All	This should be selected if the client receives help from other carers, family members, friends or neighbours. Such support is generally provided on an informal basis. Should a client indicate that they have somebody that helps them, record the name of the person and their relationship to the client. Consider whether the person should be established as a representative, carer or support person to the client.

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Item	Level	Guidance
Are you supporting or looking after another person? **Mandatory**	All	This question asks whether the client is supporting or looking after another person. It should be selected if the client is required to assist another person with activities of daily living and/or self-care tasks.

11.2.2 Carer Overview – Client perspective

Item	Level	Guidance
What type of care does the carer provide? How often? **Mandatory**	All	This question asks what type of care the carer provides and how often it is provided. The response to this question should include the people involved in providing practical assistance, a brief description of the type of assistance provided and how often it is provided. For example, a carer may assist a client with a day-to-day task such as showering daily, may complete their shopping on a weekly basis, or drive them to medical appointments as required. The assistance may be provided by one person or multiple people. If more than one person provides support, state which person provides the support and how often they provide this support.
Have there been recent significant changes in carer or family support arrangement? **Mandatory**	All	This question asks whether there have been recent significant changes in carer or family support arrangements that impact on their ability to provide ongoing care for the client. A recent significant change in carer or family arrangements may include the carer or family member becoming unwell, passing away, moving out of the client's home or moving away from the client's area, a conflict between the client and their carer or family members, the carer or family member choosing not to provide care anymore or being unable to provide assistance for financial reasons. Should there have been recent significant changes in carer or family arrangements, include details of the changed carer or family support arrangements and the impact that this has had on the client.

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Does the carer experience any difficulties or have any concerns with the caring arrangement? Mandatory	All	This question asks whether the carer experiences any difficulties or has concerns with the caring arrangement. If the client indicates that the carer experiences difficulties or concerns with the caring arrangement, categorise the type of difficulty or concern being experienced. Multiple responses might be appropriate. **Carer – emotional stress and strain:** If the client reports that their carer presents with feelings such as sadness, depression or anxiety that they believe have been made worse by the tasks of caring. **Carer – acute physical exhaustion/illness:** If the client reports that their carer presents with symptoms of fatigue such as feeling exhausted, weak, needs to rest more than usual or is having difficulty sleeping. The client may notice that this is having an impact on their carers' ability to concentrate or think clearly. **Carer – slow physical health deterioration:** If the client reports that their carer's health has deteriorated as a result of their caring role. It may include the carer having sustained injuries from their caring role or the carer may have an identified illness or disability which has been made worse by the tasks of caring. **Carer – difficulties with specific tasks:** If the client reports that their carer is having difficulty with specific tasks such as lifting, helping them shower, managing medicines etc. The carer may have an identified illness or disability such as severe back pain or arthritis which has been made worse by the tasks of caring and is assisting a client with difficult transfers and/or personal care. **Carer – factors unrelated to care situation:** If the client reports that their carer has changed work circumstances, is starting a new job, is relocating, has their own family commitments such as looking after children or grandchildren or have financial commitments that need to be addressed. **Client – increasing needs:** If the client reports that they need more assistance to complete everyday tasks as a result of being acutely unwell, a newly diagnosed medical condition or a deterioration of an existing medical condition. Reported changes in memory and cognition may also be mentioned. **Client – other factors:** If the client reports anything else about their living situation that may impact on the caring arrangement. For example relocation, commencement or cessation of services, financial commitments, family conflict. **Other:** All other difficulties or concerns that a client mentions about the caring arrangement. Specify the client's

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Item	Level	Guidance
		concerns clearly and precisely.
Are carer arrangements sustainable without additional services or supports? Mandatory Assessor recorded	All	This question asks whether carer arrangements are sustainable without additional services or supports. Where it is identified that carer arrangements are not sustainable without additional services or supports, specify why and document any issues identified by the client that are currently impacting on their ability to continue receiving care at a satisfactory/adequate level. For example: • Carer arrangements have already broken down and they are no longer able to assist with activities of daily living. The carer requires immediate help to sustain their role. • A carer is available to assist but will not be available to continue for more than a few weeks/months. Services/ supports need to be in place within a few weeks/months. • A carer is not willing to continue to provide care for much longer. The carer may be unable to continue due to health issues or is feeling 'burnt-out'. It may be a change in circumstances e.g. a daughter who is expecting a child or moving interstate for work purposes.
Is there an emergency care plan in place if something should happen to the carer?	All	This question asks if the client has an emergency care plan in place if something should happen to their carer. Should the client have an emergency care plan in place if something should happen to their carer, specify details about the emergency care plan. This may include other family members, people to contact, short-term care and long-term care options, other support options including respite. Where there is no emergency care plan in place, a recommendation will display in the Action Plan or Support Plan for the contact centre staff member or assessor to provide this recommendation or not to the client.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record. Types of comments or information that could be included here: • Information about why you have been unable to determine a response to a question in this section. • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in this section.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

11.2.3 Carer Overview – Carer perspective

Item	Level	Guidance
What type of care do you provide? How often?	All	This question asks what type of care that the carer provides and how often it is provided. The response to this question should include a brief description of the type of assistance provided and how often it is provided. For example, a carer may assist a client with a day-to-day task such as showering daily, may complete their shopping on a weekly basis, or drive them to medical appointments as required.
		If the assistance is provided by more than one person or multiple people, state which person provides the support and how often they provide this support.
Do you receive any support in your caring role (e.g. from family, friends, community, other organisations)?	All	This question asks whether the carer receives any support in their caring role from family, friends, community, and/or other organisations.
		Should the carer receives support in their caring role from family, friends, community, or other organisations, specify the type of support that the carer receives in their caring role and how often it is received. Document if the support is from other family members, friends, community services and/or other organisations including service providers as per 'Are you currently receiving support or assistance from any of the following programs (if known)?'
Do you have any other responsibilities (e.g. employment, education)?	All	This question asks whether the carer has any other responsibilities or has competing roles and commitments (including employment, family and/or recreation).
		Should the carer have other responsibilities such as employment, family and/or recreation, specify the carer's responsibilities and/or commitments as stated by the carer.
		If the carer states that these responsibilities impact on their ability to provide care, document how they feel the commitment impacts on their caring role. Alternatively, the carer may state that their caring role impacts on their ability to perform their employment, family and/or recreation activities. Document how they feel the caring role impacts on their responsibilities. .
Do you have other	All	This question asks whether the carer has other caring responsibilities.

Item	Level	Guidance
caring responsibilities?		Should the carer does have other caring responsibilities, document the carer's other caring responsibilities as stated by the carer. This can include the carer providing assistance or supports for more than one disabled/elderly person. For example, consider a daughter/son who is caring for both parents especially when these roles are time intensive or conflicting. The carer may also have parental responsibilities. If the carer states that the other caring responsibilities impact on their ability to provide care for the client, document how they feel the other caring responsibilities impacts on their caring role. Alternatively, the carer may state that the caring responsibilities impacts on their ability to complete other caring responsibilities. Document how they feel the caring role impacts on these responsibilities.
Do you receive a carer payment or allowance?	All	This question asks whether the client receives a carer payment or allowance. Should the carer receive a carer payment or carer allowance, specify which one. Choose both options if the carer receives a carer payment and a carer allowance. Record if the carer has applied for a carer payment and/or carer allowance but is not in receipt in Comments/Further information.
Do you experience any difficulties or have any concerns with the caring arrangement?	All	This question asks whether the carer experiences any difficulties or has concerns with the caring arrangement. Should the carer state that they experience difficulties or concerns with the caring arrangement, choose the relevant responses. Multiple responses may be appropriate. **Carer – emotional stress and strain:** The carer is experiencing feelings such as sadness, depression or anxiety that they believe have become worse by the tasks of caring. This includes whether or not the carer sounds anxious, stressed or distressed. **Carer – acute physical exhaustion/illness:** The carer reports that they have symptoms of fatigue such as feeling exhausted, weak, need to rest more than usual or they are having difficulty sleeping. The carer may notice that this is having an impact on their ability to concentrate or think clearly. This may be a result of long term intensive care-giving and/or sleep deprivation, the carer may be solely responsible for a client's well-being (receives no assistance from informal or formal supports), the client may require physical assistance as well as supervision. **Carer – slow physical health deterioration:** The carer reports that their health has deteriorated as a result of

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Item	Level	Guidance
		their caring role. The carer may have multiple health problems and they are caring for a highly dependent client. It may include them having sustained injuries from their caring role or they may have an identified illness or disability which has been made worse by the tasks of caring.
		Carer – difficulties with specific tasks: The carer reports that they are having difficulty with specific tasks of caring such as lifting, helping a person shower, managing medicines etc. The carer may have an identified illness or disability such as severe back pain or arthritis which has been made worse by the tasks of caring and is assisting a client with difficult transfers and/or personal care.
		Carer – factors unrelated to care situation: The carer may have changed work circumstances, may be starting a new job, are relocating, have their own family commitments such as looking after children or grandchildren or have financial commitments that need to be addressed.
		Client – increasing needs: The carer reports that the person they provide care for needs more assistance to complete everyday tasks as a result of being acutely unwell, a newly diagnosed medical condition or a deterioration of an existing medical condition. Reported changes in memory and cognition may also be mentioned.
		Client – other factors: The carer reports anything else about the client's living situation that may impact on the caring arrangement. For example relocation, commencement or cessation of services, financial commitments, family conflict.
		Other: Should be selected for all other difficulties or concerns that a carer mentions about the caring arrangement.
		Use Comments/Further information to provide detail for any of these responses.
		Note: Consider whether the carer's role may be at risk because of their own support needs. In this instance, it may be appropriate to create a referral for the carer and assess them. Complete 'Carer requires an assessment as a client'.
Are your caring arrangements	All	This question asks whether carer arrangements are sustainable without additional services or supports.
		Should the carer state that carer arrangements are not sustainable without additional services or supports,

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Item	Level	Guidance
sustainable without additional services or supports? Mandatory		specify why the carer does not feel carer arrangements are sustainable without additional services or supports and document any issues identified by the carer that are currently impacting on their ability to provide care at a satisfactory/adequate level. For example: • Carer arrangements have already broken down and they are no longer able to assist with activities of daily living. The carer requires immediate help to sustain their role. • The carer is available to assist but will not be available to continue for more than a few weeks/months. Services/supports need to be in place within a few weeks/months. • The carer requires information/education to increase their knowledge about the client's issues/needs and services to assist/support them in their role. The carer may need information/education in order to increase their knowledge about the client's issues, needs etc. and to assist them in the caring role. For example, the client's diagnosis/prognosis, appropriate community services including respite and support. Of particular importance is when the carer is fairly new to the caring role, such as following a recent event (e.g. stroke or a diagnosis of dementia). • The carer requires training to develop or improve their skills and capability within their role. • The carer may require training to develop/improve skills in order to minimise the risk to the carer and/or client. Training needs may include manual handling, behaviour management and developing or improving coping strategies. A carer may state that they are having difficulty managing a particular issue such as the client's behaviour or transfers. • The carer is not willing to continue to provide care for much longer. The carer may be unable to continue due to health issues or is feeling 'burnt-out'. It may be a change in circumstances e.g. a daughter who is expecting a child or moving interstate for work purposes.
If no, what support(s) would assist you in the managing your caring role?	All	Should the carer specify that their caring role is not sustainable, record what supports could be put into place to help them manage in their caring role.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
Is there an emergency care plan in place if something should happen to you?	All	This question asks if the client has an emergency care plan in place if something should happen to their carer. Should the client have an emergency care plan in place if something should happen, specify details about the emergency care plan in place. This may include other family members, people to contact, short-term care and long-term care options, other support options including respite. Where there is no emergency care plan in place, a recommendation will display in the Action Plan or Support Plan for the contact centre staff member or assessor to provide this recommendation or not to the client.
Does the carer require an assessment as a client? Assessor recorded	All	This question asks whether the carer requires an assessment as a client. This question will rely on your judgement to determine if the carer requires an assessment as a client and should be guided by information that was provided by the carer in 'Does the carer experience any difficulties or have any concerns with the caring arrangement?' and 'Are carer arrangements sustainable without additional services or supports?' Complete the question based on information available, your judgement based on the conversation with the carer, information on the inbound referral and/or information provided by another source such as a representative or friend. Where the carer requires an assessment as a client, a recommendation will display in the Action Plan or Support Plan for the contact centre staff member or assessor to consider and complete relevant actions.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the carer that you have been unable to record. Types of comments or information that could be included here: • Information about why you have been unable to determine a response to a question in this section. • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in this section.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

11.2.4 Client as a carer

Item	Level	Guidance
What type of care do you provide? How often? Mandatory	All	This question asks what type of care that the client provides to another person in their caring role and how often it is provided. The response to this question should include who the client cares for/provides support to, a brief description of the type of assistance provided and how often it is provided. For example, the client may assist their partner/spouse with showering daily or may supervise their taking of medications. A client may be the primary carer for a child with disabilities where they are required to assist with all activities of daily living. The client may be providing care for more than one person, for example a partner/spouse and a child with disabilities.
Do you receive any support in your caring role (e.g. from family, friends, community, other organisations)?	All	This question asks whether the client receives any support in their caring role from family, friends, community, and/or other organisations. Should the client receives support in their caring role, specify the type of support that the client receives and how often it is received. Document if the support is from other family members, friends, community services and/or other organisations including service providers as per 'Are you currently receiving support or assistance from any of the following programs (if known)?'
Do you experience any difficulties or have any concerns with the caring arrangement? Mandatory	All	This question asks whether the client experiences any difficulties or has concerns with the caring arrangement. Should the client state that they experience difficulties or concerns with the caring arrangement, choose the relevant responses. Multiple responses may be appropriate. **Carer – emotional stress and strain:** The client is experiencing feelings such as sadness, depression or anxiety that they believe have been become worse by the tasks of caring. This includes whether or not the client sounds anxious, stressed or distressed during the telephone call. **Carer – acute physical exhaustion/illness:** The client reports has symptoms of fatigue such as feeling exhausted, weak, need to rest more than usual or they are having difficulty sleeping. The client may notice that this is having an impact on their ability to concentrate or think clearly. This may be a result of long term intensive care-giving and/or sleep deprivation, the client may be solely responsible for another person's well-being

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		(receives no assistance from informal or formal supports), the person may require physical assistance as well as supervision.
		Carer – slow physical health deterioration: The client reports that their health has deteriorated as a result of their caring role. The client may have multiple health problems and they are caring for a highly dependent person. It may include them having sustained injuries from their caring role or they may have an identified illness or disability which has been made worse by the tasks of caring.
		Carer – difficulties with specific tasks: The client reports that they are having difficulty with specific tasks of caring such as lifting, helping a person shower, supervising their taking of medicines etc. The client may have an identified illness or disability such as severe back pain or arthritis which has been made worse by the tasks of caring and they are assisting a person with difficult transfers and/or personal care.
		Carer – factors unrelated to care situation: The client reports that they have changed work circumstances, may be starting a new job, are relocating, have their own family commitments such as looking after children or grandchildren or have financial commitments that need to be addressed.
		Client – increasing needs: The client reports that they need more assistance to complete everyday tasks as a result of being acutely unwell, a newly diagnosed medical condition or a deterioration of an existing medical condition that is impacting on their caring role. Reported changes in memory and cognition may also be mentioned.
		Client – other factors: The client reports anything else about their living situation that may impact on the caring arrangement. For example relocation, commencement or cessation of services, financial commitments, family conflict.
		Other: Should be selected for all other difficulties or concerns that a client mentions about the caring arrangement.
		Use Comments/Further information to provide detail for any of these responses.
Are these caring arrangements	All	This question asks whether carer arrangements are sustainable without additional services or supports. Should the client state that carer arrangements are not sustainable, specify why the client does not feel carer

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
sustainable without additional services or supports? Mandatory		arrangements are sustainable without additional services or supports and document any issues identified by the client that are currently impacting on their ability to provide care at a satisfactory/adequate level. For example: • Carer arrangements have already broken down and they are no longer able to assist with activities of daily living. The client requires immediate help to sustain their role. • The client is available to assist but will not be available to continue for more than a few weeks/months. Services/supports need to be in place within a few weeks/months. • The client requires information/education to increase their knowledge about the issues/needs and services to assist/support them in their caring role. The client may need information/education in order to increase their knowledge about the issues, needs etc. of the person they provide care for to assist them in the caring role. For example, the care recipient's diagnosis/prognosis, appropriate community services including respite and support groups (e.g. Alzheimer's Association). Of particular importance when the client is new to the caring role such as following a recent event (e.g. stroke) or new diagnosis of dementia. • The client requires training to develop or improve their skills and capability within their caring role. • The client may require training to develop/improve skills in order to minimise the risk to the person they care for. Training needs may include manual handling, behaviour management and developing or improving coping strategies. A client may state that they are having difficulty managing a particular issue such as the person's behaviour or transfers. • The client is not willing to continue to provide care for much longer. They may be unable to continue due to health issues or they are feeling 'burnt-out'. It may be a change in circumstances e.g. a daughter who is expecting a child or moving interstate for work purposes.
Is there an emergency care plan in place?	All	This question asks if the client (as a carer) has an emergency care plan in place if something should happen to them. Should the client have an emergency care plan in place if something should happen to them, specify details about the emergency care plan in place. This may include other family members, people to contact, short-term

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Item	Level	Guidance
		care and long-term care options, other support options including respite.
		Where there is no emergency care plan in place, a recommendation will display in the Action Plan or Support Plan for the contact centre staff member or assessor to provide this recommendation or not to the client.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record.
		Types of comments or information that could be included here:
		• Information about why you have been unable to determine a response to a question in this section. • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in this section.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

11.3 Family, Community Engagement & Support

The purpose of the Family, Community Engagement and Support Profile is to understand the relationships and activities that are important to the client, and how they are maintained. Having meaningful relationships and social connections is important in how clients can achieve and maintain quality of life, and prevent social isolation or losing community connections.[3] Assessors should explore a client's interests, strengths and abilities; identify if there are supports available to the client to assist them accessing the community; and explore option and opportunities for involvement in social and community activities.

Item	Level	Guidance
Describe the client's personal and family support networks Mandatory	RAS ACAT	This question asks the client to describe their personal and family support networks. Prompts that may assist the client in answering this question include: • Describe your family situation, such as your close family (partners, children) and your extended family – what is their relationship with you? • Who are the people that are important to you? Tell me about these relationships. • Describe your support networks (e.g. friends, neighbourhood). Who is part of your community? What role do you play in these networks/communities? • Do you meet up with your friends and family regularly?
Describe the client's involvement in community based activities, the client's interests, hobbies, or special	RAS ACAT	This question asks the client to describe their involvement in community based activities, their interests, hobbies, or special interest groups. Prompts that may assist the client in answering this question include: • What activities do you enjoy doing most in the community? • How do you go getting out and about in the community? • Are you having difficulty attending these activities? What is stopping you? • Is there an activity that you used to do that you would like to do again?

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[3] Department of Health, 2010, Strengthening Planning and Assessment: A Guide for HACC Assessment Services in Victoria.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
interest groups		• Are you happy with your current activities?
Describe the client's engagement with family, social/community groups, clubs etc.	RAS ACAT	This question asks the client about their engagement with family, social and/or community groups. Prompts that may assist the client in answering this question include: • How often do you talk to or see your family? • What sort of social activities do you participate in? Did you previously participate in social activities that you now no longer participate in? What stopped you from participating in these? • Do you know your neighbours? • Do you have any cultural connections? • Do you prefer participating in individual or group activities?
Has there been any recent changes in your family, cultural and social situation? Do you have any concerns?	RAS ACAT	This question asks whether there have been any recent changes in the client's family, cultural and social situation and whether the client has any concerns about these changes. Should the client have experienced recent changes in their family, cultural and social situation, specify the recent changes as reported by the client and their concerns about these changes. For example: • Recent death or accident in their close or extended family. • A close or extended family member has moved away. • Close or extended family members have experienced their own changes such as death, loss, grief, a change in their financial situation and/or have become unwell and they see and/or talk to them less often than they used to. The client may be worried about the impact of these changes on their family member. • Birth of grandchildren and/or great grandchildren therefore other family members are not as readily available as they used to be. • Death of a close friend/s and/or dwindling support network. • Friends have become unwell and/or have relocated into residential aged care. • Neighbours have moved away; new neighbours have moved in. • Activities that they enjoy participating in are closing down for refurbishment or forever. • Main mode of transport to the activities is no longer available.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		• Forced relocation due to sale or acquisition of property. • A change in their financial situation.
Comments/Further information	All	This section should be used to record details of any information regarding the client's social situation, cultural background, or diverse needs that may need to be considered as part of recommendation for support. It allows you to document any additional general comments and information provided by the client that you have been unable to record.

| Client Record | Event Details | Reason for Contact | Current Support | Carer | Family, Community Engagement and Support | Health | Function | Cognitive | Psychosocial | Psychological | Home & Personal Safety | Complexity Indicators | Summary of Needs | Assessment Outcomes | Action Plan | Support Plan | Assessment Tools |

12 Medical Domain

- A complete history is required and may be obtained from a number of sources (general practitioner, client, carer, hospital staff and patient notes, specialists).
- Medical history must contain current problems, past medical conditions, operations, fractures, including any past or current psychiatric diagnosis.
- Assist client/carer to recall past problems using a systematic method such as a head to toe scan (start at head and work down).
- Record any hospitalisations, reasons for admission and any inpatient events.
- Check history of abnormal blood pressure, diabetes, smoking, alcohol intake, head injuries involving loss of consciousness, black outs, history of depression and any other medical history.

Consider whether the client requires a comprehensive medical review by their general practitioner, or geriatrician.

12.1 Health conditions

The Health conditions questions gather information about a client's health conditions, mental health conditions and disabilities. It asks about the assistance the client is receiving to help manage these conditions, as well as the impact these conditions are having on their ability to undertake day-to-day tasks. This information is likely to be provided on an inbound referral from a health professional. It is not the role the contact centre or RAS to make a medical diagnosis.

Item	Level	Guidance
Do you have any health conditions, mental health conditions or disabilities? Mandatory	All	This question asks whether the client has any health conditions, mental health conditions or disabilities that have an impact on the person's need for assistance with activities of daily living and social participation. These can be new conditions or have existed for some time. Should the client reports that they have health conditions, mental health conditions or disabilities, specify the type of condition the client has. A list of the health conditions, mental health conditions and disabilities can be found at Appendix B. In some instances, a client may not provide the actual name of the condition. Consider the following:

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		• A client may state that they have a 'bad back', 'bad hips', 'heart trouble' or 'my memory isn't as good as it used to be and I'm having difficulty remembering things'. Ask the client if they have these difficulties as a result of a pre-existing condition such as arthritis, hypertension (high blood pressure), recent diagnosis of dementia or another physical, neurological or mental health condition/disability that is impacting on them. Document the information that is provided by the client. • A carer may also provide similar information about the client's health conditions, mental health conditions or disabilities and how it is impacting on the client's ability to complete day-to-day tasks. Document the information that is provided by the carer. • A referrer such as a General Practitioner or other health professional may provide more accurate and complete information regarding the client's health conditions, mental health conditions or disabilities. Document the information that is provided by the referrer. If there is an attachment that provides more detail, this can be viewed on the Client Record. In instances that the client does not have any health condition, mental health condition or disability, select 'no health conditions present' from the list.
Diagnosis status	ACAT	This question relates to whether the health condition, mental health condition or disability has been diagnosed. Options include GP confirmed, other health practitioner diagnosis and self-reported.
Are you receiving help to manage these conditions?	All	This question asks whether the client is receiving help to manage the condition selected. Should the client report that they are receiving help, specify details about the type of help they are receiving to help manage the conditions. For example, the client: • May be on medications to help manage symptoms of the condition. • May receive practical assistance from a carer, friend, doctor, specialist, allied health professional (physiotherapist, occupational therapist, speech pathologist, dietician, nurse). • May have a scheduled appointment with a doctor, specialist, allied health professional.

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Item	Level	Guidance
		• May have attended or be scheduled to attend a hospital clinic such as a falls clinic, continence clinic, diabetes clinic. • May use aids/equipment, blister pack/dosette box for medications, oxygen or a Continuous Positive Airway Pressure (CPAP) machine to complete day-to-day tasks. • May have or need home modifications to allow the client to function more independently at home. **Note:** Responses to this question may be reflected throughout the 'Health Overview' and the 'Functional Overview'.
Does the health condition(s) or disability impact on your ability to carry out day-to-day personal, household or social activities?	All	This question asks whether the health condition(s) or disability impacts on the client's ability to carry out day-to-day personal, household or social activities. Should the client report that their condition impacts on their ability to carry out day-to-day tasks, specify details about how the condition impacts their ability to complete such tasks. For example, a client who: • Becomes breathless and fatigued due to heart disease may no longer be able to walk to their local shops to complete the shopping. • Has had a recent hip replacement and is using a walking frame may no longer be able to catch a bus to their doctor. • Has arthritis in their hands may no longer be able to prepare their own meals due to their inability to cut or chop ingredients. • Has undergone back surgery may not be able to complete their housework due to post surgery precautions and pain. • Is suffering from grief or depression and finding they are unable to initiate or complete tasks. • Has poor eyesight as a result of macular degeneration or glaucoma may not be able to complete their grocery or clothing shopping as they are unable to see the items they are selecting. • Has a diagnosis of dementia may be forgetting to take their medication.

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Item	Level	Guidance
		• Has had a leg amputation may be unable to complete their personal care tasks or get in/out of the shower or bath without supervision as they have poor balance and are worried they may fall. • Has other cognitive changes causing difficulty in starting, organising or finishing tasks. This question will be verified by the responses to the questions in the 'Functional Overview'. A client who has no difficulty with day-to-day tasks as a result of their health conditions(s) or disability may not be eligible for aged care services. This question may need to be revised following the completion of the 'Functional overview'.

12.2 Health

The Health questions gather information about a client's health and wellbeing challenges. Assessors should consider opportunities to improve, influence and build upon client's current strengths to improve well-being. The questions include whether the client has recently seen their GP or has been in hospital. Other questions relate to whether the client is taking medication, weight loss, nutritional and/or oral health concerns, fluid intake and health literacy.

Item	Level	Guidance
General observations Assessor recorded	RAS ACAT	During an assessment, observation provides an opportunity to observe a client's abilities. An assessor can make observations about a client's energy levels, stamina, affect, comprehension, memory, concentration, physical appearance and interpersonal behaviour. This extent to which a client engages in the assessment can indicate how they will engage in interventions or goal setting.
What are your main health and wellbeing challenges?	RAS ACAT	This question asks the client about their health and wellbeing challenges that can help inform day-to-day issues impacting on their ability to undertake simple tasks.

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Item	Level	Guidance
What do you do to take care of yourself and your health?	RAS ACAT	This question asks the client about their ability to actively participate and communicate the strategies they undertake daily, weekly and/or monthly to live healthy lifestyles. This can include activities such as attending exercise classes, diabetic check-ups, reading nightly.
Clinical services the client receives Assessor recorded Mandatory	ACAT	Document the clinical services and the provider of these services. It is at this time the client may be concerned about the continuation of their current services. It is important to explain to the client that the comprehensive assessment will determine what they could be eligible for in regards to services to help keep them at home for as long as possible. The information which is relevant in this section also pertains to any ongoing services through specialist clinics e.g. pain clinics, exercise programs.
Relevant medical history (including diagnosed conditions) Assessor recorded Mandatory	ACAT	Information about a person's health condition(s) contributes to the assessor's understanding of the complexity of a client's needs and circumstances. The aim is not to make a medical diagnosis but to gather information about the client's medical conditions, including those that have been diagnosed by a medical practitioner. It is useful to have a good understanding of the range of common illnesses and chronic conditions (e.g. diabetes, Parkinson's disease, cardio-vascular disease, pulmonary disease, arthritis and stroke) that affect the older person so that you can be alert to potential undiagnosed conditions, potential risks and relevant questions to ask. Information about the health conditions experienced by clients contributes to an understanding of the complexity of a client's needs and circumstances. The disease and disorders collected at screening or home support assessment may not be a complete medical history of all diseases and disorders. Where possible, a medical summary should be requested by the assessor from the client's GP. This summary should not hold up assessment outcomes.
Are you taking prescribed medication? Mandatory	All	This question asks whether the client is taking any prescribed medication to manage their health conditions, mental health conditions or disabilities. The medications may have been recommended by their doctor, specialist or pharmacist. In some instances, they can also be self-prescribed. Medications may be known by their prescribed name or a generic brand. Should the client report that they take prescribed medications, specify how many types of medications the client

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Item	Level	Guidance
		takes. In some instances, the client will know their list of medications and may provide this information. Document the details as stated by the client and/or their representative in Comments/Further information. Contact centre staff and home support assessors are not required to record information relating to medication details.
		The client's ability to take their own medicine will be answered in 'Can the client take their own medicine?'.
	RAS ACAT	Use the following prompts and/or questions to gather additional information regarding a client's medication and administration:
		- Check if the person is clear about their medication schedule. - Are there any concerns about medications, side effects or are a high number of medications being taken? - Do any of the medications the client is taking impact on their daily activities (e.g. causes lethargy, lack of focus, mobility etc.). - Do the client's pain levels fluctuate throughout the day? How do they manage this? - Have there been any recent changes in the client's medications? - Does the client self-administer their medication? - Does the client receive assistance with their medications? If yes, by whom and how often during the day? - Is medication prompting required? - Does the client use any form of dispenser for medication administration i.e. blister pack or dosette box - Does the client carry any medications for emergencies?
	ACAT	Consider:
		- Adverse drug reactions are five times more frequent in older populations. - Older people are greater consumers of drugs, taking twice that of younger groups. 80% of older people admitted to hospitals are taking multiple medications (known as polypharmacy). - At least 10% of admissions of older people to hospitals are a result of an adverse drug reaction. - Polypharmacy is a significant risk factor for older people's deteriorating conditions. Reducing the number of drugs used from 7.8 to 6.9 in a monitored ward caused the number of adverse drug reactions to drop

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		from 24.3% to 7%. Even small changes can have a pronounced effect. • People over 80 years are 25 times more likely to receive ten or more drugs than the 10 – 25 years age group can lead to greater side-effects, adverse reactions and acute or chronic illness.
Medication details *Mandatory*	ACAT	The effect of drugs on an older person is a significant variable to consider when completing an assessment. It is important to be familiar with common medications, usual doses and likely reactions so that you can be alert to symptoms and conditions that may be a result of poor medication management. Consider whether the client should be referred back to their GP for a home/residential Medication Review (an Australian Government subsidised programme). When recording a client's medication history: • Document all current medications by name. • Note if a medication is self-administered, supervised or given by another and why. State if an aid is used such as a Webster pack or dosette box or other similar devices. • Document the source of the medication information (for example from discharge summary, general practitioner, pharmacist, direct observation of medications). • Compare all medications against source of information and the label directions with client's report of what they are taking. • Clarify the client's understanding of the medications and attempt to assess compliance. • Ask about eye drops, creams/lotions, inhaled medication, natural therapies, injections and any over the counter or non-prescription medications that the client is taking. • Obtain a detailed history of any known allergies/adverse reactions.
Do you have any allergies and/or sensitivities?	RAS ACAT	This question asks the client whether they have or had allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities. Should a client have allergies and or sensitivities to environment, medication or food, specify details of the

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		identified allergies and/or sensitivities.
		A client's allergies and/or sensitivities can change over time and may need to be re-addressed during the assessment.
Have you had a GP check-up in the past 3 months?	RAS ACAT	This question asks whether the client has seen their GP in the past 3 months. This may include a health assessment for people aged 75 years and older. It is important to note that a client may respond to this question in a way that implies they do not visit the GP unless they are ill or require a script for medication. It is important to advocate regular GP check-ups where they could have had a hospital admission and have not followed up with their GP. This follow-up can be beneficial for the client if they have had changes to medications or there has been further medical advice regarding any of their diagnoses and/or disorder. GP's are an important link in the continuity of care for clients and can be a good advocate for goal setting and achieving wellness for an increase quality of life. Should the client have not had a GP check-up in the past 3 months, a recommendation will display in the Action Plan or Support Plan for the client to see a GP. It is for the contact centre staff member or assessor to provide this recommendation or not to the client. For example, if a client has recently seen another health professional, they may not need to see their GP.
Do you have regular health checks?	RAS ACAT	This question asks the client if they have regular health checks For example, GP, specialists i.e. endocrinologist (diabetes), mobility, falls, and oral health. Should the client indicate that they have regular health checks, specify details of who conducts the client's regular health checks, how often and for what reason.
Have you been discharge from hospital in the past 3 months?	All	This question refers to whether the client has been discharged from hospital in the past 3 months. Should the client have been discharged from hospital in the past 3 months, record details of the hospital admission (e.g. date of admission, reason for admission, information about the hospital stay, date of discharge). Specify whether aids/equipment were recommended and implemented as a result of the hospital stay. List the aids/equipment that were recommended as a result of the hospital stay. This may also include

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		recommendations for home modifications such as grab rails. For example: • Self-care aids such as special cutlery and crockery, grab rails in bath/shower, bowel and urinary appliances, bath seats, shower chairs/stools, commodes, hand held showers etc. • Support and mobility aids such as splints, hospital beds, cushions/pillows, crutches, walking sticks, walkers, wheelchairs etc. • Communication aids such as telephone attachments, writing aids, speaking aids, hearing aids. • Reading aids such as magnifying / reading glasses, braille books, reading frames, talking books etc. • Personal alarm. If aids/equipment were not implemented as a result of the hospital stay recommendations, consider whether it was due to: • Unavailability of the aids/equipment post discharge. • Inability to afford the aids/equipment post discharge. • Having to be on a waiting list for the aids/equipment. • Having to be on a waiting list for post discharge follow up by the relevant allied health professional. • The client may have declined to use the aids/equipment. **Note:** Information about services that are in place post discharge from hospital will be recorded in 'Current Support', information about aids/equipment in use will be further reflected in the 'if difficulty, who/what assists?' of the 'Functional Overview'.
Do you have any oral health concerns?	All	This question asks to whether a client has any oral health concerns such as problems with their teeth, mouth or dentures. A good standard of oral health enables an individual to eat, speak and socialise without active diseases, discomfort or embarrassment. Problems associated with poor oral health include impaired nutrition, systemic morbidity, speech problems and decreased personal satisfaction, resulting in an impaired quality of life. This may lead a home support assessment making a recommendation for the client to see a dentist or nutritionist, as appropriate. Should the client have oral health concerns, specify details about the client's oral health concerns. For example:

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Item	Level	Guidance
		• Teeth, mouth or swallowing problems that make it hard to eat. • Loose fitting dentures, loose teeth. • Gum disease, painful gums.
Have you had a dental check-up in the last 12 months?	RAS ACAT	This question asks whether a client has regular dental check-ups. A dentist can identify oral cavity issues which could be impacting on other areas of health such as diet, weight loss behaviour and pain. Options include yes, no or not sure/unable to determine.
Do you have any problems with your teeth, mouth or dentures?	RAS ACAT	This question asks whether a client has any problems with their teeth, mouth or dentures. This can include tooth loss, dental cavities, periodontal disease, gingivitis (inflammation of the gums, dry mouth, tooth wear). . Many oral problems can be either prevented or effectively treated. The following prompts and/or questions can be used to gather additional information regarding a client's teeth, mouth or dentures: • Do you have your own teeth/partial denture or full dentures? • When do you clean your teeth/dentures? • Do you experience any pain when cleaning your teeth? • Do your gums bleed when you brush your teeth or gums? • Do you regularly clean your gums and if yes how? Options include yes, no and not sure/unable to determine. Should the client have problems with their teeth, mouth or dentures, a recommendation will display in the Support Plan for the client to see a dental practitioner. It is for the assessor to provide this recommendation or not to the client.
Do you experience any pain or sore teeth when you	RAS ACAT	This question asks if a client experiences pain or sore teeth when they eat. Options include yes, no or not sure/unable to determine.

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Item	Level	Guidance
eat?		
Do you have problems swallowing?	RAS ACAT	This question asks if a client has problems swallowing (dysphagia). Swallowing involves nerves, muscles of the mouth, throat and the oesophagus. A client who has swallowing difficulties could be at risk of choking, malnutrition or dehydration. Poor oral hygiene, severe illness, disabilities, Parkinson's disease and/or dementia can significantly increase the client's risk of swallowing deficits.[4] The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked if there are any 'yes' answers: • Do you have any problems swallowing your food or fluid, for example tea, coffee, water? • Does food get stuck in your throat after chewing and swallowing? • Do you have difficulty swallowing your saliva? • Do you constantly have a sore throat? Options include yes or no.
How is your appetite?	RAS ACAT	This question asks the client about their appetite. Nutrition is integral to maintaining good health, muscle and bone strength and the ability to be physically active. Poor nutrition is one of the major reasons why people become frail and dependent. Decreased appetite can be due to sore gums and teeth, poor swallowing, feeling unwell, nausea and/or cognitive impairment. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked if there are any 'yes' answers:

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[4] Australian and New Zealand Society for Geriatric Medicine 2011, 'Position statement: dysphagia and aspiration in older people', *Australasian Journal on Ageing*, vol. 30, no. 2, pp. 98-103.

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		• Has your appetite changed recently? If so, what is the reason for this?
		• Do you have a special diet (consider cultural or religious practices such as fasting)?
		• Are there foods you are allergic to or cannot eat?
		• Has a special diet ever been suggested for you?
		An assessor may wish to ask to see the kitchen to observe the state of the benches (clean/dirty/unused) and whether there is any food in the fridge and cupboard.
Have you noticed any loss of taste?	RAS ACAT	This question asks the client if they have noticed any loss of taste. Options include yes, no or not sure/unable to determine.
Have you been eating poorly as a result of decreased appetite?	RAS ACAT	This question asks the client if they have been eating poorly as a result of decreased appetite. Options include yes, no or not sure/unable to determine.
Have you lost any weight without trying, or had other nutritional concerns in the last 3 months? Mandatory	All	This question asks whether the client has lost weight unintentionally, or has had other nutritional concerns in the past 3 months. Should the client have lost weight without trying, specify details about the client's weight loss or other nutritional concerns. For example: • Weight loss without wanting to in the past 3 months may be evidenced by loose clothing, rings or dentures. • Wounds or pressure sores that won't heal. • Poor appetite and/or poor dietary intake for more than 2 weeks. • Teeth, mouth or swallowing problems that make it hard to eat. • Trouble shopping, preparing food, cooking and/or feeding themselves.

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		Options include yes, no or not sure/unable to determine.
	HSA CA	During assessment observations should also be considered. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked if there are any 'yes' answers: • Have you gained or lost weight recently? • How long have you been at your current weight? • Have any of your friends or family commented on your weight recently? • What circumstances have affected what you eat, how you prepare meals, difficulties with shopping?
Do you regularly drink more than 8 cups of fluid a day?	RAS ACAT	This question asks if a client drinks more than 8 cups of fluid a day. It is important for people to drink regularly, even though they may not feel thirsty. Some people reduce their fluid intake due to continence issues, cognitive issues or haven't been big water drinkers over their life. Older people are susceptible to dehydration. An assessor should emphasise the importance of drinking water or fluids regularly to keep hydrated and especially during the hot months. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked if there are any 'yes' answers: • Have you had fluids or water today? • How many glasses of water or fluids would you normally have in a day? Options include yes, no or not sure/unable to determine. Should the client indicate that the client have recently decreased their fluid intake, specify reasons why. This may be due to continence issues, medications or cognitive impairment.
Do you have any major skin	RAS	This question asks if the client has any major skin conditions. Skin is a person's protective layer. During the ageing process the skin thins and loses elasticity, moisture and is more easily susceptible to injury such as skin

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condition(s)?	ACAT	tears, ulcers and dry skin. Nutrition, mobility, cognition, falls, pain management and continence are vital to healthy skin integrity. Clients may not consider skin conditions as a potential issue therefore observation at assessment is important.
		Should the client indicate that the client has major skin conditions, consider whether the skin condition is:
		Pressure ulcer: Signs that a pressure ulcer is beginning to form may include colour changes, temperature changes, changes in consistency of skin, changes in sensation.
		Other skin ulcer: Signs of other skin ulcers include open craters, often round, red, swollen and tender to touch. These can appear anywhere on the body and can be caused by a number of factors including circulatory impairment.
		Healing surgical wounds: Signs of surgical wounds include the presence of dressings and stitches. The assessor should ask the client if they are being medically treated.
		Other skin tears, cuts or lesions: Signs of unusual skin tears, cuts or lesions. The assessor should ask the client if they are being medically treated.
		Other skin problems (e.g. bruises, rashes, itching, eczema): Signs can also include dry skin which can be an indicator of dehydration and a change in skin colour i.e. yellow signifies possible liver problems.
		The following observations, prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked:
		• Colour changes in the client's skin – skin over bony areas (lower back, hips, heels, elbows, etc.) may appear reddened and may or may not blanch white when pressed. Skin may also appear bruised, having a blue, purple, or black colour.
		• Temperature changes – compared to skin surrounding the affected area, the beginning stage of a pressure ulcer may feel warm to the touch or cool.
		• Changes in consistency of skin - the beginning stage of a pressure ulcer may make the affected skin feel firm to the touch or may make it feel boggy. Boggy skin can best be described as feeling as though it's

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		filled with fluid. • Changes in sensation – the person may start complaining about pain, tingling, or itching in affected areas. • If a client has a dressing in place, ask why they have the dressing on; did they knock themselves; did they have a fall where they sustained the wound? Some dressings may not be visible. • Ask the client if they have cream that they apply regularly to their skin. Note what they put the cream on their skin. Should the client indicate that they are receiving treatment for the skin condition, include details of the treatment that is required for the specific skin condition.
Do you have bladder or bowel issues that affect your lifestyle?	RAS ACAT	This question asks if the client has any bladder or bowel issues that affect their lifestyle. Continence is the ability to exercise voluntary control over the bladder and bowel. There are many causes of urinary and faecal incontinence. Poorly managed incontinence has a negative impact on a person's ability to perform activities of daily living. Continence issues can often be prevented with appropriate screening, assessment, prevention and management strategies. Incontinence is not and should not be an expected outcome of older age. Continence is a sensitive issue to most people. Common reasons for bladder issues/urinary incontinence include: • A weak pelvic floor, leading to leakage of urine when a person sneezes, laughs, strains, lifts or plays sport • A sudden strong urge to urinate, which may be due to conditions such as stroke, enlarged prostate gland, Parkinson's disease, constipation or the outcome of a long history of poor bladder habits • Poor bladder emptying leading to overflow • Inability to reach or use the toilet • Problems with the nerves that control the bladder • Urinary tract infection.

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		• Some medications • Delirium. Common reasons for bowel issues/faecal incontinence include: • Weakness of anal sphincter muscles • Severe diarrhoea • Constipation and impaction • Disorders of the nervous system such as spina bifida or dementia, or disorders of the lower bowel such as haemorrhoids. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked: • Do you mind if I ask you some personal questions? • Do you have trouble getting to the toilet on time? • How often do you have to go to the toilet during the night? • Do your bowels or bladder cause embarrassment, pain, concern? • Do your bowels or bladder affect your self-image? • Are you worried about going out, as you may need a toilet? • Do you leak urine before you get to the toilet? • Do you suffer from constipation or diarrhoea? • Observation of odour or stains. Options include yes, no or not sure/unable to determine. If it is identified that the client has bladder or bowel difficulties (or difficulties with both), record details such as the frequency of incontinence episodes; or worry about constipation, pain, difficulty in passing stool, increased need to urinate at night, abnormal bowel pattern, frequent diarrhoea or urination.

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		Should the client have discussed these continence problems with someone (e.g. GP, continence adviser, family member), specify details of who the client has discussed these problems with.
		Record whether the client would like to discuss their continence issues with a continence advisory service.
		Should the client wish to discuss their continence issues with an advisory service, a recommendation will display in the Support Plan recommended that the client to contact a continence advisory service. It is for the assessor to provide this recommendation or not to the client.
Do you have difficulty understanding information, instructions or written material received from doctors or other health professionals?	RAS ACAT	This question asks about health literacy. Health literacy is the ability to read, understand and use healthcare information to make informed decisions about their own health and have the ability to follow treatment instructions where required.
		The assessor could ask the client information related to their current health status and their understanding of how treatment could be affecting their well-being.
		Should the client have difficulty with health literacy, include details of such difficulties.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record.
		Types of comments or information that could be included here:
		• Information about why you have been unable to determine a response to a question in this section.
		• Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in this section.

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13 Physical domain

Physical function is a key determinant of independence in activities of daily living and a contributing factor to overall health status and quality of life. Mobility is a component of physical function which includes the ability to stand, sit down, walk, turn, transfer, and climb. These basic movements are required, in varying degrees, to perform personal, household and social activities. Age related physiological decline can affect a person's ability to carry out activities of daily living. An assessment of a person's capacity to perform daily living tasks is necessary to determine whether, and to what extent, support is required for an older person to remain living independently or whether other options should be considered.

13.1 Health and Lifestyle

Information gathered on health and lifestyle builds a foundation on how a person is managing in their everyday life. Current general health information can inform how a client completes Activities of Daily Living and Instrumental Activities of Daily Living.

Item	Level	Guidance
Have you had two or more falls in the past 12 months? Mandatory	All	This question asks the client whether they have had two or more falls in the past 12 months, the cause of the falls and whether they are afraid of falling. This includes slips, drops and fainting. Research indicates that age-specific rates of fall related injury incidents increase exponentially from the age of 75 years. Falls may contribute to decreased confidence. It is important to assess for falls risk and address fall issues promptly. Environmental, health and behavioural factors may also contribute to a high falls risk. Many falls occur in the home environment and are preventable. Common examples contributing to falls include medication side effects, poor balance or strength, musculoskeletal disorders, obesity and arthritis which decrease agility, sore feet and inappropriate footwear, neurological disorders, hypotension, vision impairment, night-time falls due to incontinence, poor lighting particularly on stairs or in bathrooms, loose or worn carpets or rugs, slippery floors, irregular walking surfaces, lack of safety equipment such as grab rails and position of power points and cords. The following prompts and/or questions can be used to gather additional information. The questions are not

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		exhaustive and should be taken in context in relation to other questions which could be asked: • Have you had any slips, trips or falls in the past twelve months? • Are you concerned about falling at home, in the garden or in the community? Examine the circumstances and the client's functional abilities • If you had a fall and couldn't get to the phone, how do you think you could get help? Options include yes, no or not sure/unable to determine. Should the client have had two or more falls, record and comment on: • The cause of the falls. This may include a trip, slip, fainting or dizziness • Where the falls occurred • Whether the client injured themselves or required medical attention/admission to hospital • If their GP is aware of the falls • If they have attended a falls clinic. Record the number of falls if known. Record whether the client is afraid of a falling. Options include never, rarely, sometimes or often. Should the client be afraid of falling 'sometimes' or 'often', ask them about the circumstances and the day-to-day tasks that make them afraid of falling. Consider a recommendation for a falls risk assessment, falls clinic or falls prevention plan by a GP or allied health professional. Enter recommendation in the Support Plan. Note a client may identify potential hazards inside or outside their home that could put them at risk of falling or having an accident. Record this information in Comments/Further information.
Does the client have difficulty with:	ACAT	This question asks the client whether they have difficulty with mobility. Options include balance, posture, endurance, gait, tremor and other difficulties related to mobility. Functional mobility is the capacity to move from one position (sitting, lying down, standing and so on) to another,

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		to enable participation in normal daily routines and activities. It includes bed mobility, transfers, walking, wheelchair mobility, driving and taking public transport.
		Having independence in functional mobility tasks significantly reduces the level of long-term care required by an individual.
		The ability to mobilise and participate in self-care is fundamental for interaction and control within a person's environment. It is important to undertake the following when assessing this dimension: • Screen or assess older people for falls risk and take action to minimise the likelihood of falls. • Provide supervision for walking or transfers for older people at risk of falls. • Maintain or retrain an older person in skills of activities of daily living and self-care. Encourage physical activity via incidental exercise and participation in functional maintenance or enhancement programs, as appropriate.
Have you had any bodily pain during the past four weeks? Mandatory	All	This question asks whether the client has experienced any pain or discomfort during the past four weeks, how the pain impacts on their daily activities (including sleep) and the strategies they use to manage the pain. Pain can be a major contributor to a person's physical and psychological wellbeing. It is subjective and with regular pain medication, is one strategy that can be effective for a client to manage their day-to-day tasks. Options include none, very mild, mild, moderate, severe and very severe. Record whether the pain affects the client's ability to cope with their performance of day-to-day tasks or their ability to sleep. A client may mention specific difficulties and sleeping patterns. Record any strategies the client uses to help manage the pain, such as: • Medication • Attendance at a pain clinic • Massage, heat pack, cold pack • Changing position on a regular basis

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Item	Level	Guidance
		• Sleeping upright in chair.
	RAS ACAT	Signs of pain can include: • Facial grimaces • Flinching or protective reactions, rubbing an area • Limping, shuffling • Avoiding certain movements or actions • Breathing and voice changes, or interruption of speech flow • Disfluency in movement • Red, swollen joints or other areas • Signs of consumption of painkillers or alcohol to manage pain.
	RAS ACAT	Pain can be divided into five categories: • Nociceptive Pain: Somatic Pain – this pain is often described as sharp, aching or gnawing sensation and can be localised. This type of pain can be related to complaints related to skin, muscles, bone. Visceral Pain – this pain is often described as dull, deep, and poorly localised. This type of pain can be related to body organs such as cardiac, liver, pulmonary. • Neuropathic Pain: This pain is often described as shooting, burning or tingling sensations and can be caused by lesions or dysfunction of the nervous system. Examples include phantom limb pain due to amputation, stroke and diabetic neuropathy. • Cancer Pain: The pain experienced by clients who have cancer is generally derived from the cancer itself. Pain in cancer can derive from a tumour compressing or infiltrating tissue as an example. • Psychological: Psychological and or psychiatric factors are rarely the only cause of this type of pain. The severity of the reported pain can be derived from the wellness of the client in relation to their mental health.

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Item	Level	Guidance
		• Mixed or unspecific Pain: This is pain that can be related to unspecified mechanisms such as recurrent headaches, fibromyalgia.
Have you had any concerns with your vision, hearing or speech in the past three months?	All	This question asks whether the client has any concerns or difficulties with their vision, hearing or speech in the past 3 months and whether they have had these assessed or reviewed. Multiple responses may be appropriate.

Vision: Should be selected if the client has concerns or difficulties with their vision. If they have concerns, has their vision been addressed or reviewed by a GP and/or an optometrist? Consider a recommendation for the client to visit a GP and/or optometrist. Enter recommendation in the Support Plan. Specify:

- Details about the client's vision concerns or difficulties as reported by the client. This may include diagnostic eye conditions such as cataracts, macular degeneration or eye disease etc.
- When the client's vision was last tested
- If and when they have a vision test scheduled for
- Whether a client reports they have regular and ongoing vision appointments
- If recent surgery, such as cataract removal, is treatment or follow up in place?
- List vision aids in use i.e. glasses, reading aids.

Other questions and observations about vision include:

- Check that clients with glasses are wearing them, as prescribed to do so.
- Do you have difficulty with vision, even with glasses?
- Do you have difficulties carrying out your daily activities due to poor vision?
- Have you had your vision tested in the last two years?
- Does your vision impact on your confidence to get around and do your day-to-day tasks?
- Do you need books or instructions in large print?
- Does your eyesight limit things you do or would like to do?

Common aged related eye conditions include glaucoma, cataracts, age-related macular degeneration (AMD)

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Item	Level	Guidance
		and diabetic retinopathy.
		Hearing: Should be selected if the client has concerns or difficulties with their hearing. If they have concerns, has their hearing been assessed or reviewed by a GP and/or an audiologist? Consider a recommendation doe the client to visit a GP and/or an audiologist. Enter recommendation in the Support Plan. Specify:
		- Details about the client's hearing concerns or difficulties. This may include hearing conditions such as hearing loss/deafness in one or both ears, partial hearing loss, tinnitus etc. - When the client's hearing was last tested - If and when they have a hearing test scheduled - Whether a client reports they have regular and ongoing hearing appointments - If recent surgery, such as cochlear implant, is treatment or follow up in place? - List hearing aids in use i.e. hearing aid(s), cochlear implant
		Other questions and observations about hearing include*:*
		- Check that hearing aids have batteries, are fitted and switched on. - Do you have trouble hearing what people are saying to you in normal or group conversations? - Do you have trouble understanding what people are saying and what they mean? - How do you go hearing people on the telephone? - How long is it since you had your hearing tested/new aid? - What different aids or equipment have you tried? - Does your hearing limit things you would like to do?[5]
		Speech: Should be selected if the client has concerns or difficulties with their speech. If they have concerns, has their speech been assessed or reviewed by a GP and/or a speech pathologist/therapist? Consider a

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[5] Strengthening assessment and care planning: A guide for HACC assessment services in Victoria

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Item	Level	Guidance
		recommendation for the client to visit a GP and/or a speech pathologist. Enter recommendation in the Support Plan. Specify: • Details about the client's speech concerns or difficulties as reported by the client. This may include a diagnosis that has been provided such as dysarthria, dyspraxia, voice issues, aphasia, swallowing difficulty etc. • When the client's speech was last tested, particularly relevant for clients with neurological conditions such as Parkinson's disease, Motor Neurone Disease, Multiple Sclerosis, stroke or a client who has sustained a head injury. • If and when they have a speech test scheduled. • Whether a client reports they have regular and ongoing speech therapy appointments. • List communications aids in use i.e. communication boards, telephone attachments, writing aids, speaking aids. • Information relevant to this question may be in 'Requires help to communicate'. Other questions and observations about speech include: • Check that communication aids have batteries, are charged and are in use. • Have you noticed changes in your voice and speech? • Are you worried about your voice? • Do you have trouble remembering things you are trying to say? • Do you have difficulty formulating sentences, conveying messages or saying words? • Do you have any problems with eating or swallowing? • Are you on any medications to help with digestion? • Do you have reflux? • Does your speech/talking limit things you do or would like to do?

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Item	Level	Guidance
		Common speech problems in older age may include difficulties in swallowing or communication from diseases such as Parkinson's disease, Alzheimer's Disease, stroke, cancer, motor neurone disease.
Have you experienced changes with your vision in the past 3 months, or experienced any new eye conditions?	RAS ACAT	This question asks if the client has experienced changes with their vision in the past 3 months, or experienced any new eye conditions. Options include yes, no and not stated/unknown. The internal and external structures of the eyes begin to wear as people get older. In general these issues can be corrected with eyeglasses, contact lenses, or surgery. Other changes in vision, however, can be a sign of eye disease such as cataracts, age related macular degeneration, glaucoma and diabetic retinopathy. Common age related vision complaints include: • "I can't see as clearly as I used to" • "I have difficulty seeing objects close up" • "It's getting more difficult to see in the dark" • "I'm less able to adapt to glare" • "I need more light to see" • "My eyes are dry and irritated".
Do you have difficulty with vision, even with glasses?	RAS ACAT	This question asks if the client has difficulty with vision, even with glasses. Options include yes, no and not stated/unknown. Observations of other aids in use to facilitate vision should also be considered. These include: • Magnifying lenses • Large-print items • Special papers and writing aids • Video enlargement systems • Computer display and enlargement systems

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Item	Level	Guidance
		• Adaptive appliances • Speech software for computer systems. Should the client have difficulty with their vision, record when the client last had their eyes checked by an optometrist and/or an eye specialist.
Do you experience any difficulties sleeping (e.g. difficulty falling asleep, fragmented sleep, insufficient sleep)?	RAS ACAT	This question asks the client if they experience any difficulties sleeping. Sleep changes with age and older people can also have changes to their sleep patterns. Sleeping difficulties can be due to diseases such as dementia (constant wandering at night), alcohol, congestive heart failure, depression, arthritis and urinary problems. Options include yes, no and not stated/unknown. Should the client indicate that they experiences difficulties sleeping, specify details of the sleeping difficulties that the client experiences. For example, issues which may affect a client sleeping can include increased toileting, feeling worried, not being as active as they used to be, pain, drinking coffee late at night, medication i.e. diuretics being taken after 6pm. The symptoms of sleep problems include difficulty falling asleep, fragmented sleep, insufficient sleep, pain impacting on sleep, difference between night and day and early morning awakening. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked: • How many hours a night do you sleep? • What medication do you take at night and when? • How many times per night do you wake? • Do you experience any pain at night? • How many times do you get up to go to the toilet? • Do you nap during the day? • What do you do to help you fall asleep e.g. reading, a glass of sherry?

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Item	Level	Guidance
Do you drink alcohol?	RAS ACAT	This question asks the client if they drink alcohol. Alcohol can have a negative impact on health and wellbeing. A number of factors need to be considered when determining whether a client's level of alcohol use places them at risk of experiencing harm. These include medication use, physical health and medical history, functional abilities (such as increased risk of falling), psychological wellbeing and age. Options include yes or no. Should a client drink alcohol, if appropriate ask the client to consider whether they are concerned with how much alcohol they drink. Options include yes or no. If they are concerned by how much alcohol they drink, specify details of the concerns such as the amount consumed and how often they drink. A follow-up question is to ask how often does the client have 6 or more standard alcoholic drinks on any one occasion. Options include never, less than monthly, monthly, weekly, daily or almost daily. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be. • How often do you have a drink containing alcohol? • How many standard drinks do you have on a typical day? Another follow-up question to ask is whether alcohol consumption is causing problems for the client. Should the client indicate that alcohol consumption is causing problem(s) specify details of the problems being caused such as accidents, adverse interactions with medications, heavy regular use, financial hardship, chronic toxicity, relationship breakdown, legal issues and dependence. Strategies for working with a person who is thought to be at risk of experiencing alcohol-related harm include: • Exploring the 'good' and 'less good' things about the use of alcohol • Avoiding confrontation or argument • Assessing the person's level of concern

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Item	Level	Guidance
		• Assessing the person's readiness to change • Developing discrepancy between the person's ideal self and actual self • Referral, with consent, to an alcohol service • Supporting the person in any decision to change their behaviour • Acceptance that not all people will want to change their alcohol use.[6]
Do you smoke or have you smoked previously?	RAS ACAT	This question asks if the client smokes or has smoked previously. According to health experts and research, smoking affects all body organs and functions. It contributes to diseases such as cancer, heart disease, respiratory disease and may affect cognitive functioning. Options include never smoked, has quit smoking, currently smokes and not stated/unknown. If the client has quit smoking, record the date in which they quit smoking or select not stated/unknown. If the client currently smokes, record the number of cigarettes the client states they smoke per day and whether the client wishes to quit smoking. Where the client wishes to quit smoking, a recommendation will display in the Support Plan recommending that the client be referred to a Quit Smoking program. It is for the assessor to provide this recommendation or not to the client.
In the past week, how often have you completed more than 30 minutes of physical activity (enough to raise	RAS ACAT	This question asks how often the client states that they completed more than 30 minutes of physical activity in the past week. This can include how much physical activity they complete each day. Regular physical activity can: • Improve fitness and balance • Have a positive impact on health concerns such as osteoarthritis, diabetes, weight management, blood pressure

[6] Strengthening assessment and care planning: A guide for HACC assessment services in Victoria

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Item	Level	Guidance
breathing rate)?		• Lift mood, confidence and self-esteem • Help deal with negative feelings and bring a sense of wellbeing • Improve sleep, which can improve emotional wellbeing • Reduce tension levels and feelings of stress or fatigue • Increase energy • Foster supportive relationships and friendships. Record the type of physical activity that the client enjoys doing or participating in most. For example, walking, gardening and/or housework. Should the client indicate that they would like to do more physical activity, specify details of the type of physical activity the client would like to do more of, how often they would like to do more activity and the benefits they would like to achieve from more physical activity. For example, engaging in walking, gardening and/or housework on a daily basis, a couple/few times per week, weekly or fortnightly. Record what the client mentions is stopping them from doing physical activity. The following prompts and/or questions can be used to gather additional information: • Have you talked to a health professional recently about what type of physical activity might be best for you? • What do you think would motivate you to increase your level of physical activity?
Comments/Further information	All	This section allows you to record details of any additional information provided by the client or their representative that you have been unable to record. Types of comments or information that could be included here: • If the client has an Advance Care Plan (ACP) in place. Advance care planning is a series of steps that can be taken to plan for health and financial matters. If possible, it should be noted where it is kept. It is not the assessor's role to develop an ACP with the client as this can occur in an informal family setting or

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Item	Level	Guidance
		via an ACP program within a health service, aged care setting or with a GP • Appropriateness of a Home Medicines Review or recommendation to visit a community pharmacist • Comments about weight, Body Mass Index, drug use, sexual health.

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13.2 Function

Questions relating to a client's function are used to screen for any difficulties the client may have in completing activities of self-care and day-to-day tasks. If the client has difficulty with these tasks, the functional overview identifies if they receive assistance to complete the activity, as well as who or where they receive assistance from, and whether assistance will be required to fulfil the need.

When recording the client's ability to complete tasks, rate what the person is capable of doing rather than what they actually do. It is important to take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour).

If a person is capable of completing the task but has chosen not to, rate as 'Without help'. For example, the spouse has always done the cleaning even though the client has the physical capacity to do it or a daughter pays the client's bills simply for convenience.

If a client's functional ability fluctuates, then rate them at their lowest ability. For example, the client may be able to complete a task one day, but cannot the following day due to joint pain; or can prepare light meals but struggles to prepare a main meal as they have difficulty standing for long periods due to back pain.

Where a client may indicate that they do not complete certain activities, use further question techniques such as what they do when:

- They need to take medication (such as if they have a headache)
- They need to prepare meals when their spouse is not home or available.

13.2.1 General guidance for questions relating to function

Item	Guidance
If difficulty, who/what assists Mandatory	The question refers to whether the client needs assistance or is completely unable to complete a task by themselves. Choose the relevant response, multiple responses may be appropriate: **No one:** No one assists the client with the task **Carer:** The client's carer (as identified in the carer questions) assists the client with the task

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Item	Guidance
	Service Provider: A service provider assists the client with the task. This includes both government subsidised service providers and private services.
	Aids and equipment: Aids and equipment refers to items that are in place to facilitate safety and independence with day-to-day tasks as well as assisting carers, service providers and/or others when providing support. Specify the aids and equipment that are in place. This may also include aids and equipment that is being trialled with the client. For example adaptive cutlery and crockery, long handled dressing and grooming tools; bath seats, shower chairs, shower stools, commodes, slip resistant mats, over toilet aid, toilet surround, bowel and urinary appliances, dosette box/blister packs for medication management, support and mobility aids such as hoists, hospital beds, belts, braces, crutches, walking sticks, walking frames, wheelchairs, scooters, callipers, splints.
	Home modifications: A home modification refers to home modifications that are in place to facilitate safety and independence with day-to-day tasks as well as preventative measures. These also may be used to assist carers, service providers and/or others when providing support. Specify the home modifications that are in place. This may also include home modifications that the client is waiting to have installed. For example grab rails in the bath and/or shower, grab rails next to the toilet, slip resistant floor surfacing/tiles in the bathroom and toilet, hand held showers, modifications to facilitate access into a client's home such as ramp access, handrails at the front/rear access, lift access.
	Other: Should be selected for any other assistance that the client receives in order to assist them with the task. For example, assistance that is provided by a relative, friend, other person on a needs only basis. Specify details of who provides this assistance.
Will assistance be required to fulfil need? Mandatory	The question should be completed for a client who needs assistance to complete a task or is completely unable to complete a task by themselves. Options include: **No:** A client does not require assistance to fulfil the identified need of the task that they are having difficulty with. This is because their needs are being met by current arrangements as identified in 'If difficulty, who/what assists?' **Yes:** A client requires assistance to fulfil the identified need of the task that they are having difficulty with. This is because

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Item	Guidance
	their needs are not being met by current arrangements as identified in 'If difficulty, who/what assists?' • **Episodic:** Where a client requires assistance, it is required intermittently, occasionally or on as needs only basis. • **Non-Episodic:** Where a client requires assistance, it is required ongoing/on a regular basis. **Unable to determine:** If you have been able to ascertain that the client needs assistance, but is unable to determine how long the client may need assistance for.
Comments/Further Information	The comments field should be used to record additional information gathered for each of the questions. This may be from the client's perspective, carer(s) perspective, referrer's perspective or the service provider's perspective and can include: • Regularity of assistance provided • Recording specific areas of difficulty or assistance required • Anything of relevance regarding a person's functional ability or difficulty in completing the task • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in the question • Information about why you have been unable to determine a response to a question.

At assessment, it is important to find out how the client manages the task. This includes whether they can do the task without help and whether they perform the task themselves. If there are limitations or difficulties, it is necessary to find out the underlying problem and look at whether the client is motivated to learn how to be more independent.

It is important to be aware that there may be sensitivities related to gender or culture when asking and/or discussing how a person manages their self-care and day-to-day tasks. It is advisable that you familiarise yourself with the gender or cultural etiquette of the person you are assessing so that questions may be asked in a positive and sensitive manner therefore ensuring cultural safety of the client. A client's abilities should be determined through a combination of questioning and observation.

Ask the client:

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- To tell you how they are managing with the particular task. Concentrate on what may have changed recently and what they want to be able to get back to doing by themselves
- If they receive any assistance from a carer, family, friends or a service provider
- What task they have most difficulty with and why? This could be due to a range of factors including pain, reduced strength or range of movement, fatigue, disinterest, a spouse or family member who used to complete the task is recently deceased, or they do not have the skills/knowledge to complete the task
- To show you around their home and for a demonstration of how they usually complete a task
- What they would like to do that they are unable to do at the moment
- What gives them the most concern out of everything that has been discussed during the assessment and what they want to change
- If they have any thoughts about what might help them achieve this change
- If they have good days and bad days with their wellbeing and ability, is today a good day or a bad day?

Observe:

- How the person completes an everyday task such as making a cup of tea, vacuuming,   opening a jar, getting things down from shelves, picking things up from the floor, how they use the washing machine, make the bed or change the bed linen. Take note of how the client manages to complete the task, specifically their cognitive ability to plan and sequence the task and their physical ability to walk, maintain their balance, bend and reach for items
- If adaptive aids and equipment are in place and whether they are utilised
- If home modifications are in place and whether they are utilised.

Consider whether the client is likely to benefit from reablement and in which areas of their day-to-day tasks by using your creative thinking, problem solving skills and a restorative approach to work with the client to develop individual goals to improve their ability to complete everyday tasks and safety around their home and community.

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13.2.2 Function

Item	Level	Guidance
Can the client get to places out of walking distance? Mandatory	All	This question asks whether the client can get to places out of walking distance. It is not used to record the mode of transport a client uses, but whether they need physical assistance or supervision from another person when travelling. Consider cognitive as well as physical reasons for requiring assistance. **Without help:** The client can travel alone on buses, taxis, or drive their own car. This includes arranging and using a taxi independently. **With some help:** The client needs someone to help or go with the client when travelling. It includes their ability to travel in a taxi; car or public transport with assistance of one person (may be informal and formal assistance). It also includes a person in possession of a restricted driver's licence who is unable to attend appointments that are out of their restricted driving distance/local area. **Completely unable:** Should be selected if the client is completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance. The client requires assistance of more than one person or is not able to travel at all unless using emergency transport.
	RAS ACAT	Observations should be considered. The following prompts and/or questions can be used to gather additional information: • How do you manage to access your local community? For example, when you last visited the GP or a medical appointment, hairdresser, shops, friends/family, how did you get there and back?
Can the client go shopping for groceries or clothes (assuming client has transportation)?	All	This question asks whether the client can go shopping for groceries or clothes if they have transportation to get to the shops. Consider the client's ability to walk the distance required; to select and carry items (vision, reaching/bending ability) as well as cognition. **Without help:** The client can take care of all their shopping needs themselves once they are at the shops. This includes using phone and/or internet shopping for convenience only. **With some help:** The client needs someone to go with them on all shopping trips as they are unable to attend

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Item	Level	Guidance
Mandatory		the shops themselves and need to be accompanied due to difficulty paying, reading labels, reaching and/or bending for items. This includes providing another person with a shopping list that they have prepared. **Completely unable:** The client is completely unable to participate in any shopping activities.
	RAS ACAT	Observations should be considered. For example, take note of the client's cupboards/pantry and fridge and the presence of food items; consider the expiry dates on food packages and milk/juice cartons; take note of the client's clothing (e.g. is it in good/poor condition). Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: • How do you manage to complete your shopping? • Where do you do your shopping? • How often do you go? • How do you manage carrying the groceries? • Do you get anything home delivered?
Can the client prepare their own meals? **Mandatory**	All	This question asks whether the client can prepare their own meals. Consider cognitive as well as physical issues. For example, a person with dementia may lack the organisational skills to prepare a meal or is at risk of scalding self or leaving the stove on. A person may have difficulty standing to prepare meals or lack the dexterity to chop food. **Without help:** The client is able to plan and cook full meals themselves. This includes heating pre-prepared meals for convenience. **With some help:** The client can prepare some things but they are unable to cook full meals themselves. For example, they are able to prepare cups of tea and coffee with toast/biscuits, light meals such as sandwiches, heating/reheating pre-prepared meals. **Completely unable:** The client is completely unable to participate in any activities associated with meal

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		preparation.
	RAS ACAT	For example, does the client have pre-prepared or frozen meals in the fridge/freezer; does the person present as malnourished or overweight; is the gas/electric stove and oven in working order and does it appear to have been used; is a microwave present? Consider asking the client to demonstrate how they use the kettle, stove, oven and/or microwave. Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: - How do you manage to prepare your meals? - What do you prepare and eat day-to-day? - How many meals do you prepare for yourself day-to-day? - Do you prepare and freeze meals for reheating at a later date? - Do you stand or sit to prepare meals?
Can the client do their own housework? Mandatory	All	This question asks whether the client can do housework. Consider the client's ability to complete vacuum cleaning and floor cleaning tasks, washing linen and clothing, changing bed linen and other general housecleaning tasks. **Without help:** The client can maintain housekeeping tasks independently. For example, washing floors, vacuuming, changing bed linen etc. **With some help:** The client can do light housework but may need help with heavy work. Light housework includes dusting, dishwashing, clothes washing, cleaning out the fridge etc. **Completely unable:** The client is unable to participate in any housekeeping tasks.
	RAS ACAT	Observations should be considered. For example, does the client have difficulty bending or reaching; does the person's home present as neat and tidy; are the floors dirty or sticky; is the bathroom and toilet dirty or mouldy; are the client's clothes and bed linen dirty and/or do they smell? Consider the cognitive and physical reasons

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		why a person may have difficulty with this task.
		The following prompts and/or questions can be used to gather additional information:
		- How do you manage with cleaning the floors (vacuuming and mopping), taking out the bins, getting to the letterbox? - What type of equipment do you use to complete the house cleaning (for example, type of vacuum cleaner)? - Do you spread your housework over the day or week? - How do you manage with cleaning the bathroom? What equipment do you use? - How do you manage to change your bed linen? - How do you manage the washing, ironing and laundry? Is your washing machine a top or front loader? - How do you manage to carry wet laundry to the clothesline? - How do you manage to peg clothes on the line? - Do you use a clothing stand in your home to dry wet laundry? - Do you find it difficult bending or reaching? - How do you manage to take out the bins?
		If there are signs of clutter and hoarding, ask whether there are areas they would like help cleaning up.
Can the client take their own medicine? Mandatory	All	This question asks whether the client can take their own medication. Consider cognitive as well as physical reasons. For example, a client may have a visual impairment and is unable to read labels correctly; or arthritic hands causing difficulty opening medication packets/bottles. **Without help:** The client is able to take their medication in the right doses at the right time (self-medicates). This includes using a dosette box or a blister pack for convenience. **With some help:** The client is able to take their medication if someone prepares it for them and/or reminds them to take it. This includes prompting the client to take or dispense medication due to memory difficulties or

Item	Level	Guidance
		confusion.
		Completely unable to take medicines: The client is not capable of organising, dispensing or taking their own medication and/or has compliance issues with their medication regime.
		Note:
		• If the client uses a dosette box or blister pack, select that 'aids and equipment' assist the client to complete the activity. Specify which one is in place.
		• Comment on whether the chemist prepares the blister pack (and if they home deliver it); or whether the client and/or their carer prepares a dosette box.
		If known, comment on medication regime; who administers or supervises medications; and management of insulin if taken.
	RAS ACAT	Observations should be considered. For example, take note of the client's medications and whether they are aware of which medications they take in the morning, afternoon and evening. Are there loose pills lying on the counter/floor; can they use their dosette box/blister pack? Consider the cognitive and physical reasons why a person may have difficulty with this task.
		The following prompts and/or questions can be used to gather additional information:
		• What medication do you take?
		• Why do you take this medication?
		Ask the client to show you their medication and to demonstrate how they use their dosette box/blister pack if present.
Can the client handle their own money?	All	This question asks whether the client can handle their own money. It is not used to record if they can physically get to the bank. Consider cognitive as well as physical reasons. For example, a client may not be able to manage their budget and pay bills reliably, but they are able to pay for their groceries.

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Item	Level	Guidance
Mandatory		**Without help:** The client manages their own finances. For example, banking, bill paying, cheque writing, manages own income. This includes using Direct Debit for convenience.
		With some help: The client manages the day-to-day buying and expenses but needs assistance with banking, managing chequebooks, bill paying and major purchases.
		Completely unable to handle money: The client is not capable of handling money or finances.
	RAS ACAT	Observations should be considered. Take note of whether there are unpaid bills lying around the client's home; ask them to show you a recent bill that they have paid or had debited. If they paid the bill themselves, ask how they did this. Consider the cognitive and physical reasons why a person may have difficulty with this task.
		The following prompts and/or questions can be used to gather additional information:
		• How do you manage day-to-day buying of groceries? • How do you pay your bills?
Can the client walk? **Mandatory**	All	This question asks whether the client can walk. Consider difficulties with indoor, outdoor and community mobility.
		Without help: The client walks with no walking aids. This also includes clients who are independent with mobility using a walking stick or similar.
		With some help: The client:
		• Uses a walking stick but it is not meeting their needs and client is at risk of falling. • Walks with the assistance of one other person and/or uses a walking frame, crutches, aids that require the use of both arms. • Walks with a quad stick or one crutch and is reliant on this aid for mobility at all times. • Has foot problems such as overgrown/ingrown toenails, calluses, bunions, amputations) that impact on their ability to walk.

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Item	Level	Guidance
		• Has breathing problems and/or uses oxygen that impacts on and limits their mobility. • Uses a wheelchair without help of others (able to self- propel manual wheelchair or use electric wheelchair). **Completely unable to walk:** The client is wheelchair bound and is unable to self-propel, is bed bound or needs assistance of more than one person to mobilise.
	RAS ACAT	Observations should be considered. Take note of how the client walks and moves around their home; do they experience pain or difficulty when walking in and out of the front and back doors, stairs, the bathroom and toilet, the bedroom, kitchen and laundry and any other rooms that they use. Observe the condition of equipment, for example walking stick height and tips; walking frame wheels and sturdiness; wheelchair seat, tyres, brakes and cleanliness; other aids. Is the equipment suitable and safe for the person? Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: • Ask the client about their mobility around the house, garden and community. Be conscious that the client may be embarrassed to disclose their limitations and may minimise the challenges. • Where do you walk to? • How far can you walk? (50m or 200m). • How long can you walk for? (10 or 20 minutes). • How often do you walk? • How do you get about best – walk without aids, use a walking stick, walking frame, wheelchair (manual/electric) or other aid? • How confident are you getting around your home – is there anything that slows you down or bothers you? • Do other health matters, such as breathing, strength, arthritis or medication affect your mobility? If so, how?

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Item	Level	Guidance
		• Do you limit activity for fear of falling?
Can the client take a bath or shower? *Mandatory*	All	This question asks whether the client can take a bath or shower. This question pertains to whether a client requires assistance, supervision or prompting from another person to shower, bath or bathe themselves. Consider cognitive as well as physical reasons. A client with dementia may be physically able to shower, but requires prompting by their carer. **Without help:** The client is able to prepare for and shower/dry themself, with use of grab rails and adaptive equipment. This includes managing to bath, shower and dry themselves independently as often as they require without additional physical, verbal or standby assistance. **With some help:** The client needs help getting in or out of the bath/shower. This includes: • Hands-on assistance, supervision or prompting of one person when getting in and out of the shower or bath, on and off equipment such as a bath chair, assistance with washing and drying, difficulty regulating water temperature. • If a client is anxious regarding showering/bathing and requires standby assistance only. • If they use equipment and require help to transfer on/off or to use any of the equipment. **Completely unable to bathe themselves:** Should be selected if the client needs total assistance with preparing and washing / drying self; utilises bed sponges only.
	RAS ACAT	Observations should be considered. Take note of whether the shower or bath has been used recently; whether the client's personal and clothing appearance presents as neat or untidy; does their appearance validate what they have told you; are there odours throughout the house or on the client that indicate difficulties with continence or personal care; are there grab rails for support if needed; is there a handheld shower or shower chair present; is there a slip resistant mat in the bathroom/bath/shower; does the client use any aids to wash, dry or groom themselves? Consider the cognitive and physical reasons why a person may have difficulty with

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Item	Level	Guidance
		this task.
		The following prompts and/or questions can be used to gather additional information:
		- How do you feel about me looking at your bathroom? - Are you able to bathe and shower yourself? Do you find any aspects difficult, such as reaching to wash your hair or feet? - How do you plan and prepare for your shower/bath? - Does the bathroom have adequate water pressure and temperature control? - Do you have any difficulties turning taps or checking the temperature of the water? - Is your bath/shower easily accessible? Where do you hold on for stability? - Do you feel confident with your ability to balance whilst washing yourself? - Are you able to apply creams or powders yourself? - Can you client your teeth/dentures effectively? - Do you have any difficulties with foot and nail care? - Can you carry out grooming tasks such as doing your hair, shaving or applying makeup? - Does the floor or base get slippery? - Are you interested in improving safety in the bathroom?
Dressing **Mandatory**	All	This question asks whether the client can dress themselves. Consider cognitive as well as physical reasons. A client with dementia may be physically able to dress, but requires prompting to do so, or a carer may also need to physically assist as client is unable to 'sequence' dressing tasks. **Independent:** The client is able to choose their clothing and is appropriately dressed, is able to do up their own buttons, zips, laces and/or put on their shoes/socks/stockings etc. **Needs help but can do about half unaided:** The client is able to dress with some assistance and/or prompting. This may include assistance to choose clothing, or to do up their own buttons, zips, laces and/or put

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Item	Level	Guidance
		on their shoes/socks/stockings etc. **Dependent:** The client is completely unable to dress themselves.
	RAS ACAT	Observations should be considered. Is the client is dressed in appropriate clothing; does the outfit match; are buttons, zips, shoelaces done up appropriately; does their appearance validate what they have told you? Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: • Are you able to choose your own clothing? • How do you decide to choose what to wear? • Do you have any difficulties in dressing or undressing (including dressing/undressing to use the toilet)? • Do you have any difficulties doing up buttons, zips, bra, tying shoelaces? • Do you have difficulty putting on or taking off shoes, socks, stockings etc.
Eating Mandatory	All	This question refers to the client's ability to feed themselves, not issues with swallowing. Consider cognitive as well as physical reasons. **Independent:** The client is able to feed themselves without assistance once the food provided is within reach including with the assistance of equipment such as built-up cutlery. **Needs help cutting, spreading butter etc.:** The client is able to eat with some assistance. A client with dementia may be physically able, but requires prompting to eat. A client may have difficulty with dexterity and is unable to cut up their food or may lack the upper limb strength/range of motion to feed themselves. They may also need 'set-up' assistance, (e.g. clients with a visual impairment). **Unable:** The client is completely unable to eat without help. This includes clients who are fed via a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube or a naso-gastric feed.

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Item	Level	Guidance
	RAS ACAT	Observations should be considered. Take note of whether the client has limited hand or upper limb strength and range of movement; whether adaptive equipment is in place or present at the dining table or kitchen. Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: • Are you able to feed yourself if food provided is within reach? • Do you require set-up assistance with your meals? • Do you have difficulty cutting up food due to difficulty with hand dexterity? • Do you lack upper limb strength and range of movement to feed yourself? • Do you use any adaptive equipment such as built up cutlery to help you feed yourself?
Transfers Mandatory	All	This question asks whether a client is physically able to move from place to place and includes difficulties with all types of transfers. For example, is the client able to transfer on/off chairs (including wheelchair), toilet or their bed? Ids the client able to transfer in/out of their bed or a car and are aids or equipment in use to facilitate their transfers? **Independent:** The client is able to transfer safely without help from a person or aid. **Minor help (verbal or physical):** The client requires verbal or physical prompting from a person to transfer. The client may use an aid such as a toilet raise; bed stick; chair platform etc. **Major help (one or two people, physical), can sit:** The client requires assistance from one or two people to transfer. It can include the use of a hoist, standing and raising aids, handi-lift/walk belt **Unable – no sitting balance:** The client is completely unable to transfer themselves and/or has no sitting balance. The client is reliant on others or the use of a hoist/ pat slide to transfer.
	RAS	Observations should be considered. Take note of how the client gets on/off their chairs, toilet, bed and any other seating that the client uses (for example shower chair/bathboard, grab rails if present); do they experience pain

Item	Level	Guidance
	ACAT	or difficulty when they sit/stand? Do they use the equipment or grab rail if it is present? If not, why not (for example, maybe the equipment or grab rail was installed for their spouse or a previous occupant and does not suit this person). Observe the condition of equipment, for example a rusty shower chair, a broken raised toilet seat. Is the equipment suitable and safe for the person to use? The following prompts and/or questions can be used to gather additional information: • Do you have difficulty stepping over the bath or getting in the shower? • Do you have difficulty getting on/off the toilet? Is the toilet a good height for you? • Do you have difficulty getting on/off your bed? Is the bed a good height for you? • Do you have difficulty getting on/off your favourite chair? Is it a good height for you? Would you consider using a different chair?
Toilet use **Mandatory**	All	This question asks about the personal care aspect of toileting and the client's ability to transfer on/off the toilet. Consider cognitive as well as physical reasons. A client with dementia may be physically able to toilet, but requires prompting. Any issues with incontinence may also be recorded here. **Independent (on and off, dressing, wiping):** The client is independent with all toileting tasks. This includes: • Moving on and off the toilet, un/dressing, wiping • Self-managing continence aids if incontinent • Self-managing catheter or ostomy if present **Needs some help, but can do something alone:** The client needs some help with toileting tasks. This includes assistance to: • Move on and off the toilet, un/dressing, wiping • Manage continence aids if incontinent • Manage catheter or ostomy if present

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Item	Level	Guidance
		Dependent: The client is completely unable to manage toileting without help.
	RAS ACAT	Observations should be considered. Take note of whether there are stains, for example on the carpets or chairs or odours present in the client's home; observe whether the toilet area is clean and tidy. Can the client explain when and how they use their incontinence aids, catheter or ostomy and the regime for managing these. This includes monitoring and support from a third person such as a nurse. Are there odours throughout the house or on the client that indicate difficulties with continence? Consider the cognitive and physical reasons why a person may have difficulty with this task. The following prompts and/or questions can be used to gather additional information: • Are you able to get on and off the toilet by yourself? Does someone need to assist you? • Do you need assistance to un/dress? How much can you do yourself? • Can you wipe yourself effectively after using the toilet? • Do you need assistance to wipe yourself? • Do you have difficulty maintaining your balance when standing to urinate (for males)? • If incontinence has been identified in 'Do you have any bladder or bowel issues that affect your lifestyle?', do you wear and/or manage incontinence aids? • If a client has a catheter or ostomy insitu, do you manage this yourself?

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14 Psychological Domain

The psychological domain has a number of dimensions which should be considered when undertaking a comprehensive assessment. To assess a client's absence or loss of cognitive functions involves consideration of the following dimensions:

Dimension	Context
Cognitive impairment	For many clients performing a cognitive screen will be appropriate; however, as with all tools this should be used with discretion. If a cognitive screen or test has recently been conducted by another health professional, you should consider whether there is a need to administer another
Capacity for decision making	Capacity is decision-specific and it is inappropriate to state that a person 'lacks capacity' without further reference to the type of capacity task. A person's capacity can vary in different circumstances, at different times and even within domains for different types of decisions.
Depression	Depression is more than a low, sad mood – it's a serious illness. Some people experience depression intensely, for long periods of time and often without reason. Depression is one of the most common of all mental health problems. Although one in five people experience depression at some stage of their lives - including older people – it is not a normal part of the ageing process[7]. Depression in older people is common and may occur with the onset of a physical illness or personal loss and sadness; however depression is not inevitable as people age. Depression in an older person is diagnosed based on consideration of how the person feels, thinks, behaves and what physical symptoms they have. An example is an older person may be feeling irritable, angry or aggressive; or experiencing feelings of hopelessness or emptiness; loss of self-esteem, or make negative comments about the worth of living over a period of weeks. Depression in an older person may become evident in behaviours such as neglect of self-care; withdrawal and lack of motivation; and uncharacteristic behaviour. Physical symptoms may include constant tiredness; unexplained headaches or backache; changes in digestive or bowel habits; or significant weight loss or gain. Early detection by a health professional may help to keep depression from becoming severe – depression is treatable and effective treatments are available.

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[7] http://www.beyondblue.org.au

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Dimension	Context
Dementia	• Dementia is a broad term used to describe memory loss along with changes to thinking, orientation, comprehension, calculation, learning capacity, language and judgment. A person with dementia may find it harder to do previously familiar tasks, such as writing, reading, showering and using numbers. The most common type of dementia is Alzheimer's disease, the cause of which is unknown. Although Alzheimer's disease is not a normal part of ageing, it is more common in older people and may affect about one in four people over the age of 85. Vascular dementia is the second most common type of dementia, associated with problems in the flow of blood to the brain[8]. The incidence of dementia is increasing. It is likely that many of the clients you will assess with have some form of dementia. The ACAT should ensure that the symptoms of dementia are medically assessed and diagnosed by a suitably qualified medical practitioner. The ACAT must have a sound understanding of dementia, be skilled in its recognition and assist clients and carers to make informed life choices in order to plan for their deteriorating condition.
Behaviour	Evidence of verbal and physical aggressiveness and disruption, self-destructive behaviour, confusion and/or impaired judgement, reasoning or attention.
Delirium	Delirium can often be misdiagnosed as dementia. Delirium is a sudden deterioration in mental functioning. It can represent a serious underlying medical condition that can be life threatening if left untreated. Any sudden change in the person's usual behaviour may indicate the presence of delirium. It is crucial to know the person's usual behaviour patterns in order to identify any changed behaviour. In an older person, delirium can be precipitated by infection, disease, metabolic disorder, carcinoma, neurological disorder, inflammation, pain, dehydration (and constipation), malnutrition, urinary retention, sensory impairment, drug effects (and interactions), and drug/alcohol withdrawal syndromes. Observation of the following factors can also inform the assessment of a client's behavioural and psychological functioning:

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[8] http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-dementia-about.htm-copy2

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Dimension	Context
	• **Appearance and behaviour**: Mode of dress (meticulous, sloppy, eccentric); general demeanour (formal, suspicious, aggressive, meek, irritable); behaviour (talkative, reticent, restless, fumbling); and general hygiene (skin, grooming, teeth, hair, finger nails, odour). • **Voice and speech:** Quantity and rate of production (slow to respond, pedantic, slurred, and spontaneous). Mood, feelings, perceptions (background feeling state, prevailing mood), affect (expressed and observed emotions – appropriate, depressed, anxious, irritable, blunted, perplexed); feelings (thought content, what do they feel); and perceptions (perceptual disturbances such as hallucinations, delusions). • **Cognition:** Consciousness (alert, clouding, attention span); orientation (time, place, person, fluctuations throughout the day); memory (remote, recent past, immediate retention, recall); concentration and attention (distractibility); and intellectual capacity (information, intelligence, abstraction, comprehension).
Judgement and insight	• Ability to assess situation correctly and act appropriately; capacity for social judgement (awareness or harmful or socially unacceptable behaviour); degree of understanding and awareness of illness (denial); awareness of need for help; effect of illness on others; and emotional insight, awareness of motives and feelings within self.

Once the assessment is completed a discussion with the client or their representative should consider whether a recommendation to the client to engage with an aged care mental health team, psycho-geriatrician or psychogeriatric nurse consultant, or a general mental health team may be appropriate.

Undertaking cognitive profile questioning is a valuable clinical skill and can determine the absence or presence of impairment. Collateral information from previous assessments can be valuable to indicate any baseline information. When assessing a client's cognitive function there are a number of cautions to consider which include the:

- **Physical environment:** Comfortable ambient temperature, adequate lighting (not glaring), free of distractions (e.g. should be conducted in the absence of others and other activities), position self to maximize individual's sensory abilities.
- **Interpersonal environment:** Prepare individual for assessment, initiate assessment within nonthreatening conversation, let individual set pace of assessment, be emotionally nonthreatening.

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- **Timing of assessment:** Select time of assessment to reflect actual cognitive abilities of the individual, avoid the following times: immediately upon awakening from sleep, (wait at least 30 minutes), immediately before and after meals, immediately before and after medical diagnostic or therapeutic procedures, in the presence of pain or discomfort.

14.1 Cognitive

Cognition is the ability to learn new things and remember. It is the basis for how we reason, judge, concentrate, plan, problem solve and organize. Good cognitive health, like physical health, is very important as people grow older, so that we can preserve independence and keep active to ensure an increased quality of life. Some decline in cognition and memory with age are normal, but sometimes factors such as a client's appearance, change in behaviors, voice, speech, concentration and attention can signal possible declines in a person's cognitive health.

If a person is displaying cognitive decline, this can impact on the client's ability to undertake all or elements of their everyday activities such as showering, dressing, attending appointments, meal preparation, managing finances.

Cognitive issues may be perceived by older people, their families and health professionals as a result of ageing, not as health problems that could respond to treatment. Various cultures view cognitive impairment differently, i.e. with shame or as madness and should be considered when asking about changes in thinking and memory. For example, dementia may be a sensitive issue for Aboriginal people and people from CALD backgrounds, people with dementia may revert to their first language. It is important to help the client maintain their sense of self and include them in decision-making.

The following table is a brief overview of elements that distinguish differences between dementia, delirium and depression:

	Dementia	Delirium	Depression
Onset	Insidious (over months); symptoms often fluctuate.	Relatively sudden – over hours to days, symptoms tend to fluctuate.	Over days to weeks.
Prognosis	Not reversible but manageable.	Recovery likely with treatment; high mortality if left untreated.	Risk of suicide, recovery likely with treatment.

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	Dementia	Delirium	Depression
Behaviour	Social skills may be preserved, withdrawal from social activities as memory deteriorates; may get lost in unfamiliar environments.	Disturbed sleep/wake cycle; hyperactive - may be restless, hypoactive - may present as somnolent, withdrawn.	Often slowed, occasionally agitated, changes to sleep, energy and appetite.
Affect	May be normal; may be flat or withdrawn; mildly perplexed.	Fluctuating; may be irritable; may be flat, withdrawn.	Sad or withdrawn or irritable; depressed, worried; helpless, guilty.
Thought	Shallow content; may appear to have paranoid ideas due to memory problems.	May lack coherence; possible delusions.	Slowed or decreased focus on past [guilt]; hypochondria; thoughts of death.
Perceptions	Often no change.	Simple misinterpretations; visual hallucinations.	Occasional auditory hallucinations.
Speech content	Repetitive; unlikely to complain of cognitive deficits.	Fluctuating; may be incoherent; non-fluent / fluent.	Coherent; often slowed; may complain of deficit.
Judgement	Declining.	Often impaired.	May seem impaired.
Insight	Reduced awareness of difficulties.	Poor.	Variable.
Memory	Impaired, especially for recent events.	Impaired.	May seem impaired, actually slowed.
Attention	Intact.	Poor; fluctuates.	May appear impaired.
Reasoning	Declining	Poor.	Often slowed.
Language	May have naming; word-finding problems.	Variable.	Intact.

	Dementia	Delirium	Depression
Orientation	May have difficulties with time and place.	Disoriented.	May appear disoriented.
Consciousness	Clear.	Clouded.	Clear.

The following are some important points to consider when assessing questions relating to cognition:

- The most basic principle is to presume that a person has the capacity to make all decisions for themselves.
- Apply the presumption of capacity for every decision the person makes. This is because a person may be able to make some, but not all, decisions for themselves.
- Don't assume a person lacks capacity based on appearances.
- Do not assume a person lacks capacity because of their age, appearance, disability, behaviour or other condition or characteristic.
- Assess a person's decision-making ability, not the decision they make. A person cannot be assessed as lacking capacity simply because they make a decision you think is unwise, reckless or wrong.
- Substitute decision making is a last resort.

Item	Level	Guidance
Have you experiences any changes in your memory and thinking?	RAS ACAT	This question asks if the client has experienced any changes in their memory and thinking over a short or long period of time. There are many different ways thinking and memory can be affected. For example, the capacity to think, reason and process information can be affected by primary and secondary health conditions such as brain tumours, Parkinson's Disease, Huntington's Disease, Cardiovascular Disease, smoking, alcohol consumption, acquired brain injury from an accident, cancer or a stoke. If a client or a representative notices a change in the way a client is handling information and day-to-day tasks, they should be encouraged to seek medical advice._x000B_

It is not uncommon for clients with memory and thinking changes to feel frustrated, defensive and anxious. The |

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		assessor should use a soft approach to asking any questions related to memory and if the client does appear to become upset, redirect the conversation to bring the client back to feeling at ease.
		Observations should also be considered. The following prompts and/or questions can be used to gather additional information. The questions are not exhaustive and should be taken in context in relation to other questions which could be asked:
		• How is your memory? • How is this impacting on the client and their carer's day-to-day tasks? • Check if the client is aware of time, place and person. • A client's appearance can be an indicator about current abilities related to day to day activities i.e. changing clothes, showering, financial management • It may be necessary to speak to the family or carer separately if the client is upset by the discussion. • Use gentle but persistent questions and encouragement to engage the person in tasks and assessment • Revisit information that has been discussed at the assessment to clarify information. • Find out if the client utilises strategies to assist with memory problems. For example, do they use a calendar to remember appointments; do they use other aids, such as a blister pack or dosette box for medications?
		Options include yes, no and not sure/unable to determine.
		Should the client indicate that they have experienced changes in their memory and thinking, specify details of the changes. Some examples of changes include:
		• Someone who used to have no issues with language now has trouble remembering the names for common objects such as the word 'cup', or other frequently used or simple words. • Asking what's for lunch, and then asking the same question a number of times with a few minute intervals • Losing the ability to read or recognize words or numbers on a page, inability to focus, inability to complete basic tasks or to follow simple instructions for example if someone needs to be directed on how to put clothes in the hamper

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		• Trouble with motor skills such as using silverware, buttoning clothes, or walking • Changes in behaviour and personality, such as sudden outbursts of anger or rudeness from a normally easy going individual. If there are concerns about changes in memory and thinking, check with the family member or carer and consider carer stress and impact. Record how long the client has experienced these changes. This can be days, weeks, months or years. Record how the memory loss is impacting on the client's everyday activities.
Is the client aware of time and place? Assessor recorded	RAS ACAT	This question asks if the client is aware of time and place. Options include yes, no and not sure/unable to determine.
Are there any reported changes in the client's personality? Assessor recorded	RAS ACAT	This question asks if there have been any reported changes in the client's personality. People differ in aspects of their personality, mood and behaviour and this will vary from day-to-day depending on an individual's circumstance. Changes in personality and behaviour may not necessarily be attributed to a client with a mental health disorder. Circumstances that may influence changes in the client's personality include: • Delirium associated by a Urinary Tract Infection. • Mental Health Disorders: Bipolar, depression, schizophrenia, post-traumatic stress disorder. • Disorders affecting the brain: Alzheimer's disease, Brain • Infections, such as meningitis, encephalitis, and human immunodeficiency virus (HIV) infection that involves the brain (HIV-associated encephalopathy), Parkinson disease, Seizure disorders, Stroke. • System disorders that can affect the brain: Kidney failure, liver failure, low blood sugar (hypoglycaemia), systemic lupus erythematous, thyroid disorders. Should there be indication that the client has experienced changes in the client's personality, specify details of

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		the reported changes in the client's personality. Changes can include aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations and delusions. If the changes are concerning the client and/or representative ask how these are impacting on the client quality of life.
Has there been a change in the client's behaviour? Assessor recorded	RAS ACAT	This question asks if there have been any reported changes in the client's behaviour. Should there be indication that the client has had changes in personality, specify details of the reported changes in the client's behaviour. Changes can include aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations and delusions. If the changes are concerning the client and/or representative ask how these are impacting on the client quality of life. Record how these behaviours are impacting on the client. Should the client be receiving help or assistance with changes in their personality and/or behaviour, specify details of the reported help or assistance the client is receiving. For example medications, day respite attendance, behaviour management.
Does the client have any memory problems or gets confused? Assessor recorded Mandatory	CC	This question asks whether the client has any memory problems or gets confused. It should be asked of third party informants, such as a friend, relative, carer or referring agency. It can be asked of the client themselves, especially if the client has insight into their memory difficulties or they have a new diagnosis of dementia that has yet to impact on their day-to-day activities. Complete the question based on information available, your judgement based on the conversation with the client, information on the inbound referral and/or information provided by another source such as a representative, carer, friend or family member. The response to this question may differ depending on whether the client or a third party informant is responding to this question. Make a note of who is responding to this question in 'Evidence'. Evidence: • Take note of signs during the telephone conversation. For example, the client may be unable to answer questions, changes the topic, becomes tangential in conversation, is not aware of the time and place.

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		• If speaking with a carer or representative, they may mention evidence of self-neglect, that the client is not aware of time and place, or has had changes in personality. • The client has been diagnosed with Alzheimer's disease or Dementia by a geriatrician or a doctor. If possible, record the approximate date of diagnosis. • The client gets confused or has a cognitive impairment and lacks the ability to plan and implement tasks. • The client presents with memory loss, confusion, disorientation and disordered thought patterns (possibly associated with mental illness or following a stroke).
	RAS ACAT	Observations should be considered. The following can be used to gather additional information: • Take note of signs during the assessment. For example, the client may be unable to answer questions, changes the topic, becomes tangential in conversation, is not aware of the time and place, there is evidence of self-neglect, presents with memory loss, confusion, disorientation and disordered thought patterns (possibly associated with mental illness or following brain or stroke). • If a representative is present, they may mention that the client is not aware of time and place, or report changes in personality. • The client is observed to be confused and demonstrates an inability to plan and implement tasks during the assessment.
Does the client have any behavioural problems (e.g. aggression, wandering or agitation)? Assessor recorded	CC	This question asks whether the client has any behavioural problems such as aggression, wandering or agitation. It should be asked of third party informants, such as a friend, relative, carer or referring agency. It can also be asked of the client themselves, especially if the client has insight into their behavioural problems. Complete the question based on information available, your judgement based on the conversation with the client, information on the inbound referral and/or information provided by another source such as a representative, carer or friend. The response to this question may differ depending on whether the client or representative is responding to this question. Make a note of who is responding to this question in 'Evidence'.

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Mandatory		Evidence: • Problem behaviours include those that are difficult to manage and may have a significant impact on the carer as well as the client's ability to live in the community. For example, being demanding, uncooperative, agitated, suspicious, repetitive, prone to wandering, socially inappropriate, or exhibits unpredictable and manipulative behaviours. Also included are harmful behaviours directed at self (neglect and/or self-harm), or others (verbal and physical abuse), sleep disturbance and mood swings. • Take note of signs during the telephone conversation. For example, the client may present as agitated, aggressive, suspicious, repetitive or inappropriate. • If speaking with a carer or representative, they may mention that the client has behavioural problems such as those outlined above. • If there are concerns, elicit what behaviours and how these are impacting on the client, carer, family members. For example, aggression, wandering, sun-downing, shadowing, inappropriate exposure, hoarding, agitation, sexual dis-inhibition, calling out, apathy, insomnia. • If the client exhibits behaviours that impacts on their ability to complete day-to-day tasks, comment on whether they been assessed by a geriatrician, psychiatrist or mental health team.
	RAS ACAT	Observations should be considered. The following can be used to gather additional information: • Take note of signs during the assessment. For example, the client may present as agitated, aggressive, suspicious, repetitive, demanding, uncooperative, socially or sexually inappropriate, or exhibits unpredictable and manipulative behaviours. • The client may also present with harmful behaviours directed at self (neglect and/or self-harm), or others (verbal and physical abuse), mood swings, apparent lack of sleep • If a third party informant is present, they may mention that the client has behavioural problems such as those outlined above. If there are concerns, elicit what behaviours and how these are impacting on the client, carer, family members.

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Item	Level	Guidance
		For example, aggression, wandering, sun-downing, shadowing, inappropriate exposure, hoarding, agitation, sexual disinhibition, calling out, apathy, insomnia.
Are there any concerns about psychological symptoms associated with memory loss? Assessor recorded	RAS ACAT	This question asks whether there are concerns about psychological symptoms associated with memory loss. Memory problems can vary in severity and can cause various signs and symptoms. If a client or a representative notices a change in the way a client is handling information and day-to-day tasks, they should be encouraged to seek medical advice. Should there be indication of concerns about psychological symptoms associated with memory loss, specify details of the concerns. For example, common symptoms associated with memory loss include the following: • Confabulation (i.e. invented memories or real memories recalled out of sequence). • Confusion. • Difficulty handling day-to-day affairs, finances, keeping appointments, or preparing meals. • Forgetting people, facts, and events that were previously known well. • Getting lost and misplacing items. • Increased difficulty in following directions or taking a step-by-step approach to a familiar task. • Irritability. • Language difficulties, such as mixing up words or trouble remembering a word. • Neurological disorders (e.g. tremors, uncoordinated movements). • Repeating the same stories and/or questions.
Are there any cognitive or mental health problems that may need to be considered as part	RAS ACAT	This question asks whether the client has cognitive or mental health problems that may need to be considered as part of the recommendation for support. Should there be indication that the client has cognitive or mental health problems that require recommendation for support, specify details of objective information as a strategy to help determine recommended support, such as:

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of the recommendation for support? Assessor recorded		• Appearance and dress (meticulous, sloppy) • Manner (formal, suspicious, aggressive, meek, irritable) • Behaviour (talkative, reticent, restless, fumbling) • General hygiene (skin, grooming, teeth, hair, finger nails, odour) • Voice and speech – quantity, rate and type (slow to respond, pedantic, slurred, spontaneous) • Perceptions (hallucinations, delusions) • Consciousness (alert, attention span) • Orientation (day, time, place, person, fluctuations) • Concentration and attention (distractibility) • Intellectual capacity (information, comprehension) • Awareness of need for help and effect on others • Recall, short or long-term memory • Behaviours that affect function.
Do you have anyone that assists you in making health or lifestyle decisions? Mandatory	All	This question asks whether the client has anyone that assists them in making health or lifestyle decisions. Complete the question based on information available, your judgement based on the conversation with the client, information on the inbound referral and/or information provided by another source such as a representative, carer or friend. Should the client have someone that assists them in making health or lifestyle decisions, record the name of the person(s) who assists and the types of decisions they provide assistance with. For example, health management, service provision, accommodation, lifestyle choices etc. Specify the person(s) relationship to the client. Consider whether the person(s) should be established as a representative for the client.
Do you have anyone that	All	This question asks whether the client has anyone that assists them in making financial decisions. Complete the question based on information available, your judgement based on the conversation with the

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assists you in making financial decisions? Mandatory		client, information on the inbound referral and/or information provided by another source such as a representative, carer or friend. Should the client have someone that assists them in making financial decisions, record the name of the person(s) who assists and the types of decisions they provide assistance with. For example, a family member who is assisting with the sale of property in preparation for relocation into residential aged care or managing other debts. Specify the person's relationship to the client. Consider whether the person(s) should be established as a representative for the client.
Are there any concerns regarding the client's decision making capabilities?	ACAT	This questions asks whether there are any concerns regarding the client's decision making capabilities. Capacity is decision-specific and it is inappropriate to state that a person 'lacks capacity' without further reference to the type of capacity task. A person's capacity can vary in different circumstances, at different times and even within domains for different types of decisions. Capacity is: - The ability to make and communicate a decision - Not a unitary or global concept - Domain specific: particular to the type of - Decision being made (e.g. personal, health, financial) - Decision or task specific: different for every decision made, even within one domain[9]. When collecting information regarding a client's cognitive state the sources of information are significant. Information can be gathered from the client's family/carer, GP, or their current service providers. Questions to ask the sources include: - How long have they noticed changes? - What can't the client do now that they could do one year ago? - Was it a gradual onset over one to two years or a recent, sharp decline over a couple of months?

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[9] Capacity Australia: Decision-making capacity & dementia: A guide for Health Professionals in NSW .Mini-legal kit Series 1.7.2013

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		Remember, it sometimes can be both.
		Options include:
		Yes: The client has minor impairment and requires occasional supervision or assistance through to severe impairment.
		No: The client is making appropriate decisions and having minor difficulty in new situations.
		Note Sure: There is no clear diagnosis of dementia and it is not clear whether the client can make informed decisions. If there are concerns a client should be referred for a review of their circumstances. There can be another medical condition i.e. deliurim which could be impacting on their decision making capacity.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record in the questions and comments.

14.2 Psychosocial

The psychosocial section gathers information relevant to a client's mental health, spiritual, emotional and social wellbeing. The term psychosocial in the literature is varied and is used as an umbrella under which certain determinants can affect a client's ability to function in everyday life. These determinants help to inform an assessment for the purposes of gaining better outcomes for a client[10]. When a client answers specific questions within this section, the assessor should consider the primary cause of identified factors impeding a client's ability to undertake daily activities.

Mental health is recognised in the elderly as complex due to factors such as previous psychiatric history, current social determinants, isolation, medication interactions due to multiple prescribing and finally the decline of a client's cognitive state due to dementia. These factors can be challenging when undertaking an assessment. If a client is feeling nervous, depressed or lonely there are many factors that can contribute to these emotions.

Spiritual wellbeing is more of an individual ability to identify one's sense of peace and purpose. An elderly person will have developed beliefs over their lifetime and what this means for them and it could be as simple as connecting with family and friends regularly. The exploration of spiritual well-being is not solely related to religious beliefs but the inner workings of the self.

Emotional and social wellbeing problems cover a broad range of issues that can result from the loss of a partner, friends, relatives and pets, financial problems, living arrangements, breakdown of social supports. Emotional health is not simply the absence of psychiatric illness, but the presence of positive emotional adaptation in areas such as emotional regulation (the ability to control one's emotions) and emotional intelligence (the ability to use and identify emotions constructively). Emotional health comprises personal traits that promote successful adaptation, such as resilience, mastery, self-efficacy, and wisdom. Self-efficacy and the ability to engage with others may decrease the feeling of sadness and depression that often depicts old age and speeds cognitive decline.

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[10] Martikaine, P., Bartley, B. & Lahelma, E. (2002). Psychosocial determinants of Health in Social Epidemiology. International Epidemiological Association. 31.1091-1093

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Item	Level	Guidance
During the past four weeks, how often have you felt nervous, depressed or lonely? Mandatory	CC	This question asks the client about their social and emotional wellbeing needs, including nervousness, depression and loneliness and how often these have been experienced over the past four weeks. This is a client's self-report of their conditions. Responses that may influence this question include the client's medical diagnosis; if they have been sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of themselves. Other factors that may influence this question include the availability of another person or service provider to assist on a daily basis, every few days, once a week or not at all. **Nervous:** Feelings of nervousness can be expressed as feeling anxious, worried, edgy, jumpy, panicky or uneasy. Should the client have had those feelings over the past four weeks, select the occurrence of this feeling as reported by the client. Options include all of the time, most of the time, some of the time, a little of the time, none of the time or not sure. **Depressed:** Feelings of being depressed can be expressed as feeling unhappy, 'blue', down, miserable, dejected, low, disheartened or sad. Should the client have had those feelings over the past four weeks, select the occurrence of this feeling as reported by the client. Options include all of the time, most of the time, some of the time, a little of the time, none of the time or not sure. **Lonely:** Feelings of loneliness can be expressed as feeling lonesome, alone, deserted or isolated from friends/family/ their community. Should the client have had those feelings over the past four weeks, select the occurrence of this feeling as reported by the client. Options include all of the time, most of the time, some of the time, a little of the time, none of the time or not sure. Note: • If you are concerned that the client may have a mental illness and/or be at risk of self-harm, seek advice from your team leader at the time of contact.
	RAS ACAT	Observations should be considered. Ask further questions to investigate statements that a client might make regarding nervousness, feeling sad and lonely.

Item	Level	Guidance
		Feeling nervous is a healthy emotion. If a person couldn't become nervous, they would take many more risks, and possibly put themselves in danger. Nervous thoughts feel completely normal but when someone develops anxiety, they may notice that they find more and more things to inspire feelings of nervousness.
		Depression is more than low and sad feelings. There are some people who suffer from this debilitating illness for long periods of time and often without a known reason. In the older population it may become evident in behaviours such as self-neglect, withdrawal from social contact, lack of motivation, constant tiredness, unexplained headaches, changes in digestive or bowel habits and decreased appetite resulting in weight loss, or in some cases weight gain due to over eating.
		Feeling lonely can be draining, distracting and upsetting. The older population will sometimes seek companionship in an animal and this can alleviate loneliness. It is important to understand a client's loneliness in regards to how they want to alleviate this feeling. Does it mean they want to attend social gatherings with a number of individuals regularly or is it that they want to have a cup of tea with a friend that lives in a nearby suburb?
Have you experienced one or more major stressful events over the past three months?	RAS ACAT	This question asks whether the client has experienced a stressful event over the past 3 months. There are a number of factors to consider. For example, clients of different cultural backgrounds may perceive stressful events differently. Responses to stress vary greatly in severity and length. The older population are resilient and are often under estimated for their ability to move forward and get on with life. Should the client have experienced one or more major stressful events over the past 3 months, specify details of the major stressful event(s).
Has the client had a sudden change in mental state recently? Assessor recorded	RAS ACAT	This question relates to a client identifying a sudden change in mental state recently. A change in mental state can occur due to a number of factors. Should there be indication that the client has had a sudden change in mental state, specify details of the sudden change. These changes can be due to the following: • A physical functionality: i.e. urinary tract infection, non-compliance with medication • A psychological function: stress or loss

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		• A medical function: resistance or change in medication • A social function: change in accommodation setting, loss of pet, change in financial circumstances.
Is the client socially isolated? Assessor recorded Mandatory	RAS ACAT	This question asks whether the client is socially isolated. Social isolation is a major and prevalent health problem among community-dwelling older adults, leading to numerous detrimental health conditions. Social isolation is defined as "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships"[11]. Examples of severe isolation include: living arrangements where the person lives alone and has limited or no support from family, friends or neighbours; limited or no social contact through organisations such as church groups, sporting, or social clubs; person's capacity to live at home is at risk due to their geographic isolation and associated difficulties with effective service provision. This indicator relates to people whose capacity to remain at home is at risk due to their geographic isolation and their associated access to required service. Should there be indication that the client is socially isolated, specify details of the indicators identifying social isolation. These indicators may include behavioural habits, cognitive changes, physiological changes: • **Health Behavioural**: An older adult's social network can impact health positively. Without the positive influence of social network members, older adults who are socially isolated are at risk of heavy drinking, smoking and being sedentary • **Psychological:** Those who have poor social connections and do not participate in social activities are at an increased risk of cognitive decline and men are at a significantly increased risk of death from suicide.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record in the questions and comments.

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[11] Nicholson, N.R, 2009, Social Isolation in older adults: an evolutionary concept analysis, *Journal of Advanced Nursing,* 65:6 pp.1342-1352

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14.3 Psychological

Item	Level	Guidance
Psychological – Record Assessor recorded Mandatory	ACAT	This question asks whether the client exhibits the following cognitive/behavioural/psychological signs and symptoms: **Short term memory problems:** When a client experiences short term memory loss he or she can remember incidents from 20 years ago but unable to remember details of events that happened 20 minutes ago as an example. Each client will have different time deficits. **Long term memory problems:** In contrast to short term memory problems a person is able to remember events/details within a short time period but is unable to remember events/details from their childhood. Each client will have different time deficits. **Impaired judgment:** This condition results in a person not being able to make good decisions due to underlying medical problems. **At risk behaviour:** These are behaviours that put the client or others at risk of harm. **Aggressive Behaviour (verbal):** E.g. Where a client yells, screams and/or threatens **Aggressive Behaviour (physical):** E.g. Where a client hits, scratches, bites, pushes, shoves, throws things, uses weapons **Resistive Behaviour:** This is where clients resist/oppose or withstand help or caregiving tasks such as taking medication, eating, feeding self. **Agitation:** Extreme emotional disturbance **Hallucinations/Delusions:** Hallucinations can occur in any sensory modality: auditory, visual, olfactory, gustatory and tactile and delusions are false or erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. **Wandering:** To move about without a definite destination or purpose. **Disturbed Sleep/Insomnia:** Persistent difficulty in initiating or maintaining sleep.

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Item	Level	Guidance
		Anxiety: Unpleasant state of inner turmoil, often accompanied by nervous behaviour such as pacing back and forth, somatic complaints and rumination. **Symptoms of Depression:** Depressive symptoms include physical symptoms, long periods of feeling lonely, overwhelming feelings of unable to keep going, teary regularly. **Apathy:** Absence or suppression of passion, emotion or excitement. **Confusion:** This behaviour can come on quickly or slowly over time depending on the cause. **Disorientation – Time:** Unable to identify the time, day, date or year. **Disorientation – Place:** Unable to identify where they live or where they currently are placed. **Disorientation – People:** Unable to identify family or friends. Each sign or symptom should be recorded by the following scale: • **Unable to determine:** This response should only be chosen due to the client unable to communicate they are exhibiting the behaviours or others are unable to quantify this type of behaviour • **Never:** There is no evidence the client exhibits this type of behaviour • **Occasionally:** A client exhibits behaviours from time to time – e.g. weekly • **Regularly:** A client exhibits behaviours at regular times – one or more times during a week • **Always:** A client exhibits behaviours daily.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record in the questions and comments. It should also be used to record information that you have obtained from the assessment that is unable to be documented elsewhere in this section.

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15 Home and personal safety

These questions ask about a client's safety needs within their home, including concerns about their living arrangements and how this impacts on their ability to live safely and independently.

Item	Level	Guidance
How are you managing at home (e.g. with stairs and floors etc.)? Mandatory	All	This question asks how a client is managing at home. For example with stairs, floors etc. Consider how the client is: • Managing to negotiate internal and/or external stairs. • Uneven/different floor surfaces. • Presence of mats, electrical cords and/or clutter. • Accessing cupboards, the garden, clothesline, letterbox, driveway.
	RAS ACAT	Observations should be considered. Take note: • If the client is able to negotiate internal and/or external stairs, uneven/different floor surfaces. • If the client is able to access cupboards, the garden, clothesline, letterbox, driveway. • Whether mats, electrical cords and/or clutter is present. • If the client's garden is neat and tidy or if the garden and/or lawns are overgrown. • If light globes are not working inside and/or outside the home. • If the home receives adequate natural lighting. • If the home is in need of general maintenance and repairs. The following prompts and/or questions can be used to gather additional information: • How do you feel you are managing within your home? • Do you feel that your home is a manageable size to maintain? • Are there ongoing maintenance costs/repairs that are beginning to concern you?

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		• If the client has a garden, how do you manage your garden and lawns? • How do you manage home maintenance tasks such as changing light globes, checking the smoke alarm, cleaning windows and gutter cleaning? • Are there specific areas around your home that need cleaning or maintenance?
Is the client self-neglecting of personal care, nutrition or safety? Assessor recorded	RAS ACAT	This question asks whether the client is self-neglecting of personal care, nutrition or safety and relates to people with cognitive, memory, mental health or substance abuse issues resulting in self-neglect that may have an impact on their health or ability to remain at home. To inform this question, consider the responses to questions: • 'Have you lost any weight without trying, or had other nutritional concerns in the past 3 months?' • 'Can the client take a bath or shower?', 'Dressing', 'Eating', and 'Toilet use' • 'How is your appetite?' • 'Do you have any bladder or bowel issues that affect your lifestyle?' Should there be indication that the client is self-neglecting of personal care, nutrition or safety, specify how they are self-neglecting of personal care, nutrition or safety. For example: • Neglecting or forgetting to shower/bath. • Refusal to use mobility aids or shower/bath adaptive equipment. • Forgetting to eat or drink water resulting in a risk of dehydration and weight loss. • Poor diet. • Non-compliance with medication resulting in overdosing or under medicating that would have an impact on the person's health. • Non-compliance with the use of a personal alarm when a person has frequent falls. • Access issues or environmental hazards. • The home is very messy, cluttered or dirty. • There is evidence of cluttering or hoarding.

Item	Level	Guidance
		• There are signs of vermin infestation. • Has the client stopped inviting guests over to the house due to it being untidy?
Are there any risks, hazards, or concerns to you in your home? Mandatory	All	This question asks whether there are any risks, hazards or concerns to a client in their home. Should there be reported or known risks, hazards or concerns to a client in their home, specify the risks, hazards or concerns. This may include access issues (broken steps, uneven footpath, overgrown lawns or garden), presence of pets, smoking, family violence (including physical danger or other threats), abuse (including physical, emotional, financial), presence of weapons, other reported issues etc.
	RAS ACAT	Observations should be considered. Take note: • If there are access issues or environmental hazards such as broken steps, uneven footpath, overgrown lawns or garden, presence of pets, smoking, family violence (including physical danger or other threats), abuse (including physical, emotional, financial), presence of weapons, other reported issues etc. • Whether there are signs of cluttering or hoarding. • Record the risk, hazard or concern as reported by the client or representative. The following prompts and/or questions can be used to gather additional information: • Do you have any concerns about risks or hazards in your home?
Would any equipment or modification to the home assist you to maintain your independence and/or safety? Assessor recorded	RAS ACAT	This question asks whether any equipment or modification to the home will assist the client to maintain their independence and/or safety. Should it be evident from the assessment that the client will benefit from equipment or home modifications to maintain their independence and/or safety, specify types of equipment or home modifications the client may require. This may include: • Self-care aids that assist the client in their day to day routines of cooking, eating, personal hygiene and medication management. For example adaptive cutlery and crockery; long handled dressing and

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Item	Level	Guidance
		grooming tools; bath seats, shower chairs, shower stools, commodes, hand held showers, slip resistant mats, grab rails in the bath and/or shower; raised toilet seat, over toilet aid, toilet surround, grab rails next to the toilet; slip resistant floor surfacing/tiles in the bathroom and toilet; bowel and urinary appliances; dosette box or blister packs for medication management. • Support and mobility aids that provide the client with ease of mobility as well as supportive mechanisms while at rest. For example belts, braces, crutches, walking sticks, walking frames, wheelchairs, scooters, callipers, splints, hospital beds, cushions/pillows. • Car modifications that allow clients access to safe and comfortable transportation, either as a driver or passenger of the vehicle. For example accelerator/brake/mirror and other driver related controls as well as modifications and room for a wheelchair. • Communication aids that help the client with their inter-personal interaction. For example telephone attachments, writing aids, speaking aids, intercom, hearing aids. • Reading aids such as magnifying/reading glasses, braille books, reading frames, talking books. • Modifications to facilitate access into a client's home. For example ramp access, handrails at the front/rear access, lift access. Note: • A referral to an occupational therapist may be required for the recommendation and prescription of home modifications and/or adaptive equipment. A referral to a physiotherapist may be required for a mobility assessment and/or walking aids. Sometimes, completing a task differently may be more effective or suitable than equipment or modifications.
Does the home environment have any barriers to the client's	RAS ACAT	This question asks whether the home environment has any barriers that impact on the client's independence. Should it be evident from the assessment that the home environment has barriers that impact on the client's independence, specify the types of home environment barriers that may impact on the client's independence. This may include:

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Item	Level	Guidance
independence? Assessor recorded		• Access issues or environmental hazards such as broken steps or floorboards, uneven footpath, overgrown lawns or garden, vermin infestation. • Stairs without handrails that the client has difficulty with or is unable to negotiate. • Shower recess has a hob that the client is unable to step over; grab rails/equipment may or may not be present. • Shower over the bath that the client is unable to get into; grab rails/equipment may or may not be present. • Bench tops and cupboards are too low/high to reach. • Chairs and bed are too soft/low/high making it difficult for the client to stand up or sit down. • Cluttering or hoarding obstructing access to all or some rooms around the client's home.
Do you have a personal alarm to use in emergencies?	RAS ACAT	This question asks whether the client has a personal alarm to use in emergencies. A personal alarm may also be known as a Personal Emergency Response System; Medical Personal Alarm; Personal Alarm Call System; Personal Emergency Response System; Personal Emergency Call System; an Emergency Pendant. Options include yes, no and not stated/unknown. Should the client indicate that they have a personal alarm, record whether it has checked in the last 12 months. By asking the client to test or check the alarm during the assessment, the assessor has an opportunity to ensure that the client knows how to use and operate the personal alarm. Notes: • If the client has a personal alarm, the assessor should ask the client whether they wear the pendant at all times in case they have a fall or need assistance. • If the client does not reflect that they have an alarm, consider whether to ask if the client has a pendant they wear around their neck just in case they have a fall or need assistance. Expanding this question will sometimes prompt clients to recall that they keep the alarm pendant beside their bed. The assessor can then stress the importance of wearing it at all times, including whilst showering.

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Item	Level	Guidance
		Where the client does not have a personal alarm or where the client's personal alarm has not been checked in the last 12 months, a recommendation will display in the Support Plan recommending that the client have a personal alarm or get it checked. It is for the assessor to provide this recommendation or not to the client.
Is there a working smoke alarm in your house?	RAS ACAT	This question asks whether the client has a working smoke alarm in their home. Smoke alarms are vital in ensuring lives are protected. They are designed to alert residents about a fire in time to escape the property safely. Smoke alarms should be kept in good working order. Smoke alarm safety tips include: • Test it once a month by pressing the test button until the alarm sounds. • Clean it with a vacuum cleaner every six months to remove dust. • Change the battery once a year. • Replace the whole unit every ten years. Should the client indicate that they have a smoke alarm, record whether the smoke alarm has been checked in the last 12 months. Record whether the client is at risk and in need of more than one smoke alarm. For example: • Where there is a high level of hoarding, smoke alarms should be installed in areas related to cooking and heating and promote the reduction of clutter. • For a smoker with signs of burns on a chair in the lounge and the bedside table, ensure there is a smoke alarm in both rooms and promote the use of a heavy ashtray. Each state and territory may have a specific program for assisting older people to install, maintain and/or replace smoke alarms in their home.
Do you have a personal emergency plan in	RAS ACAT	This question asks whether the client has a personal emergency plan in place in case of fire, heat wave or flood. Clients should be encouraged to develop a personal emergency plan that links them to family, friends, neighbours or local groups that can be actioned in the event of an emergency. The client's personal emergency

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case of fire, heat wave or flood?		plan should be developed in collaboration with the people and/or groups that they intend to utilise in an emergency. People who are socially isolated, have limited or no supports, or who have a cognitive impairment may need assistance to develop their emergency care plan. Options include yes, no and not stated/unknown. Details may be recorded in Comments/Further information. Where the client does not have a personal emergency plan, a recommendation will display in the Support Plan recommending that the client prepare a personal emergency plan in case of fire, heat wave or flood. It is for the assessor to provide this recommendation or not to the client.
Do you drive a motor vehicle?	RAS ACAT	This question refers to whether the client drives a motor vehicle. Should the client drive a motor vehicle, the following additional questions can be asked: • Where do you drive to? • Do you drive at night? • Do you hold a restricted drivers licence? If so, is it restricted to day time driving only or is it restricted by kilometres? Details may be recorded in Comments/Further information. Should there be concerns in relation to the client being able to drive, specify these concerns. It is important to note that driver safety can often be a sensitive issue for a person as a driver's license signifies more than the ability to drive a car; it is a symbol of freedom and independence. The client may be aware of their reduced ability but still be reluctant to give up driving completely. If a relative or friend has raised concerns in relation to the client being able to drive, it is important to be respectful of the client as driving is an integral part of their existence. At the same time, don't be intimidated or back down if you have a true concern. For example, the client may be experiencing: • Neck pain or stiffness making it more difficult to look over their shoulder to change lanes or look left and right at intersections to check for other traffic or pedestrians.

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		• Leg pain that makes it difficult to move their foot from the accelerator to the brake pedal. • Reduced arm strength making it difficult to turn the steering wheel quickly and effectively. • Difficulty spotting vehicles emerging from side streets and driveways, or realising that the vehicle ahead of them has slowed or stopped due to reaction times slowing down with age. • Difficulty keeping track of road signs, signals, and markings, as well as all the other traffic and pedestrians as a result of being able to effectively divide their attention between multiple activities. • Symptoms as a result of medications or combinations of medications causing reduced senses and reflexes • Eye conditions that interfere with peripheral vision, or cause them to experience extra sensitivity to light, trouble seeing in the dark, or blurred vision. • Loss of hearing that causes them to miss out on important cues to drive safely such as hearing emergency sirens or the honking of a car horn. • Problems with memory that has resulted in them missing exits that used to be second nature, or finding they are getting lost frequently. Note: • Suggest the client and/or their representative seeks medical advice about their concerns in relation to the client being able to drive. Details may be recorded in Comments/Further information.
Do you have any concerns with your living arrangements? Mandatory	All	This question asks whether the client has concerns with their living arrangements. Complete the question based on information available, your judgement based on the conversation with the client, information on the inbound referral and/or information provided by another source such as a representative, carer, friend or health professional. Should there be reported concerns with the client's living arrangements, specify the concerns. This may include concerns such as their tenancy is at risk, homelessness, squalor, behind in rent, informal supports are breaking down, living arrangements are placing them at risk, conflict/abuse between client and carer/family and

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Item	Level	Guidance
		client/family and carer.
	RAS ACAT	Observations should be considered. Take note: • If the client is living in squalor. • How the client's personal and clothing appearance presents and how maintained their home is, especially if they have a carer who is meant to be assisting with these tasks. • Does the client present as nervous, worried or scared about something. Take note of how they respond to your questions. • Are there concerns about the behaviour of the representative, carer, family member, or other persons present? The following prompts and/or questions can be used to gather additional information: • Do you have concerns with your living arrangements? • What are the concerns that you have with your living arrangements, for example is your tenancy at risk, are you behind in rent, are you at risk of becoming homeless, are your informal supports breaking down, are your living arrangements placing you at risk, is there conflict/abuse between client and carer/family and client/family and carer?
Do you have any concerns about your financial situation?	RAS ACAT	This question asks whether the client has any concerns about their financial situation. It is important to note that a person's financial situation may impact on their overall health and wellbeing as the costs of care and support, adaptive aids, home modifications, transport, housing and family circumstances can impact on the quality of their life and their mental health, spiritual, emotional and social well-being. Ask the client for permission to discuss their financial situation to help understand what options may be most suitable to meet their needs. Should the client have concerns about their financial situation, specify the concerns they have taking into account how they manage their finances. For example, do they manage their finances independently (such as

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Item	Level	Guidance
		banking, bill paying, writing, managing own income, using Direct Debit) or with help (client manages the day-to-day buying and expenses but needs assistance with banking, bill paying and major purchases). A person's ability to manage their money and finances may be impacted by cognitive or physical reasons. The following prompts and/or questions can be used to gather additional information: • Are you worried about money, worried about losing money or having less money than you used to have to live on? • Do you have difficulty paying bills and meeting basic needs, such as paying for food and medication? Observations should be considered: • Look for evidence of unpaid and overdue bills, bank account statements, piles of paper or unopened mail • Observe the client's response and body language when you raise the subject.
Is the client experiencing financial hardship threatening the use of services essential for supporting them at home? Assessor recorded	RAS ACAT	Should the client be experiencing financial hardship threatening the use of services essential for supporting them at home, specify the financial hardship that the client is experiencing. For example: • Can the client afford food and medication? • Do they have enough money to pay their bills? • Have they had or are they at risk of having services such as electricity, gas or water disconnected? • Can they afford to pay their rent/mortgage, strata fees and council rates (if relevant)?
Are you afraid of someone who hurts, insults, controls or threatens you, or who prevents you	RAS ACAT	This question asks whether the client is afraid of someone who hurts, insults, controls or threatens them, or who prevents them from doing what they want. Abuse of older people is defined as any pattern of behaviour or action resulting in financial, psychological, physical, sexual or social harm to an older person. The harm may be intentional or unintentional and may be caused by another person with whom the person has a relationship of trust. Abuse of older people also involves neglect or failure to provide necessary food, shelter, clothing, medical care or emotional support. There is no

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from doing what you want?		clear reason for abuse and its causes are complex and concealed. Key risk factors for abuse include carer stress, difficulties accepting care due to health status, family violence or conflict, isolation, dependency, psychological problems and addictive behaviours in the abuser. Abuse and neglect can sometimes be detected from the behaviour of the people involved as well as the more obvious physical signs and symptoms.
		A person who has experienced or is experiencing abuse may not explicitly answer this question. It is important to be aware of sudden and unusual behaviour patterns in the client, not only in the home, but in other situations and settings.
		Options include yes, no and not stated/unknown.
		If the question is not answered, observe the behaviours that a client may display. For example:
		• Contradictory statements. • Avoiding eye contact. • Physical contact or other contact with carer or service. • Reluctance to talk openly. • Waiting for another person to answer. • Rigid posture and/or bouts of shaking, trembling and/or crying. • Irritable or easily upset. • Worried or anxious for no obvious reason. • Depression or withdrawal. • Lack of interest. • Presenting as helpless, hopeless or sad. • Thoughts of suicide. • Changing sleep patterns or eating habits. • Being afraid of one or more person/s.

Item	Level	Guidance
		If information is provided by the client, document these details. It is important to be as accurate as possible when documenting what the client states about the person who hurts, insults, controls or threatens them, or prevents them from doing what they want. Incidents can be defined by one or many types of abuse: • Financial Abuse: the illegal or improper use of an older person's finances or property. Examples include stealing, misappropriation of property, money or valuables, forcing changes to a will or other legal documents, denying access to personal funds, forging signatures, misusing Power of Attorney or doing their grocery shopping and not returning the change • Psychological Abuse: inflicting mental anguish through actions that cause fear of violence, isolation or deprivation, and feelings of shame and powerlessness. Examples include verbal intimidation, humiliation or embarrassment, shouting, bullying, threats of physical harm, threats of institutionalisation, withdrawal of affection such as refusing access to grandchildren, emotional blackmail, damage to or removal of property and possessions, removal of decision-making powers, preventing access to services • Physical Abuse: inflicting pain or injury. Examples include hitting, pushing, punching, kicking, biting, scratching, shaking, slapping, dragging, burning, inappropriately restraining or confining, inappropriately medicating, and damage to property • Sexual Abuse: unwanted sexual behaviour. Examples include rape, indecent assault, sexual harassment or inappropriate touching • Social Abuse: preventing a person from having contact with friends or family, or access to social activities. • Examples include moving the person far away, or cutting the person off from the support of friends or family members, not allowing the person to use the telephone or monitoring their calls, not allowing the person to socialize or meet neighbours, claiming that the person's friends or family are interfering • Neglect: the failure of a carer to provide the necessities of life to a person for whom they are caring. Neglect can be intentional or unintentional. Intentional neglect is when an older person is abandoned or not provided with adequate food, clothing, shelter, medical or dental care, or where their

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		spiritual needs are not met. Examples include the improper use of medication, poor hygiene or personal care, or the refusal to allow other people to provide adequate care. Unintentional neglect occurs when a carer does not have the skills or knowledge to care for a dependent person. They may not be aware of the types of support that are available, they may be ill themselves and unable to provide care.
		Should it becoming worse or happening more frequently, document the details as provided by the client. Should the client be scared for their safety, document the details as provided by the client. It is important to be as accurate as possible when documenting what the client states about the duration and frequency of the harm caused by the person who hurts, insults, controls or threatens them, or prevents them from doing what they want.
Does the client have any legal issues that may affect services (E.g. AVO)? Assessor recorded	RAS ACAT	This question asks whether the client has any legal issues that may affect services. Should the client have legal issues that may affect services, specify the details as provided by the client. It is important to be as accurate as possible when documenting the legal issues impacting on the client that may affect services. For example, does the client: • Have an Apprehended Violence Order (AVO) in place against a family member, friend or person who makes them fear for their safety, or to protect them from further violence, intimidation or harassment. • Need help or advice with making a will. • Need help or advice with the administration of finances and legal decisions. • Need help or advice with Enduring Power of Attorney or Guardianship Issues. • Fear for their safety from family, friends or other persons.
Comments/Further information	All	This section allows you to document any additional general comments and information provided by the client that you have been unable to record in the Screening questions. Types of comments or information that could be included here: • Prompt the client or carer about the assistance that may be required to maintain safety and wellbeing at home.

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		• Information about why you have been unable to determine a response to a question in this section. • Information that you have obtained from the conversation or referral that is unable to be documented elsewhere in this section.

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16 Complexity indicators

The NSAF includes indicators which will assist the contact centre and assessors to identify vulnerable clients with complex needs who require linking support. Specific responses to screening assessment questions will trigger the indicators, which will assist in identifying whether the client is at risk of vulnerability and may require case management.

The complexity indicators profile are measurable characteristics of a client's circumstances to determine actions related to short and long term service provision and the urgency of any interventions.

Where it is identified at screening that the client has a level of complexity, the client will be referred for a face-to-face assessment (either home support assessment or comprehensive assessment).

Item	Level	Guidance
Person is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing and ability to remain living in the community	All	This indicator reflects people living in inadequate housing or precarious tenure or having imminent loss of ownership or accommodation rights where there is a likelihood of having to move because of increased rental and/or unsuitability of accommodation meeting needs. Unstable housing includes boarding and lodging, public housing, and staying with friends and/or relatives. Inadequate housing relates to substandard dwellings, poor sanitation, squalor, or unsafe/unsuitable housing for the person's level of functioning. For example, a person with dementia who wanders and lives on a main road, or a person with a bilateral above knee amputation who lives in a two storey house. Homelessness reflects people who do not have an acceptable roof over their head, are moving between various forms of temporary or medium term shelter such as hostels, refuges, boarding houses or friends, are constrained to living permanently in single rooms in private boarding houses and/or housed without conditions of home e.g. security, safety, or adequate standards (includes squatting).[12] Homeless people have an increased risk for adverse health-related outcomes. Those having experienced long term homelessness are more likely to have factors such as alcohol and drug misuse, higher rates of mental and physical illness.

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[12] Assistance with Care and Housing for the Aged Program. Program Manual version 1 July 2012. P. 10

Item	Level	Guidance
		Special needs cohorts that may be particularly susceptible to unstable housing and/or homelessness include people of Aboriginal and Torres Strait Islander background, LGBTI and other gender diverse Australians, refugees, asylum seekers and recent migrants without support, people who are socially isolated and people lacking carer support. The following prompts and/or questions can be used to gather additional information: • Are you happy living here? • Do you find this is affordable for you? Do you manage to keep up with the payments? • Do you feel safe living here? Have you had experience with the police or legal system? • Do you have anyone that will help you find somewhere else to live? • Explore what the client would like to achieve. • Discuss practical ways of how you can help. • Elevate their sense of self-worth and competency through focussing on achieving simple goals. This complexity indicator may be pre-populated given answers to: • The client's type of accommodation (e.g. boarding house/rooming house/private hotel; short term crisis, emergency or transitional accommodation; public place/temporary shelter).
There is risk of, or suspected or confirmed abuse	RAS ACAT	This indicator reflects people who are at risk of, suspected or confirmed abuse that requires further investigation. People who are experiencing abuse may be at risk of harm, and/or suffering neglect. They may be feeling unsafe and/or afraid of someone who hurts, insults, controls or threatens them, or prevents them from doing what they want. Types of abuse can include physical abuse, sexual abuse, psychological abuse and financial abuse (including lack of control of finances). Other issues that may play a role include carer stress, tension from overcrowded housing and conflict[13]. The harm may be intentional or unintentional and may be caused by

[13] Petersen, M 'Preventing first time homelessness amongst older Australians', paper presented at New Homelessness Research conference, 14 November 2013.

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		another person with whom the person has a relationship of trust. Abuse of older people also involves neglect or failure to provide necessary food, shelter, clothing, medical care or emotional support. Special needs cohorts that may be particularly susceptible to elder abuse include people of Aboriginal and Torres Strait Islander background, LGBTI and other gender diverse Australians, and people affected by institutionalisation and/or systems abuse. The principles for consideration in the intervention of any suspected abuse of older people case include: • Self-determination and autonomy should be encouraged. Individuals should be encouraged and assisted to make their own decisions. The older person should be provided with information about all relevant options and given the option to refuse services if they are able to do so. Even where people cannot make all of their own decisions, their views should be taken into account. • The interests of the victim take precedence over those of the victim's family or of other members of the community. • Intervention must be victim focused with a view to ensuring safety and ongoing protection from violence and abuse. • Victims of violence, abuse, threats, intimidation and harassment should be offered protection through legal remedies. • Assault and some other forms of abuse (for example, theft and fraud) are criminal offences and, if discovered, it is a legal requirement that they be reported to police. • Confidentiality of information is to be respected in accordance with professional ethics, agency policy and legal obligations. • The desire of the older person for an independent advocate of their own choice should be respected. This complexity indicator may be pre-populated given answers to: • 'Are you afraid of someone who hurts, insults, controls or threatens you, or who prevents you from doing what you want?'

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Item	Level	Guidance
Person has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support	All	This indicator reflects people who have emotional or mental health issues that affect their ability to cope with daily living and/or stressful life events, including change. Some mental health conditions can be cyclic and if not managed, lead to periods of rapid deterioration. Poor mental health may impact on a person's social relationships and risk being marginalised by mainstream services. This indicator also includes threats to spirituality where spirituality plays a particularly important part in an individual's life and related changes or threats are impacting on the individual's wellbeing. Special needs cohorts that may be particularly susceptible to emotional and mental health issues include Veterans, refugees, asylum seekers and recent migrants without support, and people affected by institutionalisation and/or systems abuse. This complexity indicator may be pre-populated given answers to: • 'During the past four weeks, how often have you felt nervous, depressed or lonely?' • 'Has the client had a sudden change in mental state recently?'
Person is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support	RAS ACAT	This indicator reflects people who are without ongoing financial support as a result of circumstances including incurred debt, unemployment, age or a disability. Financial issues may also include gambling issues and an inability to pay for services needed (such as private medical bills that people ineligible for Medicare may have). For example, a person may not have the available resources to purchase healthy food, afford appropriate housing, pay for utilities and services or cover medical and dental costs as a result of high external expenses such as medical, accommodation or living beyond existing means that limits their capacity to pay for essential home-based services, which threatens their ability to remain safely at home. This indicator is included as a priority because people with this risk factor may not "…have available money to buy healthy food, afford appropriate housing, pay for utilities and services, enrol in recreational activities or cover medical and dental costs".[14]

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[14] *'United Way Seniors Vulnerability Report Aging with Dignity – Making it Happen for Everyone 2011', United Way of the Lower Mainland,* Burnaby, B.C.

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		Special needs cohorts that may be particularly susceptible to financial disadvantage include refugees, asylum seekers and recent migrants without support, people who are socially isolated and people lacking carer support.
		This complexity indicator may be pre-populated given answers to:
		• 'Is the client experiencing financial hardship threatening the use of services essential for supporting them at home?'
Person has experienced adverse effects of institutionalisation and/or systems abuse (e.g. spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing	RAS ACAT	This indicator reflects people who have experienced adverse effects of institutionalisation and/or systems abuse and they are refusing assistance or services when they are clearly needed to maintain safety and wellbeing. It includes people who have spent time in institutions, prisons, foster care, residential care or out of home care as well as Forgotten Australians, Child Migrants and Stolen Generations who may be susceptible to the effects of institutionalisation and/or systems abuse.
		Forgotten Australians, Former Child Migrants and Stolen Generations may experience abandonment and loss, grief through separation from their parents and siblings, and loss of identity. Many children suffered from neglect, exploitation, mistreatment and physical and sexual assault at the hands of their caregivers. People separated from their children through forced adoption or removal may have a history of trauma associated with this and may be intensely distrustful of authorities and institutions. Those who have been incarcerated for longer periods are likely to have more difficulty adjusting to community living, particularly if they have lost family and social support, as well as housing, possessions and the capacity to be employed.
		Special needs cohorts that may be particularly susceptible to the effects of institutionalisation and/or systems abuse may be people of Aboriginal descent who were of the Stolen Generation.
		This complexity indicator may be pre-populated given answers to:
		• 'Do you have a history of experiences (e.g. spending time in institutions, foster care or out of home care) that is important to know or would affect services being provided?'

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Person is exposed to risks due to drug and/or alcohol related issues and likely to cause harm to themselves or others	RAS ACAT	This indicator reflects people exposed to risks due to drug and/or alcohol issues and is likely to cause harm to themselves and others and impede a person's access to aged care services. Drug issues can also include misuse of prescribed drugs such as pain relief drugs. This complexity indicator may be pre-populated given answers to: • 'Are you concerned about how much alcohol you drink?' • 'Is alcohol consumption causing problem(s) for you?'
Person is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others	All	This indicator reflects people who are exposed to risks or who are self-neglecting of personal care and/or safety and are likely to cause harm to themselves and others. It is reflective of situations where individuals are living in physical and/or social environments that expose them to risks that are likely to result in harm (includes living in squalor). People who may be susceptible include those who are socially isolated and/or lacking carer support. This complexity indicator may be pre-populated given answers to: • 'Are there any risks, hazards or concerns to you in your home?' • 'Is the client self-neglecting of personal care, nutrition or safety?'
Person has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support	All	This indicator reflects people with declining cognitive health, memory issues or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes in support. The range includes people with mild cognitive impairment to those with severe dementia. Cognitive decline can have a major impact on a person's functional abilities and can lead to a loss of autonomy and capacity to function independently. People experiencing cognitive decline have greater difficulty making decisions. They will be more vulnerable if they have not granted someone they trust a POA. People with cognitive decline may be more vulnerable if there is significant change to carer/ family arrangements affecting their care. Limitations in self-care capacity relates to the impact of the condition on the person's ability to perform self-care

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		tasks without the need for intensive supervision, prompting and/or physical assistance. Intensive supervision refers to the need to constantly monitor, prompt and/or standby with self-care or other activities. People requiring intensive supervision may not be able to be safely left alone for longer than five minutes.
		Conditions that can be associated with a memory problem or confusion include:
		• Dementia type diseases such as Alzheimer's disease, vascular dementia, frontal lobe dementia. • Acquired brain injury such as trauma related head in jury and stroke.
		Mental health issues that may limit self-care capacity include:
		• Major depression. • Post-Traumatic Stress Disorder (PTSD). • Psychosis, schizophrenia, bipolar disorder.
		This complexity indicator may be pre-populated given answers to:
		• 'Does the client have any memory problems or get confused?' • 'Does the client have any behavioural problems (e.g. aggression, wandering or agitation)?'
Risk of vulnerability cohort	All	This refers to the cohorts of people who are identified as being at risk of vulnerability.
		Options include Aboriginal and Torres Strait Islander; Veteran; change in family/carer support arrangements; refugees, asylum seekers or ethnically diverse individual; culturally and linguistically diverse individual; and socially isolated individual.
		The risk of vulnerability cohort may be pre-populated given answers to:
		• 'Do you identify as being Aboriginal and/or Torres Strait Islander?' • 'Are you a veteran or war widow/widower? • 'Does the carer experience any difficulties or have any concerns with the caring arrangement?' • 'Have there been recent significant changes in carer or family support arrangements?' • 'Are carer arrangements sustainable without additional services or supports?'

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Item	Level	Guidance
		• 'Gender' • 'Do you have any cultural and/or religious values or beliefs that are important to know or would affect services being provided?' • Ethnicity • Communication difficulties • Main language spoken at home • TIS required • 'Who does the client live with?' • 'Are there people we can contact (e.g. in the event of an emergency?)' • 'Is anyone helping you at the moment, such as a family member or friend?' • During the past four weeks, how often have you felt nervous, depressed or lonely?' • 'Is the client socially isolated?'
Does the client have one or more complexity indicators that impact on their ability to live independently in the community? Mandatory	RAS ACAT	This question asks whether the client has one or more complexity indicator that impacts on their ability to live independently in the community. Options include yes or no.
Does the risk or issue warrant urgent intervention	RAS ACAT	This question asks if the risk or issue warrants urgent intervention and/or support to minimise deterioration. Options include yes or no.

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Item	Level	Guidance
and/or support to minimise deterioration? Mandatory		
Does the client present with indicators that impede access to delivery of aged care services? Mandatory	RAS ACAT	This question asks if the client presents with indicators that impede access to delivery of aged care services. This can include clients who refuse assistance required to maintain safety and wellbeing at home resulting from e.g. a lack of insight due to cognitive, memory, mental health or substance abuse issues, or people who are fiercely independent. Refusal or reluctance to accept services can be expressed overtly or passively. The person may outwardly agree with suggestions and observations but avoid or subvert them being carried out. It is important to clarify what if anything the person wants to happen, and to acknowledge their ambivalence in a respectful manner. Options include yes or no.
Comments/Further information	RAS ACAT	This section allows you to document any additional general comments and information provided by the client that you have been unable to record.

17 Summary of needs

The information included in summary of needs is in most instances pre-populated from the previously selected screening and assessment information. It is a re-presentation of the information for contact centre staff and assessors in order to inform the level of support the client requires. Should the information presented in the summary of needs not reflect the screening or assessment process, contact centre staff and assessors should update the information where it was originally recorded (e.g. in the function section).

Item	Level	Guidance
Summary of needs	All	The summary of needs is pre-populated from questions relating to the client's function and includes the type of support a client may require and whether this support is needed episodically, or on an ongoing basis or if this is unable to be determined. • **Episodic:** Where a client requires assistance, it is required intermittently, occasionally or on as needs only basis. • **Non-Episodic:** Where a client requires assistance, it is required ongoing/on a regular basis. • **Unable to determine:** If you have been able to ascertain that the client needs assistance, but is unable to determine how long the client may need assistance for. The summary of needs may be pre-populated given answers to: • 'Can the client get to places out of walking distance?' 'Will assistance be required to fulfill need?' • 'Can the client go shopping for groceries or clothes (assuming client has transportation)?' 'Will assistance be required to fulfill need?' • 'Can the client prepare their own meals?' 'Will assistance be required to fulfill need?' • 'Can the client do housework?' 'Will assistance be required to fulfill need?' • 'Can the client take their own medicine?' 'Will assistance be required to fulfill need?' • 'Can the client handle their own money?' 'Will assistance be required to fulfill need?' • 'Can the client walk?' 'Will assistance be required to fulfill need?'

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Item	Level	Guidance
		• 'Can the client take a bath or shower?' 'Will assistance be required to fulfill need?' • 'Dressing' 'Will assistance be required to fulfill need?' • 'Eating' 'Will assistance be required to fulfill need?' • 'Transfers' 'Will assistance be required to fulfill need?' • 'Toilet Use' 'Will assistance be required to fulfill need?'
Other considerations	All	The summary of needs is pre-populated from the screening and assessment process. Other considerations may be pre-populated given answers to: • 'Do you experience any difficulties or have any concerns with the caring arrangement?' 'Does the carer experience any difficulties or have any concerns with the caring arrangement? • 'Are carer arrangements sustainable without additional services or supports?' 'Are your caring arrangements sustainable without additional services or supports?' 'Are these caring arrangements sustainable without additional services or support?' • There is a health condition present • 'Have you been discharged from hospital in the past 3 months?' • 'Have you lost any weight without trying, or had other nutritional concerns in the past 3 months?' • 'Do you have any oral health concerns?' • 'Have you had any concerns with your vision, hearing or speech in the past 3 months? • 'Have you had two or more falls in the past 12 months?' • 'Have you had any bodily pain during the past four weeks?' • 'During the past four weeks, how often have you felt nervous, depressed or lonely?' • 'Does the client have any memory problems or get confused?' • 'Does the client have any behavioural problems (e.g. aggression, wandering or agitation)?' • 'Are there any risks, hazards or concerns to you in your home?'

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Item	Level	Guidance
		• 'Do you have any concerns with your living arrangements?'
	RAS ACAT	Other considerations may also be pre-populated given answers to: • 'Do you have any allergies and/or sensitivities?' • 'Do you have any major skin condition(s)?' • 'Have you recently decreased your fluid intake?' • 'Are you concerned about how much alcohol you drink?' • 'Are you concerned about your level of physical activity?' • 'Do you experience any difficulties sleeping (e.g. difficulty falling asleep, fragmented sleep, insufficient sleep)?' • 'Do you have any bladder or bowel issues that affect your lifestyle?' • 'Have you experienced any changes in your memory and thinking?' 'Is the client aware of time and place?' 'Are there any concerns about psychological symptoms associated with memory loss?' • 'Are there reported changes in the client's personality?' 'Has there been a change in the client's behaviour?' • 'Do you have any concerns about your financial situation?' 'Is the client experiencing financial hardship threatening the use of services essential for supporting them at home?' • 'Would any equipment or modification to the home assist you to maintain your independence and/or safety?' 'Does the home environment have any barriers to the client's independence?' • 'Are you afraid of someone who hurts, insults, controls or threatens you, or who prevents you from doing what you want?' • 'Do you have difficulty understanding information, instructions or written material received from doctors or other health professionals?'

Item	Level	Guidance
Complexity indicators	All	The complexity indicators are pre-populated from the screening and assessment process. Complexity indicators may be pre-populated given answers to: • Person is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing and ability to remain living in the community • Person has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support • Person is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others • Person has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.
	RAS ACAT	Complexity indicators may also be pre-populated given answers to: • There is a risk of, or suspected or confirmed abuse • Person is experiencing financial disadvantage or other barriers that threaten their access to services essential for their support • Person has experienced adverse effects of institutionalisation and/or systems abuse (e.g. spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing • Person is exposed to risks due to drug and/or alcohol related issues and likely to cause harm to themselves and others.
Assessment Tools	RAS ACAT	Supplementary Assessment Tools are available to assessors to inform a holistic assessment of client need. The assessment tool score and outcome of the assessment will be pre-populated when it has been entered in to relevant fields within the assessment process.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
Is it evident the client requires support in order to be able to remain living in the community? Mandatory	All	This question asks whether it is evident that the client requires support in order to be able to remain living in the community. Complete the question based on the information available and your judgement based on the assessment. Record the reason why the client requires support in order to be able to remain living in the community. For example, the client wish to remain in the community but needs basic support with particular activities; the client needs some short-term support to regain their independence etc.
Is it evident that the client requires ongoing support (i.e. case management or care coordination) or has ongoing multiple needs that impact their ability to remain living in the community? Mandatory	All	This question asks whether it is evident that the client requires ongoing support (i.e. case management or care coordination) or has ongoing multiple needs that impact on their ability to remain living in the community. Complete the question based on information available and your judgement based on the assessment. Record the reason why the client requires ongoing support (i.e. case management or care coordination) or has ongoing multiple needs that impact on their ability to remain living in the community. For example, the client has complex needs/health conditions, is unable to continue to live in their current environment, or needs ongoing support to complete a range of activities etc.
Is linking support to services in aged care and/or in other sectors required to address issues and barriers?	RAS ACAT	This question asks whether linking support to services in aged care and/or in other sectors is required to address issues and barriers. Depending on the person's vulnerability, the linking service support might be extensive in the short term until the support structure for the person is in place, which is the point of effective referral. An assessor can determine whether a client requires linking support by identifying whether: • The client has any complexity indicators

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
Mandatory		• The client belongs to a cohort that is at risk of vulnerability • The risk or issues warrant urgent intervention and/or support to minimise deterioration • The client's complexity impedes access to the delivery of aged care services. Options include: • No – Client does not consent to proposed linking support • No – There is an aged care service pathway to support the client's complex issues (e.g. referral to community nursing or allied health) • No – Client is recommended for comprehensive assessment which will address client's complex issues • No – Client or informal support is able to self-manage linking support • No – Other. Specify why linking support services are not required • Yes - Assistance with Care and Housing for the Aged (ACHA) • Yes - Short term case management.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

18 Assessment Outcomes

The assessment outcomes page highlights the outcomes of the screening and assessment process, based on decision support. The outcomes generated are to be considered but can be over-ridden during the development of the action plan and support plan.

Item	Level	Guidance
The client's priority for referral is	All	As a result of the answers given during the screening or Assessment, a priority for assessment or for service delivery will be generated. The priority rating has three levels and classifies each client into one of three levels which are associated with timeframes for assessment or service(s). The priority rating is based on a client's level of function, the level of risk in relation to the care situation, and any other psychosocial or other problems. These are derived from answers to the following questions: • The Functional Overview (can the client complete the activity without help, with help or is completely unable to complete the activity) • Whether the client has anyone helping them at the moment • Whether current caring arrangements are sustainable without additional services and supports • Whether there are other people that help the client • Whether it is evident the client needs support • Whether the client has felt nervous, depressed or lonely • Whether the client has memory problems or gets confused • Whether the client has any behavioural problems. A client may be classed as a high, medium or low priority. The following timeframes for response are associated with each level of priority: • Low priority (more than 14 days • Medium priority – between 3 and 14 days • High priority – within 48 hours

| Client Record | Event Details | Reason for Contact | Current Support | Carer | Family, Community Engagement and Support | Health | Function | Cognitive | Psychosocial | Psychological | Home & Personal Safety | Complexity Indicators | Summary of Needs | Assessment Outcomes | Action Plan | Support Plan | Assessment Tools |

Item	Level	Guidance
		Whilst the system can generate these priority ratings based on information collected during the screening or assessment process, it is up to the contact centre staff or assessor to either agree with this rating or change the rating when developing the action plan or support plan with the client. The following are examples of what may influence a change in the priority generated: • The impact of pain or falls on the client's ability to carry out everyday tasks • The vulnerability of the individual to further deterioration • The level of service to be provided • The effect of service delivery on the family or carer • The client's motivations to achieve certain goals • The likely effect of the service provided in assisting client's to attain their goals.
CHSP eligibility and other assistance	CC	This question is based on the information collected as part of the screening and assessment process and generates whether the client is eligible to receive support through the Commonwealth Home Support Programme (CHSP) or other types of assistance such as linking support services. This is based on the eligibility criteria as outlined in the CHSP Programme Manual. **CHSP on an interim basis** This may be pre-populated given answers relating to: • The client's ability to perform activities of daily living • Where the client lives • The client having needs that exceed a basic support programme **CHSP** This may be pre-populated given answers relating to: • The client's age and Aboriginal and Torres Strait Islander status • The client's ability to perform activities of daily living • Where the client lives

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Item	Level	Guidance
		• The client not having needs that exceed a basic support programme
	RAS ACAT	Other assistance may also be pre-populated given answers to: **Linking support services (short term case management)** This may be pre-populated given answers relating to: • The complexity indicators and whether they impede access to the delivery of services • Whether the risk or issue warrants further intervention and/or support **Assistance with Care and Housing** This may be pre-populated given answers relating to: • The client's ability to perform activities of daily living • The client's type of accommodation • The client not having needs that exceed a basic support programme
Recommended pathway	CC	This question is based on the information collected as part of the screening process and generates whether the client requires home support assessment, comprehensive assessment or could be referred direct to service. **Home support assessment** This may be pre-populated given answers relating to: • The client's eligibility for CHSP • The client not having needs that exceed a basic support programme • The client requires support in order to live in the community.

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Item	Level	Guidance
		Comprehensive assessment This may be pre-populated given answers relating to: • The client's ineligibility for CHSP • The client having needs that exceed a basic support programme • The client requires ongoing support. **Direct to service** This may be pre-populated given answers relating to: • The need for support is episodic • The client has relatively simple needs • The client does not have a level of complexity.
	RAS	A recommended pathway for the client to have comprehensive assessment may also be generated, based on the answers to questions as provided above.
Other recommendations	CC	This question is based on the information collected as part of the screening process. Recommendations may be pre-populated given answers to: • 'Does the carer require an assessment as a client?' • 'Have you had a GP check-up in the past 3 months?' • 'Is there any emergency care plan in place?'
	RAS ACAT	Other recommendations may also be pre-populated given answers to: • 'Do you have any problems with your teeth, mouth or dentures?' • 'Do you have a personal alarm to use in emergencies?' 'Has the personal alarm been checked in the last

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		12 months?' • The client's K-10 score • 'Would you like to discuss continence issues with a continence advisory service?' • 'Do you wish to quit smoking?' • 'Do you have a personal emergency plan in case of fire, heat wave or flood?'
	ACAT	Other recommendations may also be pre-populated given answers to: • The AUDIT tool • The RUDAS.

19 Action Plan

Screening outcomes are recorded in an action plan – the actions the contact centre staff member is going to make on behalf of the client. It is generally based on the Assessment Outcomes, but can be over-ridden.

The Action Plan is generally made up of the following:

- The referral (to home support assessment, comprehensive assessment or direct to service)
- The client's priority associated with the referral
- The client's consent to the referral
- Relevant notes

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20 Support Plan

During and following the face-to-face visit(s) with the client, an assessor will work with the client to establish and document their strengths, goals and motivations in the form of a support plan.

The plan contains the agreed recommendations for support which address the needs identified during the assessment, and may include reablement or restorative care interventions. An assessor is responsible for ensuring that the client understands all aspects of the support plan, including the implications of recommended actions.

20.1 Developing a support plan

Developing a support plan involves an assessment and goal setting with the client leading to the implementation of an individual support plan. Interpreting the assessment information and assisting the person to make decisions which are realistic and appropriate to their needs, values and circumstances. Support planning with a wellness approach aims to maximise independence and be responsive to cultural requirements and maintains cultural sensitivities whilst balancing competing needs. This is a collaborative process with the client and/or carers, family and other key people. A support plan can be continuous and consistent with regular reviews to finalise a goal and set other goals that can be achieved following an achievement of a client's independent state.

A support plan identifies what is most important to the client, their current strengths and abilities, as well as their areas of difficulty. It asks clients to consider how satisfied they are with their current level of independence, and what they hope will change if they are able to receive support. The support plan also identifies any considerations that would be important to know or would affect services being provided.

Clients are asked to identify what they would like to improve (their area of concern), how they would like to achieve it (their goal), their motivation to achieve each goal, and the agreed action to be taken to meet their goals. This may be a combination of client-initiated solutions, support received through Commonwealth funded services, or support provided through other services/organisations/community groups.

The ongoing process of goal directed support planning allows assessors and clients to work together to establish priorities and develop strategies to achieve positive and meaningful outcomes for clients. This continuous process can include:

- A timeline with start and end points, including review processes along the way
- Identifying service options, interventions, referrals and connections

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- A potential to work with service providers through a collaborative approach[15]
- Asking the client who they want involved in planning and decision making to empower them to make informed decisions about their care
- Ensuring information is recorded and used to inform and monitor ongoing care[16]
- Allowing the client to consider their needs within and beyond the scope of service provision and take responsibility for self-management, where appropriate[17]
- To provide a way of documenting essential information to be shared by others, including life-saving actions for emergencies
- Focusing on being proactive rather than reactive
- Allowing diverse needs to be identified and taken into account.

20.2 Goal setting

Goal setting is an important step to formulate a support plan and is essential to the success of a reablement and wellness approach to aged care. Goal development assists with:

- Ensuring a person-centred and family-centred approach
- Ensuring people are empowered to make decisions about their services and support
- Providing purpose and motivation for the person
- Linking between assessment and support planning
- Communication across organisations and between staff
- Fostering greater satisfaction with services and a sense of achievement for individuals
- Providing a focal point for integrating and coordinating service delivery between organisations.[18]

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[15] Pascale, K. 2013 Goal Directed Care Planning Toolkit: practical strategies to support effective goal setting and care planning with HACC Clients, Kate Pascal & Associates on behalf of EMR HACC Alliance

[16] Pascale, K. 2013 Goal Directed Care Planning Toolkit: practical strategies to support effective goal setting and care planning with HACC Clients, Kate Pascal & Associates on behalf of EMR HACC Alliance

[17] Victorian Service Coordination Practice Manual 2012, *Primary Care Partnerships Victoria*

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The 'SMART' principles are a useful guide to goal setting, remembering they should be applied in a way that is responsive to individual's needs.

- **S**pecific – It's easier to accomplish a specific goal than a general one. For example, 'return to playing Bridge three times a week'
- **M**easurable – There should be concrete criteria for measuring progress toward the attainment of goals
- **A**ttainable – When people identify goals that are really important to them (e.g. 'be able to make my lunch daily again') they are more likely to develop the attitudes and ability to reach them.
- **R**ealistic – Goals should represent an objective that people are willing and able to work toward. They should also be set at a sufficiently high level that they represent real progress. Of course, progress is relative
- **T**imely – Goals should be grounded within a time frame (e.g. 'by the end of the week I will be able to button up my shorts and pull the zip up')[19].

20.3 Monitoring and review

Quality support plans provide an excellent framework for ongoing discussion, monitoring and review. Review and monitoring can occur at regular intervals where a client's goals are centred solely on reablement or where a client's needs may increase and service provision needs to be shifted to meet the client's needs and goals. This may include a re-assessment or a decrease in service where a client has become independent in areas where service provision has been supporting the client. As part of a review it is important to negotiate the location, participants and timing of reviews in line with the client and family wishes. This way the support plan remains current and there is a system in place to manage any change to service provision. It is important to have good negotiating and teamwork as well as tact and diplomacy as this will contribute to positive outcomes for the client.

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[18] Victorian Service Coordination Practice Manual 2012, *Primary Care Partnerships Victoria*

[19] *Reablement, Module 2: Reablement for care workers*, Social Care Institute for Excellence, UK, at: http://www.scie.org.uk/assets/elearning/reablement/module_2_web/index.html

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

20.4 Support plan information

Item	Level	Guidance
Professions of those involved in the client's Assessment	ACAT	This question refers to other person(s) who may be present and contributing to the comprehensive assessment. Identifying the range of disciplines or areas of expertise contributing to the client's comprehensive assessment provides a picture of the extent to which a comprehensive assessment requires a multidisciplinary approach. It is acknowledged that a multidimensional approach to comprehensive assessment does not necessarily require contribution from more than one discipline. Record the profession of each clinician or professional person, assessment organisation member or non-team member that contributes to the comprehensive assessment of the client. If more than one assessor belongs to the same professional category, the category should only be recorded once. **Medical Practitioners** – includes generalist medical practitioner, geriatrician, psycho-geriatrician, psychiatrist, rehabilitation specialist, other medical practitioner (includes specialist physicians e.g. neurologists). **Nursing Professionals** – includes nurse manager, nurse educator and researcher, registered nurse, registered mental health nurse, registered developmental disability nurse, other nursing professional. **Health Professionals** – includes occupational therapist, physiotherapist, speech pathologist/therapist, podiatrist, pharmacist, aboriginal health worker, other health professional (includes audiologist, orthotists and health professionals not elsewhere classified). **Social Welfare Professionals** – includes social worker, welfare and community worker, counsellor, psychologist, other social professional (includes social professionals not elsewhere classified), interpreter, other professional (includes occupational therapy assistants, physiotherapy assistants).

20.4.1   Identified needs

This is a re-presentation of the Summary of Needs information so that an assessor can address these needs as part of the development of the support plan, without having to re-open the assessment.

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20.4.2 Client motivations

Item	Level	Guidance
What is most important to you right now? Why? Mandatory	RAS ACAT	This question asks the client to share what is important to them. At times this can be tough in some circumstances and the approach taken by an assessor can be different for each individual client. There is no right or wrong answer and one size doesn't fit all. It is important to encourage the client to speak openly if they feel comfortable and for the assessor to ask open ended questions. Three priority categories for consideration reinforce a holistic approach and validates the importance of happiness and wellbeing for the client and is useful to prioritize expectations that could be the same or different from others around them. **Important to me =** What makes me happy / content / fulfilled and improves my sense of wellbeing? **Important for me =** What is required to ensure my health and safety, develop a positive perception of myself and optimise my community connections? **Important for us =** What makes the client happy when key persons within their life are happy/content and feeling supported. Open-ended questions to encourage a client to share what is important to them: • Ask the client (and their family / carers) to think about what's important to them (what makes them tick) and then look at what is required to ensure they are healthy and safe. • Try and be as specific as possible – find out about the specific elements of the role, activity or issues that are important. • Aim for balance (we need to remain safe, but also recognise that it's important to do things that make us happy). • What would you like to be doing that you're not doing at the moment? • Is there something new that you would like to try or get involved in? • Is there something that you used to do, that you miss and would like to do again? • Do you get an opportunity to do the things you like to do? • How would you like to spend your time?

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Item	Level	Guidance
		Once there is information gathered an assessor can then use more targeted questions to further explore issues that arise[20].
		An example of what may be important to a client may be a preference for a male or female health worker, or a health worker of the same culture or who speaks the same language. When a client is encouraged to be as independent as possible, the client may not like to be rushed, and may want consideration for their daily routines to be taken into account. They may prefer not to be called by their Christian name; and may want to be kept informed in advance of any changes to support staff or to be involved in all decisions about their support.
Is there anything that the client has identified as important to them in relation to their support? Assessor recorded Mandatory	RAS ACAT	This question allows an assessor to record whether the client has identified anything important to them in relation to support situation. Should the client have identified something important to them, record the identified supports the client has indicated are important.
What are the client's current	RAS ACAT	This question asks what the client identifies as their strengths and abilities. A strengths-based and solution-focused approach requires the assessor to identify the person's strengths, talents, capabilities and resources

[20]Pascale, K. 2013 Goal Directed Care Planning Toolkit: practical strategies to support effective goal setting and care planning with HACC Clients, Kate Pascal & Associates on behalf of EMR HACC Alliance

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Item	Level	Guidance
strengths and abilities? Assessor recorded Mandatory		through a conversational dialogue. The assessor can encourage the person to develop and use these strengths to work on particular goals and tasks in their support plan[21]. To help the client identify their strengths and abilities the following is a set of questions to guide the conversation: • What's working really well for you at the moment that we could build on? • What do you do really well? • What are the things that you're managing well at the moment or feel good about? • What are your interests? What do you enjoy? • What gives you a sense of accomplishment, confidence or makes you proud? • Who are the people that are especially important to you? Tell me about these relationships. • What motivates you to do things to improve your health and wellbeing? • Tell me about your daily routine and what makes a good day for you. • What are the things you do, each day or each week, because you really want to – not because you have to? • Can you describe how you do specific tasks and their components (for example, can push a shopping trolley and select items from a shelf but cannot lift heavy bags; can push the vacuum but cannot bend down to plug it in; can shower but cannot step over the bath edge into the shower)?
What are the client's current areas of difficulty or activities where the client needs support?	RAS ACAT	This question is identifying any current areas of difficulty or activities where the client needs support. When the client identifies their difficulties and/or supports they become individualised for the client. Choices have been discussed and made unique to their situation. By doing so the client is not a passive recipient of the support but a determinant of it and therefore far more likely to achieve any goals related to the support[22].

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[21] Department of Health, 2010, Strengthening Planning and Assessment: A Guide for HACC Assessment Services in Victoria.

[22] CommunityWest, 2012, Guidance Notes for WA HACC Assessment

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Item	Level	Guidance
Assessor recorded **Mandatory**		
How satisfied are you with your current level of independence? **Mandatory**	RAS ACAT	This question asks the client how satisfied they are with their current level of independence on a scale from 1 (not at all satisfied) to 5 (very satisfied). This question can start a conversation with the client leading to goal setting.
What do you hope will change is you are to receive support? **Mandatory**	RAS ACAT	This question asks the client what they hope to change by receiving support. Empower the client to make suggestions and contribute**.** This provides them with the opportunity to take the lead, set the direction and reinforces your commitment to collaborative planning. - How can we best help/support you? - Finish this sentence, "If I could, I would …" - What changes do you think would support you to improve your situation? - What are you hoping for, when we work together? - What would you like to work towards? - What do you think are the most important things for us to work on?[23]
Does the client have any cultural and/or religious values or beliefs	RAS ACAT	This question asks the client about their cultural and/or religious values and beliefs that are important to them and could affect services to be provided. Should the client have identified important cultural and/or religious values, specify the details as provided by the

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[23] Pascale, K. 2013 Goal Directed Care Planning Toolkit: practical strategies to support effective goal setting and care planning with HACC Clients, Kate Pascal & Associates on behalf of EMR HACC Alliance

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Item	Level	Guidance
that are important to know or would affect services being provided?		client. It is important to be as accurate as possible when documenting what the client states about their cultural and/or religious values and beliefs important to them. It is important for an assessor to be sensitive to the client's cultural beliefs and practices and to convey respect for the client's cultural values through the manner in which they communicate. The following prompts and/or questions can be used to gather additional information: • So that I might be aware of and respect your cultural beliefs and values could you tell me if you have any special dietary restrictions related to your beliefs related to times during the year when you change your diet in celebration of religious and other ethnic holidays? • Do you use any traditional health remedies to improve your health? • Is there someone, in addition to yourself, with whom you want us to discuss your medical condition? • Are there certain health care procedures and tests which your culture prohibits? • Are there any other cultural considerations I should know about to serve your health needs? Should the client not want to answer the question, record that the client declined to answer. Should you not be able to determine if the client has cultural and/or religious values and beliefs that are important to them, record that it is unknown/unable to be determined.
Does the client have any gender identity or sexual preferences or history of discrimination that is important to know or would affect services being provided?	RAS ACAT	This question asks whether the client has gender identity or sexual preferences or any history of discrimination that may affect services to be provided. LGBTI people rarely want to be solely defined by their sexual orientation, sex or gender identity but for many it is an important part of who they are. Some LGBTI people are, or have been, very involved and visible in LGBTI communities and will happily identify and socialise with these communities. Others will have minimal contact with groups of LGBTI people. It is important to consider the needs of LGBTI people as distinct individuals and to take into account the diversity within the groups to which they belong. Each of the LGBTI communities may have its own needs, as do the individual people in these groups. For example, some LGBTI people will want to be able to move through the aged care system without disclosing their sexual orientation, sex or gender identity. Others will strongly wish to

Item	Level	Guidance
		disclose and have their identity recognised and embraced. Others may not have any choice about disclosing – which can often be the case for transgender and intersex people[24].
		It is important for those assessing for aged care services to consider the impact of the historical discrimination faced by older LGBTI people and its effect on LGBTI people using aged care services. While legislative reforms have gone a long way to promoting equality, many LGBTI people hide their sexual orientation, sex or gender identity on a daily basis because they continue to fear discrimination. The experience of discrimination has a detrimental impact on the health and wellbeing of LGBTI people. There is now clear evidence that the more discrimination an LGBTI person encounters, the poorer their health and wellbeing.
		Should the client have gender identity or sexual preferences or history of discrimination that is important to know or would affect services being provided, specify the details as provided by the client. This may include specific information relevant to previous experiences with service provision and the client's fears.
		Should the client not want to answer the question, record that the client declined to answer. Should you not be able to determine if the client has cultural and/or religious values and beliefs that are important to them, record that it is unknown/unable to be determined.
Does the client have a history of childhood experiences (e.g. spending time in institutions, foster care or out of home care) that are important to know or would	RAS ACAT	This question asks whether a client has experienced a history of spending time in institutions, foster care or out of home care that would affect services being provided.
		In the 20th century, more than 5,000,000 children were denied their childhood in institutions and out of home care around Australia. They were often taken from their families, frequently without permission and life was hard for them. Many of those who spent time in institutions or out of home care as children were deprived of love and a sense of belonging. Most were denied family support and contact, and experienced separation, loss and abandonment. They were often lonely, beaten, abused and exploited. Many were denied an identity and lost their culture or were taught to fear and hate their own cultural heritage. They learned shame, anger and low self-esteem.

[24] Australian Government: Department of Health and Ageing (2012) National Lesbian, Gay, bisexual, Transgender and intersex (LGBTI) Ageing and Aged Care Strategy.

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affect services being provided?		Working with members of institutional, foster care or out of home care groups requires an understanding of and sympathy for the mistreatment experienced during childhood. Through no fault of their own they are burdened with memories which create fear and anxiety. However, if assessors can recognise and understand the triggers, they can help to make their time in aged care more positive and engaging.
		Should the client have experienced a history of spending time in institutions, foster care or out of home care, specify information that the assessor or service provider may require that has been unable to be recorded elsewhere in the screening.
		Should the client not want to answer the question, record that the client declined to answer. Should you not be able to determine if the client has cultural and/or religious values and beliefs that are important to them, record that it is unknown/unable to be determined.

20.4.3 Goals and recommendations

This section refers to the agreed actions or solutions and strategies that are identified in collaboration with the client. It should clearly outline the steps that will be undertaken to support the client achieve their goals. Many people can only take on so much change and intervention in their lives at any one point and it is therefore important not to set the client up for failure. Use your professional judgement to stage interventions or the introduction of new services, starting with the person's highest priority, and/or the agreed highest risk area. Actively engaging the client in identifying solutions and strategies allows you to work together and encourages them to think outside the square, recognising that there is a range of ways to achieve their goals.

Before you start exploring options with the client, the following prompts and/or questions can be used to facilitate the agreed actions:
- What do we have? (e.g. skills, resources, assets, support)
- What do we want to achieve?
- Do not limit the solutions. Look at how you can engage other services, engage informal supports and build on the client's existing strengths and resources.

Talk with the client about how you could implement these options, who should be involved and what supports are available to assist them.

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An assessor should be aware of what services are available within their area. These may include:

- Information on specific clinics or services such as falls or memory clinics, hearing or vision loss service
- Information on disability/disease specific support networks
- Information on culturally specific groups
- Information on carer support groups
- information on community health services such as chronic diseases self-management programs information on social and recreational groups such as seniors groups, U3A, libraries, leisure centres, interest based groups, volunteering
- Information on a specialist provider e.g. occupational therapist for equipment (e.g. shower chair/rails or a home modification such as removal of a high shower hob/door threshold that may enable independent showering/mobility).

Item	Level	Guidance
Area of concern	RAS ACAT	This question asks the client their area of concern – what they would like to improve. It should be short and simple and does not need to include every detail. It should capture key information about their life, interests, abilities and challenges; it is not just a list of all their issues or problems. Ask the client to prioritise their concerns in order of priority. One or more goals can be associated with an area of concern.
Goal	RAS ACAT	This question asks the client what they would like to achieve and should describe their agreed goal. Goal setting provides you with a clear focus about the way you will work with the client. A client's goal shows you the destination, and you can work together to design the roadmap that you will use to get there. Evidence demonstrates that setting goals that align with the client's values and priorities, encourages the client to take responsibility and commit to making the changes necessary to improve their health and wellbeing. Evidence also shows that the assessment process alone is insufficient to improve outcomes. It has to be followed by goals, strategies and solutions to address the issues identified. Goal development should be seen as the interface between the assessment and support planning. Throughout the assessment it is likely that the person will have referred to various goals but they are not seen as or called 'goals'. This provides a focal point for coordinating care between organisations and ensuring there is an integrated approach.

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Item	Level	Guidance
		Typical goals that are not specific and where an assessor could investigate further include: "I want to remain at home" • What do you need to be able to do to stay at home? It could be that the steps required are to improve their walking and balance; or that the client needs to be able to shower independently. • What it is about being at home that is important to you? This can help clarify what the client needs to do personally to stay at home, i.e. they have a dog/cat to look after or love their garden. "I want to get to the local shops/church/social club/work place" • Ask what they need to be able to do to get to the local shops. It could be that they need to improve their walking and balance; need to learn to use a walking aid; look at purchasing a scooter. "I want to stay independent" • Ask what they think they need to be able to do to remain independent (e.g. it may be they need to be able to feed their animals) To achieve any goal there may be a series of steps to underpin the goal. For example, if the goal is to go to the local shops, depending on the person's circumstances the smaller steps may include needing to able to dress themselves; walk to the front door or down the front path; get in and out of a car; get up/down steps; walk 500 metres; balance a cup of coffee; be continent; get on and off a chair; learn to take medications at the right time and so forth. Where a client has limited insight, has difficulties making decisions (e.g. due to Dementia or a cognitive impairment), mental health concerns, communication difficulties (e.g. clients who are non-verbal), limited or no English speaking and those from Culturally And Linguistically Diverse (CALD) backgrounds, a terminal condition and/or is receiving palliative care and/or limited motivation or is resistant to care, assessors need to ensure that

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		they maintain an empowering, strengths-based approach that values the individual needs and preferences of the client.[25] The assessor is to record the client's goal, and the client's motivation to achieve the goal on a scale from 1 (not motivated) to 10 (extremely motivated). This is a judgement of the client, not of the assessor. By understanding the reasons why a client may not want to change certain elements of their day to day living, what they might value as important we are more likely to motivate them to take the first steps to changing. Rating the problem is important so that the client can see changes over time and feel motivated to keep trying. In developing the support plan with the client, the client's goal should be set to 'in progress'. When undertaking a review or new assessment, the assessor should review the client's progress towards achieving their goals and update the goal status. Options include in progress, achieved or no longer relevant.
Add a general recommendation	RAS ACAT	General recommendations are a type of support that is non-Commonwealth funded and will generally be actioned by a client, or in some instances by an assessor. Recommendations may include that the client sees a health practitioner for a particular concern, that they join a local support group, or it may be an activity that the client identifies they wish to undertake. A general recommendation can be associated to one or more of the client's goals.
Add a service recommendation	RAS ACAT	Service recommendations are for adding recommendations for services to a client's Support Plan, e.g. CHSP services. An assessor is to identify: • The relevant service type and (where required) service sub-type • The priority to be associated with the referral to the service type. The assessor should make a judgement on whether the priority rating provided as part of Assessment Outcomes is appropriate or should be

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[25] GDCP

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Item	Level	Guidance
		changed.
		• Recommend a start date for when services should be started. For example, to start when the client's carer is leaving to go on holidays.
		• Recommend a review date for the service provider to review the delivery of services in line with the client's goals. For example, the client should have met some or all of their goal in six weeks' time and a review should occur to see whether current levels of service provision should reduce or cease.
		• Recommend an end date for service provision. For example, the client's carer will be returning and therefore services should no longer be required.
		• Whether there is an action to be taken by the assessor or client
		• Whether the service recommendation is associated to one or more of the client's goals.
Add recommended living arrangements	ACAT	Following a comprehensive assessment and after discussing the goals with the client and/or their representative, the most appropriate long-term care should be identified from the following list of accommodation settings. Include comments where relevant to provide additional information regarding the most appropriate long term care needs for the client.
		Private residence: Includes private residences such as houses, flats, units, caravans, mobile homes, boats, marinas.
		Independent living within a retirement village: Includes living in self-care independent-living units within a retirement village irrespective of the type of tenure held over the residence. Living in a retirement village with the provision of care services should be coded to Supported community accommodation.
		Supported community accommodation: Includes community living settings or accommodation facilities in which clients are provided with support in some way by staff or volunteers. This category includes domestic-scale living facilities (such as group homes for people with disabilities, cluster apartments where a support worker lives on site, community residential apartments, congregate care arrangements, etc.) which may or may not have 24-hour supervision and care; larger-scale supported accommodation facilities providing 24 hour supervision and support services by rostered care workers (such as hostels for people with disabilities and

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		government-regulated Supported Residential Services/Facilities (Victoria and South Australia only); and Aged Care Flexible service pilots.
		Residential aged care service: Includes permanent residents of residential aged care services (formerly nursing homes and aged care hostels) and multi-purpose services or multi-purpose centres.
		Hospital: Refers to recommendations for long-term care in a hospital setting.
		Other institutional care: Includes other institutional settings which provide care and accommodation services such as hospices and long-stay residential psychiatric institutions.
		Other community: Includes all other types of community settings.
Add a care type for delegate decision	ACAT	Care type recommendations relate to care types under the Act which require approval by an ACAT Delegate. An assessor is to identify: • The care type that applies • The reason for the recommendation or any relevant comments for the Delegate. Where an ACAT wishes to recommend multiple care types, they must enter each care type individually.
Other recommendations	RAS ACAT	These recommendations may be generated as part of the Assessment Outcomes. They are for the assessor to review with the client and add or remove as necessary.
Recommend the client be referred for comprehensive assessment	RAS	From home support assessment, a client may be recommended to have a comprehensive assessment. This may be based on a recommendation generated as part of the Assessment Outcomes. An assessor is to identify: • The reason that comprehensive assessment is required • The priority to be associated with the referral to the ACAT. The assessor should make a judgement on whether the priority rating provided as part of Assessment Outcomes is appropriate or should be

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Item	Level	Guidance
		changed.
		• That client consent has been provided for a referral to be sent to an ACAT.

20.4.4 Decisions

Item	Level	Guidance
Add a care type for delegate decision	ACAT	This displays the care type recommendations that have been added as part of Goals and Recommendations. An ACAT is also able to add new care type recommendations.

20.4.5 Manage services and referrals

Item	Level	Guidance
Services not yet in place	RAS ACAT	This displays the service recommendations that have been added as part of Goals and Recommendations. An assessor is also able to add new service recommendations. Per service recommendation, an assessor is able to: • Find a service provider. An assessor can find services based on the client's address, near a suburb or postcode or by provider name • Manually arrange a code. An assessor generates a referral code to provide to the client so that they can visit providers prior to selecting their preferred provider • Remove the service recommendation. An assessor is also able to generate a referral code letter to provide the client with.

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Services pending	RAS ACAT	An assessor is able to view where a referral to service is pending. This includes information on the service type and sub-type (where applicable); the priority of the referral; the start date, recommended review date and recommended end date for the service; the goal(s) the service is associated with (if applicable); and the status of the referral.
Services in place	RAS ACAT	An assessor is able to view services that the client has in place. This includes the date the provider accepted the referral; the provider of the service and their contact information; the start date, recommended review date and recommended end date for the service; and the goal(s) the service is associated with (if applicable).

20.4.6 Associated people

Item	Level	Guidance
People associated with support plan	RAS ACAT	This question asks who is involved in the support plan. It is often appropriate to involve not only the client, but their care coordinator, carer, GP, other professionals and/or organisations in the development of the support plan, particularly when the client's needs are more complex. Identifying and including who is involved in the support plan assists the client to achieve their goals and address their identified needs. Including the people and/or organisations who are involved in the support plan: • Assists the client in setting and achieving goals and enables these to be made known to all involved in the client's care and service provision • Encourages the client to be actively involved • Manages long-term service delivery in a clear, concise way • Provides an essential checklist to ensure continuity of service delivery • Encourages a team approach • Increases client and carer awareness of support services available, and how and when to access them • Facilitates monitoring of the client's health and social wellbeing. An assessor can associate such people with the support plan. This can be completed by recording their name,

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Item	Level	Guidance
		relationship to client and contact details. It also requires the assessor to identify whether the person has been involved in the support planning process, and whether they have been provided with a copy of the support plan.

20.4.7 Review

An assessor may set a review date of the support plan at the time of the assessment. A review may also be requested by a client or a service provider. It may be completed over-the-phone with the client.

A review by an assessor will look at the following aspects:

- The reason a review has been requested and its impact on the client's existing assessment information and support plan
- The appropriateness of the services in meeting the client's goals
- Any new goals for the client, and associated referral(s) for service
- The appropriateness of setting another review date or an end date for service delivery.

The outcome of a review by an assessor may be no change or an increase or decrease in services. Where the results of a review by an assessor affects the current delivery of services to the client, the assessor is to contact the service provider and discuss the results of the review and the recommendations as it relates to the delivery of the service.

Where changes to the support plan no longer reflect the outcomes on the assessment, a new assessment is to be undertaken.

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21 Supplementary Assessment Tools

Good assessment thinking and practice is not static or limited to the use of a single assessment tool. Assessor judgement plays a major role when to administer assessment tools. Where there are screening questions which identify a potential problem e.g. loss of weight over a short period of time, oral health issues, an assessment tool could be used to refine and find out further information related to the problem.

A number of standardised assessment tools have been provided to allow assessors to identify need and assist the client to set goals. These goals will assist in the development of the client focused support plan. These tools are part of the evidence which can be provided to the delegate to make a decision on care types under *the Aged Care Act 1997*.

When using assessment tools, assessors should consider:

- Tools should be valid, reliable, and culturally sensitive so as not to unfairly discriminate against people on grounds of age, gender, race, disability and other factors
- The necessity for relevant training in the use of the tool to ensure valid and reliable results
- Assessment Tools must not be adapted or modified. Changes are potentially infringements of the intellectual property rights and most importantly, mean that the tool is no longer standardised
- The order and use of tools should be carefully considered. Difficult questions at the beginning of the assessment may not be received well and may impact on the remainder of the assessment
- Assessors must feel comfortable in dealing with responses arising from the use of tools, for example, "Do you sometimes feel that your situation is hopeless?" (GDS – 15)
- A literal and narrow interpretation of scales should be avoided.

Where applicable, attach a copy of the assessment tool(s) and its outcomes to the client's record.

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Item	Level	Guidance
Abbey Pain Scale[26]	ACAT	Multidimensional pain assessment scales have been developed specifically for use in older people. The Abbey Pain Scale is suitable for residents with dementia who cannot verbalise their pain, and may also be useful for cognitively intact residents who aren't willing or cannot talk about their pain. The Resident's Verbal Brief Pain Inventory is suitable for residents able to verbalise their pain. The same scale/s selected for the individual resident should be for reassessment.
		The Abbey Pain Scale is best used as part of an overall pain management plan.
		Objective: The Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.
		The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.
		Recent work by the Australian Pain Society recommends that the Abbey Pain Scale be used as a movement-based assessment. The staff recording the scale should therefore observe the patient while they are being moved, e.g. during pressure area care, while showering etc.
		Complete the scale immediately following the procedure and record the results in the patient's notes. Include the time of completion of the scale, the score, staff member's signature and action (if any) taken in response to results of the assessment, e.g. pain medication or other therapies.
		A second evaluation should be conducted one hour after any intervention taken in response to the first assessment, to determine the effectiveness of any pain-relieving intervention.
		If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as

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[26] http://www.racgp.org.au/your-practice/guidelines/silverbook/tools/geriatric-depression-scale/

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		appropriate. Complete the pain scale hourly, until the patient appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken. If pain/distress persists, undertake a comprehensive assessment of all facets of patient's care and monitor closely over a 24-hour period, including any further interventions undertaken. If there is no improvement during that time, notify the medical practitioner of the pain scores and the action/s taken.[27]
AUDIT Scale	ACAT	There are many forms of excessive drinking that cause substantial risk or harm to the individual. They include high level drinking each day, repeated episodes of drinking to intoxication, drinking that is actually causing physical or mental harm, and drinking that has resulted in the person becoming dependent or addicted to alcohol. Excessive drinking causes illness and distress to the drinker and his or her family and friends. It is a major cause of breakdown in relationships, trauma and hospitalization[28].
		The AUDIT was developed by the World Health Organization as a measure of alcohol consumption, alcohol dependence, and alcohol related problems (Saunders et al., 1993). It has reported that the AUDIT was better than other related measures at being able to differentiate between problem and non-problem drinkers (Kelly et al., 2002). The AUDIT has 10 items, with both interviewer administered and self-report versions available.
		Where the client's AUDIT score is between 8 and 15, a recommendation will display in the Support Plan recommending that the client is provided advice on reduction of hazardous drinking. It is for the assessor to provide this recommendation or not to the client.
		Where the client's AUDIT score is between 16 and 19, a recommendation will display in the Support Plan recommending that the client is provided with brief counselling and continued monitoring. It is for the assessor to provide this recommendation or not to the client.

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[27]

http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=11&sqi=2&ved=0CEgQFjAK&url=http%3A%2F%2Fwww.bcf.nhs.uk%2Fdocs%2F19354_8582738196.pdf&ei=iCdAVJXWM6W2mAWI_oCoCg&usg=AFQjCNG3ubhQ3zlPUZixWtOQVOspUsOPzw

[28] http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

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		Where the client's AUDIT score is 20 and above, a recommendation will display in the Support Plan recommending that the client undergoes diagnostic evaluation for alcohol dependence. It is for the assessor to provide this recommendation or not to the client.
Barthel Index of Activities of Daily Living	RAS ACAT	The Barthel Index is a clinical rating scale and contains 10 Activities of Daily Living items looking at personal care or self-care and mobility (Mahoney and Barthel, 1965). The items cover feeding, mobility from bed to wheelchair, personal toilet (washing, getting on and off toilet), bathing, walking (propel wheelchair) on a level surface, going up and down stairs, dressing, bowel and bladder incontinence. The modification of the 10 item version uses a 20 point scoring system (Collin et al., 1988). Scores range from 0 to 1, 2 or 3 for each activity with a score less than 4 indicating total dependence and a score less than 12 indicating dependence (Gupta, 2008). This tool has been widely used in hospital settings, with older people and with frail patients and those with chronic and disabling conditions (Gupta, 2008). The Barthel ADL Index is simple to use (2-5 minutes for a trained observer) and a popular measure of ADL functioning (self-care and mobility), especially for elderly people with neurological conditions. **Guidelines for completing the Barthel ADL Index** This is the most widely used measure of basic personal activities. It relates well to many factors such as level of nursing care or personal support needed, and no measure performs any better despite its apparent simplicity and crude levels. Data can be collected in whatever way seems appropriate (asking, observing, by post etc.); common sense should be used at all times. 1. The index should be used as a record of what a patient does, not as a record of what they could or should do. 2. The main aim is to establish the degree of independence from any help, physical or verbal, however minor and for whatever reason.

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Item	Level	Guidance
		3. The need for supervision, prompting, or any external support renders the patient *not* independent. 4. A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses are the usual sources but direct observation and common sense are also important. Direct testing is not needed. 5. Usually the patient's performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant. 6. Middle categories imply that the patient supplies over 50% of the effort. 7. The use of aids to be independent is allowed, provided the patient uses them independently. 8. Lack of safety only causes dependence if the patient actually has an accident needing help.
Brief Pain Inventory[29]	ACAT	**Purpose:** To assess the severity of pain and the impact of pain on daily functions **Population:** Patients with pain from chronic diseases or conditions such as cancer, osteoarthritis and low back pain, or with pain from acute conditions such as postoperative pain **Assessment areas:** Severity of pain, impact of pain on daily function, location of pain, pain medications and amount of pain relief in the past 24 hours or the past week **Responsiveness:** Responds to both behavioural and pharmacological pain interventions **Method:** Self-report or interview **Time required:** Five minutes (short form), 10 minutes (long form) **Scoring:** No scoring algorithm, but "worst pain" or the arithmetic mean of the four severity items can be used as measures of pain severity; the arithmetic mean of the seven interference items can be used as a measure of

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[29] http://www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
		pain interference.
Geriatric Depression Scale (GDS) – Short Form	ACAT	The Geriatric Depression Scale (GDS) (15 point version) is a depression assessment tool specifically designed for older people. This short form of the GDS was developed in 1986 by Sheikh and Yesavage. There are four 'trigger' questions that often alert a practitioner to complete the 15-item GDS. The 15 score item should be completed whenever possible. The GDS can be filled out by the client or administered by an interviewer. It comprises 15 questions about how the client has felt over the past week. Questions require yes/no answers.
		While this tool is commonly used with people who have dementia, most studies investigating the GDS have excluded participants with dementia. Alternatively, the Cornell Scale for Depression (Alexopoulos, et al., 1988) has been recommended for use with people in residential care (Sansoni et al, 2007), however training is required to use it.
		Higher scores indicate more depressive symptoms are present. A score of 6 or more suggests the presence of depression which indicates further medical/psychiatric assessment is required. A score of 11 or more usually always indicates depression with higher scores indicating more severe depression.
		It has been reported that a number of items in the GDS contain Western value judgments of optimism, happiness, stoicism and looking forward (Sansoni et al, 2007). These include:
		• Do you prefer to stay at home, rather than going out and doing new things? • Do you think it is wonderful to be alive now? • Do you worry a lot about the past? • Do you think that most people are better off than you are?
		These items may not be appropriate at all times for all cultural groups. Also, it is important to note that clients from some cultural groups may not disclose such information[30].

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[30] (TIP 6 Fact Sheet-ACAP victoria)

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)	ACAT	The IQCODE is widely used as a screening test for dementia, particularly where the subject is unable to undergo direct cognitive testing or for screening in populations with low levels of education and literacy[31].
		The IQCODE should be used to supplement the other patient administered tools (e.g. the SMMSE; to increase sensitivity and specificity (Flicker et al, 1997; Flicker, 2010), or used in situations where the patient is unable to complete the assessment[32].
		The IQCODE takes approximately 10-15 minutes to administer and is filled out by an informant. It can be used for people with lower levels of education and for those who are illiterate.
		The cut-off scores are based on the total score divided by the number of questions (average item score range 1-5). Higher scores indicate greater impairment. A score below 3.00 indicates improvement, 3.00 indicates no change, 3.01 – 3.50 indicates slight decline; 3.51- 4.00 indicates moderate decline; and 4.01 – 5.00 indicates severe decline.
		The review shows that the questionnaire has high reliability and measures a single general factor of cognitive decline. It validly reflects past cognitive decline, performs at least as well at screening as conventional cognitive screening tests, predicts incident dementia, and correlates with a wide range of cognitive tests. A particular strength is that the IQCODE is relatively unaffected by education and pre-morbid ability or by proficiency in the culture's dominant language. The disadvantage of the IQCODE is that it is affected by informant characteristics such as depression and anxiety and the quality of the relationship between the informant and the subject.
		Conclusions: Because the IQCODE provides information complementary to brief cognitive tests, harnessing them together can improve screening accuracy.

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[31] International Psycho-geriatrics (2004) The informant Questionnaire on cognitive Decline in the elderly (IQcode): a review.Vol 16, Issue 3.

[32] Flicker, L. (2010). Screening and assessment instruments for the detection and measurement of cognitive impairment. In D. Ames, A. Burns, & J. O'Brien (Eds.). Dementia (4th ed, pp. 55-60). London; Hodder Arnold.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
K10	RAS ACAT	The K10 is recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. It is a self-report measure to identify need for treatment. The 10 item scale has five response categories and the score is the sum of those responses: - None of the time scores 1 - A little of the time scores 2 - Some of the time scores 3 - Most of the time scores 4 - All of the time scores 5 Questions 3 and 6 are not asked if the preceding question was 'none of the time' in which case questions 3 and 6 would automatically receive a score of one. Total scores range from 10 (no distress) to 50 (severe distress). **People who score 0-15** have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the CIDI, and a remote chance of reporting a suicidal attempt in their lifetime. **People who score 16-30** have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder and 1% chance (three times the population risk) of ever having made a suicide attempt. **People who score 30-50** have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and 6% chance (20 times the population risk) of ever having made a suicide attempt. The first group comprise 78% of the population and are told their score is low and that they probably do not need the self-help information. The second group, 20% of the population, are encouraged to use the information and self-help techniques. The third group, 2% of the population, are strongly encouraged to seek medical help. Where the client's K10 score is over 17, a recommendation will display in the Support Plan recommending that the client be referred to their GP for a mental health assessment. It is for the assessor to provide this

Item	Level	Guidance
		recommendation or not to the client.
Kimberley Indigenous Cognitive Assessment (KICA) – COG	ACAT	The Kimberley Indigenous Cognitive Assessment (KICA) is the only validated dementia assessment tool for older Indigenous Australians. It is recommended for use with rural and remote Indigenous Australians aged 45 years and above for whom other dementia assessments are not suitable.
		The KICA-Cog section has been validated with Indigenous Australians aged 45 years and above from the Kimberley and Northern Territory. A short version (KICA-Screen) has been validated in Far North Queensland.
		The questions in the KICA survey provide the first specific instrument for assessing cognitive decline in older Indigenous Australians.
		The Kimberley Indigenous Cognitive Assessment (KICA) was developed by Dr Dina LoGiudice (geriatrician, National Ageing Research Institute) and Ms Kate Smith (occupational therapist, Kimberley Aged and Community Services) in collaboration with the University of Western Australia in 2004-2005, using a Healthy Ageing Grant from the National Health and Medical Research Council. A second phase of the project addressed the prevalence of aged care issues including cognitive impairment in older Indigenous people of the Kimberley.
		The KICA was developed in response to the need for a validated cognitive screening tool for older Indigenous Australians living in rural and remote areas. The KICA was adapted from cognitive assessment tools in current use and refined after extensive consultation with community members of the Kimberley, including members of the Kimberley Aboriginal Medical Service Council (KAMSC), Kimberley Aged and Community Services (KACS), Kimberley Interpreting Service (KIS), psychologists and linguists. The KICA was translated into Walmajarri, a commonly used language originating from a desert area of the Kimberley. The KICA was validated with older Indigenous people of the Kimberley to assess cognitive status.
Kimberley Indigenous Cognitive Assessment (KICA)-ADL	RAS ACAT	The Kimberley Indigenous Cognitive Assessment (KICA) was developed in response to the need for a validated cognitive screening tool for older Indigenous Australians living in rural and remote areas. The KICA should only be used with Indigenous clients from rural or remote areas. The KICA-ADL is the daily living skills (ADL and IADL) section of the tool (Stevenson et al., 2008; Smith et al., 2009). It has 10 items, but no score is generated. It requires three minutes for an interviewer to administer the KICA-ADL to an informant (using an interpreter if required). It can be used to assist health and community workers to determine the appropriate level of support services required by the older person.

Client Record	Event Details	Reason for Contact	Current Support	Carer	Family, Community Engagement and Support	Health	Function	Cognitive	Psychosocial	Psychological	Home & Personal Safety	Complexity Indicators	Summary of Needs	Assessment Outcomes	Action Plan	Support Plan	Assessment Tools

Item	Level	Guidance
Mini-Nutritional Assessment	RAS ACAT	There is a high prevalence of overweight elderly people but the main concern in the elderly is the decline in food intake and the loss of the motivation to eat. This suggests the presence of problems associated with the regulation of energy balance and the control of food intake. The reduction in the energy intake causing body weight loss may be caused by social or physiological factors, or a combination of both. Poverty, loneliness, and social isolation are the predominant social factors that contribute to decreased food intake in the elderly. Mental health issues such as Depression can be associated with loss or deterioration of social networks, and this can be a factor with a loss of appetite. Physical factors such as ill-fitting dentures or age-associated changes in taste and smell may influence food choice and limit the type and quantity of food eaten in older people. Common medical conditions in the elderly such as gastrointestinal disease, malabsorption syndromes, acute and chronic infections, and hypermetabolism often cause anorexia, micronutrient deficiencies, and increased energy and protein requirements. The elderly are major users of prescription medications, a number of which can cause malabsorption of nutrients, gastrointestinal symptoms, and loss of appetite. Research suggests that, although age-related reduction in energy intake is largely a physiologic effect of healthy ageing, it may predispose to the harmful anorectic effects of psychological, social, and physical problems that become increasingly frequent with ageing. Poor nutritional status has been implicated in the development and progression of chronic diseases commonly affecting the elderly. Protein-energy malnutrition is associated with impaired muscle function, decreased bone mass, immune dysfunction, anaemia, reduced cognitive function, poor wound healing, delayed recovery from surgery, and ultimately increased morbidity and mortality. An increasing understanding of the factors that contribute to poor nutrition in the elderly should enable the development of appropriate preventive and treatment strategies and improve the health of older people[33]. A dietary assessment includes information about the patient's intake of food and liquids during a 'usual day', preferably the previous 24 hours. This includes quantitative and qualitative questions regarding breakfast, lunch,

[33]Donini.L.M., Savina, C. & Cannella.C. (2003). Eating habits and appetite control in the elderly: the anorexia of aging. International Psychogeriatric. (1) 73-87.

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Item	Level	Guidance
		dinner, snacks, and vitamin/mineral supplements. Such information is generalizable since there is typically little variability in intake patterns from day to day, especially in the elderly. The practitioner can then evaluate the patient's diet in light of their medical history, medications and supplements. They can use the encounter to make specific dietary suggestions based on standardized guidelines such as the food pyramid. The areas of particular concern in this population include adequate protein intake, five or more servings of fruits and vegetables, three servings of dairy foods for adequate calcium intake, and appropriate quantity of food. In the reference section on Nutrition in the Elderly you will find a copy of the food pyramid and a 24-hour intake sample sheet
OARS-IADL	RAS ACAT	This tool is "an advance on the Lawton and Brody IADL scale with improved psychometric properties and less reliance on gender role stereotypes; and it has been adapted for use in primary and community care settings in Australia" (Green et al., 2006; Sansoni et al., 2008). It is recommended for the assessment of care needs of older people living in the community (Pearson, 2004) and takes approximately five minutes to administer (Burns et al., 2004). The OARS-IADL scale (Fillenbaum and Smyer, 1981) is based on direct or proxy observation and contains seven items: • Telephone; • Transportation; • Shopping; • Meal preparation; • Housework; • Medication management; and • Money management. Each item has a core three point response format: without help (2), with help (1) or unable (0). The score range is from 0 (dependent) to 14 (independent). Higher total scores reflect greater independence (Eagar et al., 2001).
Oral Health Assessment Tool (OHAT)	ACAT	OHAT was a component of the Best Practice Oral Health Model for Australian Residential Care study. The OHAT provided institutional carers with a simple, eight category screening tool to assess residents' oral health, including those with dementia. Within the increasing older Australian population, there is a significant group at very high risk for developing complex oral diseases and dental problems—institutionalized older adults in

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Item	Level	Guidance
		Australian residential care facilities. There is abundant general health, functional, cognitive, social and financial problems among this group of high-risk older adults. These problems are associated not only with their development of oral diseases, such as dental caries, but with the many barriers they encounter to accessing adequate dental care. In the Australian residential aged care community, it is the carers who play an essential role in the delivery of oral hygiene care and the maintenance of residents' oral health. Better integration of carers into oral hygiene care delivery and the timely identification of oral health problems are essential in improving residents' access to and equity in oral health[34].
Residents Verbal Pain Inventory	ACAT	The Resident's Verbal Brief Pain Inventory (RVBPI) is a modification of the BPI for communicative clients in residential care facilities (Gouke et al., 2005). The RVBPI uses verbal descriptors instead of a numeric rating scale. It may also be appropriate to use this instrument in community care settings when a moderate degree of cognitive impairment is suspected.
Revised Faecal Incontinence Scale	ACAT	People respond to the Revised Faecal Incontinence Scale (RFIS) questions by selecting one particular response option from the set of standard response options for each question. These response options can then be scored by using the numbers presented in brackets to the right of each response option. The RFIS total score is then calculated by adding up a person's score for each question. Adding the score for each of the five questions results in a possible score range of 0 - 20. At this stage, there is no data about grouping people into valid clinical categories representing different severity levels of incontinence (e.g. mild, moderate, or severe); however, further clinical research is being undertaken to provide this information. Finally, users should check that each question has a response option selected in order to avoid any missing data. This is because missing data cannot be adjusted for in short scales like the RFIS[35].

[34] Australian government-Australian Institute of Health and Welfare, http://www.aihw.gov.au/publication-detail/?id=6442468243&tab=2

[35] http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-continence-patient-satisfaction-tools-instructions-report.htm~ageing-continence-patient-satisfaction-tools-revised-faecal.htm

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Item	Level	Guidance
Revised Urinary Incontinence Scale	ACAT	If there are indicators within the home support questions that indicates further assessment is necessary, use the Revised Urinary Incontinence Scale (RUIS) (University of Wollongong's Centre for Health Services Development, 2010) and the Revised Faecal Incontinence Scale (RFIS) (University of Wollongong's Centre for Health Services Development, 2010) as follow up tools. A National Continence Management Strategy project *Refining Continence Measurement Tools* (Sansoni et al., 2006) was undertaken to revise and develop some short incontinence assessment tools (5 items). From the analysis of the urinary and faecal incontinence items and scales included in the 2004 South Australian Health Omnibus Survey (SAHOS) community survey, this study developed the RUIS and RFIS (University of Wollongong's Centre for Health Services Development, 2010). These scales improved the assessment of incontinence when compared with the original measures (Sansoni et al., 2006). When completing the RUIS, respondents select one particular response option from the set of standard response options for each of the five questions. These response options can then be scored by using the numbers presented in brackets to the right of each response option. The RUIS total score is then calculated by adding up a person's score for each question, resulting in a possible score range of 0-16[36] When completing the RFIS, respondents select one particular response option from the set of standard response options for each of the five questions. These response options can then be scored by using the numbers presented in brackets to the right of each response option. The RFIS total score is then calculated by adding up a person's score for each question, resulting in a possible score range of 0-20 (University of Wollongong's Centre for Health Services Development, 2010). (ACAP Toolkit)

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[36] (University of Wollongong, Centre for Health Service Development, 2010.

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Item	Level	Guidance
		This scale includes both questions from the Incontinence Severity Index (ISI; Sandvik, Seim, Vanvik, and Hunskaar, 2000) and therefore an ISI score can also be calculated. This is done by multiplying the scores from questions 4 and 5, resulting in a score range from 0 to 12, where a 0 score represents no incontinence. Scores from 1 to 12 are grouped into the following four severity levels: 1 - 2 = slight, 3 - 6 = moderate, 8 - 9 = severe, 12 = very severe
		Finally, users should check that each question has a response option selected in order to avoid any missing data. This is because missing data cannot be adjusted for in short scales like the RUIS[37].
Rowland Universal Dementia Assessment Scale	ACAT	The Rowland Universal Dementia Assessment Scale (RUDAS) is a short cognitive screening instrument designed to minimize the effects of cultural learning and language diversity on the assessment of baseline cognitive performance.
		General Guidelines for the Administration:
		Test Anxiety: Make sure the test taker is as relaxed as possible, as test anxiety can interfere with performance on cognitive tests.
		Hearing: Conduct the RUDAS in a quiet area and make sure the test taker can hear clearly. It is important to identify at the beginning of the assessment if the test taker has impaired hearing and accommodate for this as much as possible by speaking slowly and clearly. Encourage the test taker to wear any hearing aids. Be careful not to speak too loudly as this may result in distortion. (There is a large print version of the RUDAS for test takers with severe hearing impairment).
		Vision: Ensure that the test taker is using reading glasses where necessary and that there is sufficient light in the room.

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[37] http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-continence-patient-satisfaction-tools-instructions-report.htm~ageing-continence-patient-satisfaction-tools-revised-RFIS.htm

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Item	Level	Guidance
		Seating: Sit opposite the test taker. This is important for communication reasons as well as for controlling the difficulty of some items on the RUDAS. Do not sit behind a desk, as this will inhibit the giving of instructions for some items on the RUDAS and may also be intimidating for the test taker.
		Recording Responses: It is important to record the test taker's full response to each item.
		Physical Disability: For test takers who have a physical disability (e.g. vision, hearing, hemiparesis, amputation, stroke, aphasia) which may affect their ability to perform certain items on the RUDAS, it is important to complete the RUDAS as fully as possible but to interpret any total score less than 22 with caution (further research is necessary to assess validity of the RUDAS in this sub-group of patients).[38]
		Where the client's RUDAS score is 22 or less, a recommendation will display in the Support Plan recommending that the client be referred for cognitive impairment investigation. It is for the assessor to provide this recommendation or not to the client.
South Australian Oral Health Referral Pad	ACAT	The SA OHRP is a useful screening tool (Slade, 2007), it is quick and easy to use and it can be used by any health professional with a minimum of training as contrasted with other tools such as the OHAT (Chalmers et al., 2005) which require an oral examination. All questions are answered yes / no / don't know. People are classified as high priority for referral if they answer 'Yes' to Q.2 and say 'Yes' to any other item dental impact item (e.g. items 1, 3, 4, and 5). People are classified as moderate priority if they answer 'Yes' to Q.2 or any other dental impact item.
		The OHAT (Chalmers et al., 2005) is a simplified oral health rating tool that has been modified from the Brief Oral Health Status Examination (BOHSE). Feedback from initial use by residential care staff indicated the BOHSE was too complicated and it took too long to complete. This simplification was designed to make it more usable by the range of residential care staff (including personal care staff) and for rating patients with dementia.
		The OHAT has eight rating categories (lips, tongue, gums and tissues, saliva, natural teeth, dentures, oral cleanliness and dental pain) and each item is rated from 0 = healthy, 1 = changes (more minor problems) to 2 = unhealthy. It takes approximately 8 minutes to administer (compared to about 9 minutes for the BOHSE) but

[38] Administrative and scoring Guide, NSW Health

| Client Record | Event Details | Reason for Contact | Current Support | Carer | Family, Community Engagement and Support | Health | Function | Cognitive | Psychosocial | Psychological | Home & Personal Safety | Complexity Indicators | Summary of Needs | Assessment Outcomes | Action Plan | Support Plan | Assessment Tools |

Item	Level	Guidance
		staff require training in its use.
		An assessor should only consider using the OHAT in those rural and remote communities where there may be limited accessibility to a dental practitioner. In most urban areas a referral to a dentist is preferred. The OHAT should only be used by assessors that have been trained in its use and this assessment is usually undertaken by a nurse.
Standardised Mini-Mental State Examination	ACAT	The Standardised Mini-Mental State Examination was developed to provide clear unequivocal guidelines for administration and scoring. The SMMSE takes less time to administer and has significantly reduced the variability of the MMSE. The test usually takes about ten minutes to complete and can be used reliably after a short training period by physicians, nurses and other health care professionals. The original MMSE had few instructions for administration and scoring. These were left to the discretion of each rater. Different raters developed their own unique styles and techniques of administration and scoring. This led to wide differences and lowered the reliability of the test. 1. Before the questionnaire is administered, try to get the person to sit down facing you. Assess the person's ability to hear and understand very simple conversation, e.g. *what is your name*? If the person uses hearing or visual aids, provide these before starting. 2. Introduce yourself and try to get the person's confidence. Before you begin, get the person's permission to ask questions, e.g. *would it be all right to ask you some questions about your memory?* This helps to avoid catastrophic reactions. 3. Ask each question a maximum of three times. If the person does not respond, score zero. 4. If the person answers incorrectly, score zero. Accept that answer and do not ask the question again, hint, or provide any physical clues such as head shaking, etc.[39] 5. The following equipment is required to administer the instrument: A watch, a pencil, reverse of

[39] Commonwealth of Australia (2014). Standardised Mini-Mental Examination (SMMSE)- Guidelines for administration and scoring instructions. The independent Hospital Pricing Authority (IHPA)

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Item	Level	Guidance
		the SMMSE score sheet with CLOSE YOUR EYES written in large letters and two five-sided figures intersecting to make a four-sided figure, and a space for the person to write down a sentence. 6. If the person answers '*what did you say?'* do not explain or engage in conversation, merely repeat. Merely repeat the same directions a maximum of three times. 7. If the person interrupts (e.g. queries *'what is this for?'),* just reply: '*I will explain in a few minutes, when we are finished. Now if we could proceed please, we are almost finished'.* The following are examples of disabilities that may exempt people from certain tasks in the SMMSE: **Physical disabilities:** The disability should be permanent. Sometimes people have temporary physical problems that effect SMMSE performance. In these cases, let the problem resolve before testing them. Some physical problems may take months to resolve and it may not be practical to wait. In these cases, carefully document the situation and proceed. Examples of physical disabilities include: amputation, chronic deformity from arthritis, paralysis of limbs, blindness/poor vision even with glasses, permanent hearing loss even with functioning hearing aid. **Language:** Sometimes language difficulties impair a person's ability to perform certain tasks on the SMMSE. If English is not the person's first language, try to score the person in his or her first language. It can be difficult to decide when to exempt a person from certain tasks. One approach is to try as many of the tasks as possible to evaluate the person's performance. If the person seems to understand some questions easily and not others, this is likely due to cognitive impairment. If the person has consistent problems understanding the questions, it is likely due to language difficulties and the score can be adjusted accordingly. If in doubt, get a translator or give the test in his or her native language. Make sure you are not missing a hearing impairment. **Speech:** Some people have severe speech problems, so their scores are out of proportion to their overall level of function. They score lower because they cannot answer within the prescribed time limits. Some may reverse words and may say 'winter' when they mean 'summer'. These deficits unfortunately bias the test against these people. It is important to be consistent and adhere to the rules of administration, observing the time limits and scoring guidelines. Notes can be made of these factors, and performance in non-cognitive tests, like ADL

Item	Level	Guidance
		function, should be assessed.
		Education: Low education or education in a language other than English can affect scores. Generally, these limitations should not exempt a person from some of the SMMSE tasks. Note should be made that these factors may cause lower scores and the final total may not reflect the person's true cognitive function. The person's disability should be clearly noted on the SMMSE score sheet. Items that are affected by this disability should also be clearly noted. The calculation of the adjusted score is done at the bottom of the SMMSE score sheet.
		Further information related to scoring can be found at the following link:
		http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/smmse-lp

Appendix A – Type of accommodation

Private residence—owns/purchasing; private rental; public rental or community housing: Includes private residences of a wide range of dwelling types, such as houses, flats, units, caravans, mobile homes, boats, marinas, etc.

Private residence—Client owns/ is purchasing: Includes private residences which are owned or being purchased by the person.

Private residence—private rental: Includes private residences which are rented on the private rental market at competitive market rates. This includes dwellings rented through real estate agents as well as private landlords who are not part of the person's family.

Private residence—public rental or community housing: Includes private residences secured through State/Territory Housing Authorities (public rental) or through community or cooperative housing groups.

Independent living within a retirement village: Includes persons living in self-care or independent-living units within a retirement village, irrespective of the type of tenure the person holds over the residence. Persons living in a retirement village with the provision of care services should be coded to Supported community accommodation.

Boarding house/rooming house/private hotel: Includes premises known as boarding house, guest house, hostel, hotel, private hotel, rooming house, lodging or similar. The accommodation is not private residential accommodation, having regard to the number of and nature of bedrooms in the premises; or the number of people who are not related to one another living at the premises; or the number and nature of the bathrooms in the premises. The accommodation is available on a daily or other short term basis. Staff are retained by the proprietor or manager of the premises to work in the premises on a daily or other frequent regular basis.

Short-term crisis, emergency or transitional accommodation: Includes temporary or short-term accommodation provided in response to crisis or emergency situations (e.g. night shelters, refuges, hostels for the homeless), or to facilitate a transition between institution-type settings and independent community living (e.g. halfway houses). These settings often provide some form of support services—such as meals, counselling, information or advocacy—but are not intended to function as a permanent or ongoing accommodation option. This should only be used when the person is living in this type of setting at the time of assessment and has no other usual accommodation setting.

Supported community accommodation: Includes community living settings or accommodation facilities in which clients are provided with support in some way by staff or volunteers. This category includes domestic-scale living facilities (such as group homes for people with disabilities, cluster apartments where a support worker lives on site, community residential apartments, congregate care arrangements, etc.) which may or may not have 24-hour supervision and care. It also includes larger-

scale supported accommodation facilities providing 24-hour supervision and support services by rostered care workers (such as hostels for people with disabilities and government-regulated Supported Residential Services/Facilities (Victoria and South Australia only)).

Residential aged care service: Includes permanent residents of residential aged care services (formerly nursing homes and aged care hostels) and multipurpose services or multi-purpose centres.

Hospital: This should only be used when the person is in hospital at the time of assessment and has no other usual accommodation setting or place they would call 'home'.

Other institutional care: Includes other institutional settings which provide care and accommodation services such as hospices and longstay residential psychiatric institutions.

Public place/temporary shelter: Includes public places such as streets and parks, as well as temporary shelters such as bus shelters or camps and accommodation outside legal tenure arrangements, such as squats.

Other community*:* Includes all other types of settings.

Private residence— Family member or related person owns/is purchasing: Includes private residences which are owned or being purchased by another member of the client's household or family (including a non-resident relative).

Indigenous community/settlement: Includes private residences in Indigenous communities or settlements.

Not stated/inadequately described: Should only be used when the person has not provided this information upon request and/or the assessor judgement.

Appendix B – List of health conditions, mental health conditions and disabilities

A

Abdominal aortic aneurysm

Abdominal hernia (except congenital)

Abnormal involuntary movements

Abnormal weight gain

Abnormal weight loss

Abnormalities of gait & mobility

Acquired brain damage—see Injuries

Agitation

AIDS/HIV

Alcoholic dementia–see Dementia

Alcoholic liver disease

Alcoholism

Allergies–respiratory (excl asthma)

Allergies–skin

Alzheimer's disease–see Dementia

Amnesia

Amputation of finger/thumb/hand/arm/shoulder—related to injury or accident

Amputation of the toe/ankle/foot/leg—related to injury or accident

Anaemia

Aneurysms (arterial or aortic)—see also Abdominal aortic aneurysm

Anger

Angina

Anxiety disorders

Arterial embolism

Arthritis and related disorders—see also Rheumatoid arthritis

Arthrosis

Asperger's syndrome

Asthma

Ataxic gait

Atherosclerosis

Autism

B

Back problems

Bedsores

Behavioural & personality disorders—adult

Bell's palsy

Blackouts

Blindness—see also Poor vision

Blood pressure—abnormal reading without diagnosis

Blood pressure—low

Blood pressure—high

Boil

Bowel (colorectal) cancer

Bowel incontinence

Brain damage—acquired—see Injuries

Brain cancer

Brain disease/disorders

Breast cancer

Breast disorders

Breathing difficulties/shortness of breath

Bronchitis/bronchiolitis—acute

Burns

C

Cardiac arrest

Cataracts

Cellulitis

Cerebral infarction[1, 2]

Cerebral palsy

Cerebrovascular accident—subarachnoid haemorrhage[1, 2]

Cerebrovascular accident—intracerebral haemorrhage[1, 2]

Cerebrovascular accident–other intracranial haemorrhage[1, 2]

Cerebrovascular accident–cerebral infarction[1, 2]

Cerebrovascular accident–unspecified[1, 2]

Cholecystitis

Cholesterol—high

Chromosomal abnormalities—other

Chronic obstructive airways disease (COAD)

Chronic/postviral fatigue syndrome

Cirrhosis of liver

COAD

Coeliac disease

Cold—common

Colitis

Colorectal (bowel) cancer

Confusion

Congenital brain damage/malformation

Congestive heart disease

Congestive heart failure

Conjunctivitis

Constipation

Convulsions

Cough

Cramp

Cushing's syndrome

CVA—see Cerebrovascular accident

Cystitis

D

Deafness/hearing loss

Deformities of joints/limbs—acquired

Deformities of joints/limbs—congenital

Delirium—not superimposed on dementia

Delirium—superimposed on dementia

Delirium—other

Delirium—unspecified

Dementia—alcoholic

Dementia in Alzheimer's, atypical or mixed type[3]

Dementia in Alzheimer's, unspecified[3]

Dementia in Alzheimer's with early onset (<65 yrs)[3]

Dementia in Alzheimer's with late onset (>65 yrs)[3]

Dementia in Creutzfeldt-Jakob disease

Dementia in HIV disease

Dementia in Huntington's disease

Dementia in other specified diseases classified elsewhere

Dementia in Parkinson's disease

Dementia in Pick's disease

Dementia—mixed cortical & subcortical vascular

Dementia—multi-infarct

Dementia—other vascular

Dementia—subcortical vascular

Dementia—unspecified (includes presenile & senile dementia)

Dementia—vascular of acute onset

Dementia—vascular, unspecified

Depression/mood affective disorders

Dermatitis

Deterioration—general physical

Developmental disorders of motor function

Developmental disorders of speech & language

Developmental learning disorders

Diabetes mellitus—Type 1 (IDDM)

Diabetes mellitus—Type 2 (NIDDM)

Diabetes mellitus–other specified/unspecified/unable to be specified

Diarrhoea

Diarrhoea & gastroenteritis of presumed infectious origin

Dislocation—arm/hand/shoulder—from injury/accident

Dislocation—leg/knee/foot/ankle/hip—from injury/accident

Dislocation—unspecified

Disorientation

Diverticulitis

Dizziness

Dorsopathies

Down's syndrome

Duodenal ulcer

Duodenitis

Dysphagia (difficulty in swallowing)

Dyspraxia

Dystonia

E

Ear & mastoid process—other diseases of

Eating disorders

Eczema

Emphysema

Encephalitis (excl. viral)

Enteritis

Epilepsy

Erythema

Excessive eating & thirst

F

Faecal incontinence

Fainting

Falls—frequent with unknown aetiology

Fatigue

Fibrosis of liver

Fluid retention n.o.s

Fracture at wrist & hand level

Fracture of femur (incl. hip (neck of femur))

Fracture of lower leg & foot

Fracture of lumbar spine & pelvis (incl. lumbar vertebra, sacrum, coccyx, sacrum)

Fracture of neck (incl. cervical spine & vertebra)

Fracture of rib(s), sternum & thoracic spine (incl. thoracic spine & vertebra)

Fracture of shoulder, upper arm & forearm (incl. clavicle, scapula, humerus, radius, ulna)

Fracture—unspecified

Fractures—multiple

Frostbite

G

Gait and mobility abnormalities

Gangrene

Gastritis

Gastroenteritis & diarrhoea of presumed infectious origin

Giddiness

Glaucoma

Gout

H

Haemophilia

Haemorrhage from respiratory passages

Haemorrhoids

Headache

Head & neck cancer

Headache syndromes

Head injuries/acquired brain damage—see Injuries

Hearing loss

Heart attack

Hemiplegia

Hernia–abdominal (except congenital)

High blood pressure

High cholesterol

HIV/AIDS

Hostility

Huntington's disease

Hypertension

Hypoparathyroidism

Hyperthyroidism

Hypotension

Hypothyroidism

I

Immune system—other disorders

Immunodeficiency disorder (excl. AIDS)

Impetigo

Incontinence—bowel/faecal

Incontinence—urinary (stress, overflow, reflex, urge)

Incontinence—unspecified

Influenza

Injuries to the head (incl. injuries to the ear/eye/face/jaw, acquired brain damage)

Injuries to the arm/hand/shoulder (incl. dislocations, sprains & strains)

Injuries to the leg/knee/foot/ankle/hip (incl. dislocations, sprains & strains)

Insomnia

Insulin dependent diabetes mellitus (IDDM)

Intellectual disability

Intracerebral haemorrhage[1, 2]

Intracranial haemorrhage—other[1, 2]

Involuntary movements—abnormal

Iodine-deficiency syndrome

Irritability

Irritable bowel syndrome

Ischaemic heart disease—acute & chronic

J

Jaundice unspecified

Joint/limb deformities—acquired

K

Kidney and urinary system (bladder) disorders (excl. incontinence & urinary tract infection)

Korsakov's psychosis (alcoholic)

L

Laryngitis—acute

Learning disorders—developmental

Leprosy

Lethargy

Leukaemia

Listeriosis

Liver disease—alcoholic

Liver disease—toxic

Loss of appetite

Low blood pressure

Lung cancer

Lymph nodes—enlarged

Lymphoma—non-Hodgkin's

M

Malaise

Malnutrition

Mastoiditis

Memory loss—see Amnesia

Ménière's disease

Meningitis (excl. viral)

Meningococcal infection

Menopause disorders

Mental retardation

Migraines

Mobility & gait abnormalities

Mood affective disorders/depression

Motor Neurone disease

Multiple sclerosis

Muscular dystrophy

Myocardial infarction

Myopathies

Myringitis

N

Nausea & vomiting

Neck & head cancer

Nephritis

Nervous tension/stress

Nutritional deficiencies

Non-Hodgkin's lymphoma

Non-insulin dependent diabetes mellitus (NIDDM)

O

Obesity

Obsessive-compulsive disorder

Oedema n.e.c

Osteoarthritis

Osteomyelitis

Osteoporosis

Otitis media

Otosclerosis

Overdose of drugs, medicaments & biological substances

P

Pain

Pancreatitis

Paralysis (non-traumatic)

Paraplegia (non-traumatic)

Parkinson's disease

Peritonitis

Personality and behavioural disorders—adult

Pharyngitis—acute

Phobic and anxiety disorders

Physical deterioration—general

Physical violence

Pins & needles

Pneumonia

Poisoning by drugs, medicaments & biological substances

Poliomyelitis

Poor responsiveness

Poor vision

Postviral fatigue syndrome

Prostate cancer

Prostate disorders

Pulmonary embolism

Q

Quadraplegia

R

Rash

Renal failure

Respiratory allergies (excl. allergic asthma)

Restlessness

Retention of urine

Rett's syndrome

Rheumatic fever

Rheumatic heart disease

Rheumatism

Rheumatoid arthritis

Rhinitis—chronic

S

Scarlet fever

Schilder's disease

Schizophrenia

Scoliosis

Septicaemia

Shortness of breath

Sinusitis—acute

Sinusitis—chronic

Skin allergies

Skin and subcutaneous tissue infections

Skin cancer

Skin sensation disturbances

Sleep apnoea

Slowness

Smell & taste disturbances

Spasm

Spastic gait

Speech impediment

Speech & voice disturbances

Spina bifida

Sprain—arm/hand/shoulder—from injury/accident

Sprain—leg/knee/foot/ankle/hip—from injury/accident

Sprain—unspecified

Stomach ulcer

Stress/nervous tension

Strain—arm/hand/shoulder—from injury/accident

Strain—leg/knee/foot/ankle/hip—from injury/accident

Strain—unspecified

Stroke—see cerebrovascular accident

Stammering

Stomach cancer

Stuttering

Subarachnoid haemorrhage[1, 2]

Swallowing difficulty

T

Tetraplegia

Thyroiditis

T.I.A.s[1]

Tingling skin

Tinnitus

Tiredness

Tonsilitis—acute

Toxic liver disease

Transient cerebral ischaemic attacks (T.I.A.s)[1]

Tremor unspecified

Tuberculosis

Twitching n.o.s

U

Ulcer—stomach/duodenal

Unhappiness

Urinary incontinence (stress, overflow, reflex, urge)

Urinary incontinence—unspecified

Urinary system disorders

Urinary tract infection

Urinary retention

Urticaria

V

Varicose veins

Vascular dementia—see dementia

Vertigo

Vertigo n.o.s.

Violence—physical

Viral meningitis

Voice & speech disturbances

Vomiting & nausea

W

Walking difficulty n.e.c.

Weight gain—abnormal

Weight loss—abnormal

Worries n.o.s.