Australian Government

myagedcare

NSAF User Guide

A guide to the information required to be considered and recorded during the My Aged Care assessment process

Home Support Assessors and Comprehensive Assessors

October 2018

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Introduction

The 'National Screening and Assessment Form (NSAF) User Guide – May 2018' (the User Guide) has been re-developed by the Department of Health in order to reflect the changes made to the NSAF in June 2018, as a result of extensive consultation with the sector. The User Guide outlines the information My Aged Care assessors are required to consider and record (where relevant) when undertaking Home Support Assessments or Comprehensive Assessments.

Review of the NSAF

In 2017-18, the Department of Health undertook a project to review the NSAF (the NSAF Review). This was in response to the feedback received through several consultation processes including the My Aged Care co-design workshops in 2016 and the *Legislated Review of Aged Care 2017*. The NSAF Review featured two main feedback mechanisms:

- The release of a targeted survey to the sector in October
- The establishment of an Expert User Group, which had representation from the My Aged Care contact centre, My Aged Care Regional Assessment Services, Aged Care Assessment Teams, service providers and health professionals.

The revised NSAF

The revised NSAF was developed as a result of the feedback received during the NSAF Review. It has been designed to better support:

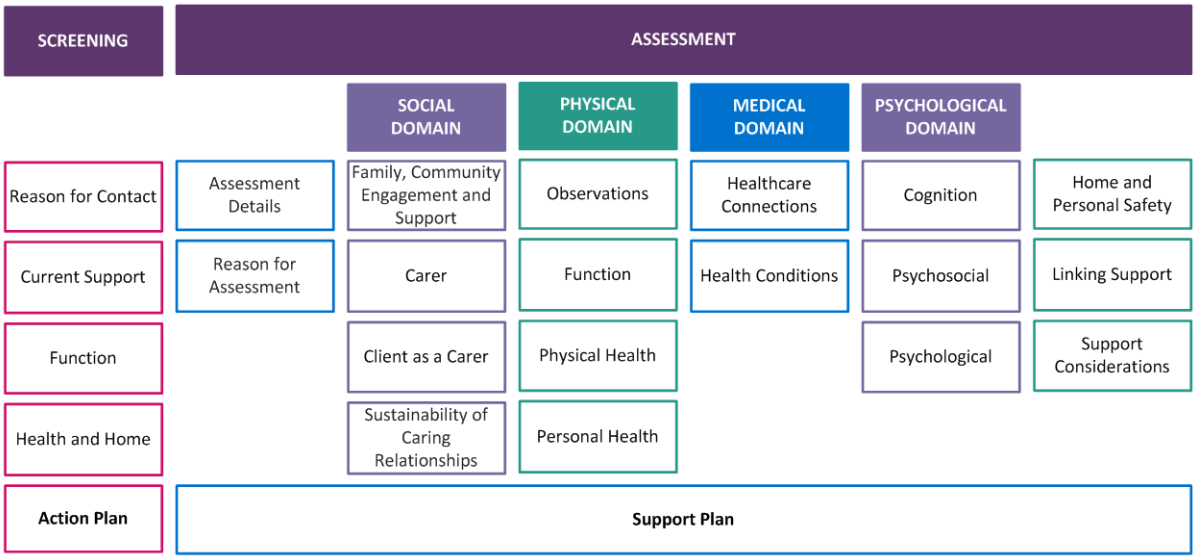
- A conversational approach to assessment with the client
- An assessors ability to record the client's story within their assessment
- The support planning process between clients and assessors
- The display of assessment and support plan information, including to providers.

Structure

The NSAF continues to support:

- Screening conducted over-the-phone by the My Aged Care contact centre
- Home Support Assessments conducted face-to-face by My Aged Care Regional Assessment Services
- Comprehensive Assessments conducted face-to-face by Aged Care Assessment Teams.

The revised NSAF has the following structure:



Further information on the NSAF is provided in the National Screening and Assessment Form fact sheet, available on the Department of Health's website.

The NSAF User Guide

Purpose

The User Guide outlines the information My Aged Care assessors are required to consider and record (where relevant) when undertaking Home Support Assessments or Comprehensive Assessments. This User Guide supersedes the NSAF User Guide of May 2018.

The User Guide complements the range of My Aged Care resources available to My Aged Care assessors and also on the Department of Health's website including:

- The My Aged Care Assessment Manual
- My Aged Care fact sheets
- My Aged Care quick reference guides.

Navigating the User Guide

The following table is a guide to the structure and information that is included in the subsequent sections of the User Guide.

Topic	The topic label as it will appear on the Assessor Portal, the myAssessor app and blank assessment forms.
Response options	The response options available per Topic. Response options may include: • Select one option (generally displayed as a radio button or list) • Select one or more options (generally displayed as check boxes) • Text fields with a maximum character count. Note: Where an assessor has the option to answer Yes or No: • Yes = The Topic has been considered and there is a need that is currently being met or unmet • No = The Topic has been considered however it is not an issue that needs to be addressed, or a response has not been able to be determined. As assessor should record text to explain why a response has not been able to be elicited.
Business rules	The rules that drive system behaviour to support the Topic and Response options.
Assessment level	Which assessment level (Home Support Assessment and/or Comprehensive Assessment) the Topic and Response options are included in. This is denoted by the ✓ or ✗ to the left of the Assessment level.

Pre-population	Whether the Topic or Response option is pre-populated in the Support Plan. This is denoted by the ✓ or ✗ to the left of the type of pre-population:
	• Add in Support Plan: Means that an assessor has the option to add a client's identified needs to the Support Plan. These needs will be categorised as:
	  • Functional Needs
	  • Other Considerations
	  • Complexity Indicators
	  • General Recommendations
	• Assessment Summary: Means that the Response option entered will pre-populate in the Assessment Summary template.

Help text	The help text/prompts available to assessors on the Assessor Portal and myAssessor app. The help text guides the completion of Response options.

Considerations for best practice	Concepts that assessors should consider in order to ensure they implement the best-practice approach to assessment. It includes: • Context relating to the Topic • What assessors should consider and record when addressing the Topic • Any prompts or recommendations associated with the Topic.

The User Guide has also been designed to support use via Microsoft Word and Adobe Reader, and as a hard-copy printed version. Hints and tips that may assist users navigating the document can be found at Appendix D.

Acknowledgements

The Department of Health wishes to thank those who provided feedback through the survey, and the members of the Expert User Group who provided advice that led to the development of the revised NSAF.

Assessment Details

Introduction

The Assessment Details section relates to the assessment that is undertaken with the client. It seeks information on the date and mode of the assessment; and who was consulted before, during and after the assessment.

Date of Assessment

Date of Assessment				
Response options	DD/MM/YYYY			
Business rules	Mandatory. Auto-populated with current date. Ability to record a prior date, but not a future date.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	The date of first contact with the client (usually face-to-face) for the purposes of conducting an assessment. In most instances, it will be the current date.			

Considerations for best practice

Context:
First clinical intervention is first date that contact of a clinical nature (i.e. non-administrative) that is made between an ACAT and the person (or their representative), their carer, a service provider or a clinician in response to the person's referral for a Comprehensive Assessment.

Consider/record:

- The current date will be displayed to support instances where assessment information is being recorded at the assessment, or immediately following.
- The date will need to be edited if assessment information is being recorded on any day following the face-to-face assessment.

Participants consulted prior to the assessment

Participants consulted prior to the assessment				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The person(s) that have been consulted prior to 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.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Participants consulted prior to the assessment' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Record the person(s) or organisation(s) name, their relationship to the client and their contact details. It is important that consent is gained to undertake this activity. Consider whether the person(s) should be established as a representative/relationship on the client's record.			

Considerations for best practice

Context:
This refers to the person(s) that have been consulted prior to the Home Support Assessment 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.

Consider/record:

- Record the person(s) name in Details.
- If the person(s) is already identified as a Representative or Relationship on the Client Record, record that contact information is available on the Client Record.
- If the person(s) is not a Representative or Relationship identified on the Client Record, consider whether they should be established as a Representative or Relationship, and/or add the person's information in Details (including their relationship to the client and their contact details). It is important that consent is gained to undertake this activity.

Mode

Mode				
Response options	• Face-to-face • Over-the-phone • Via tele-health			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	✓	Assessment Summary
Help text	The main approach taken to collecting assessment information. Tele-health includes options such as video-conferencing.			

Considerations for best practice
Context: Face-to-face contact is the preferred approach to Home Support and Comprehensive assessment and must take place where possible. **Consider/record:** • Where face-to-face contact between the assessor and a client is not possible (for example, when assessing a client in a remote area), a phone, video conference, telehealth or teleconference assessment may be undertaken. Another suitably qualified person (such as a local health worker) may attend the assessment with the client to assist the assessment process. • Further information is available in the My Aged Care Assessment Manual.

Assessment setting

Assessment setting				
Response options	**Home Support Assessment:** • Client's home • Carer's home • Other community setting		**Comprehensive Assessment:** • Client's home • Carer's home • Other community setting • Private Hospital • Public Hospital • Other hospital inpatient setting – Private • Other hospital inpatient setting – Public • Clinic • Residential aged care service	
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	✓	Assessment Summary
Help text	The primary location of assessment. If the assessment is occurring over-the-phone or via tele-health, record the client's location at the time of the assessment. 'Other community setting' includes locations such as Aboriginal Medical Centres.			
Details				
Response options	Text (maximum 100 characters)			
Business rules	N/A			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Provide additional relevant details about the assessment setting, for example, if the assessment was undertaken in multiple settings.			

Considerations for best practice
Context: This refers to the location of the first contact with the client for the purposes of a Home Support Assessment or a Comprehensive Assessment. Information about the setting of the first contact describes the environmental context in which the assessment has occurred. **Consider/record:** • The location at which the assessment occurred with the client. **Prompts:** • **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, and supported accommodation settings in the community. • **Hospital (Public or Private):** For clients in hospital. • **Other hospital inpatient setting (Private or Public clinic):** Hospital settings other than acute care, in which the person is an admitted patient receiving overnight care, admitted patients in extended care or rehabilitation facilities or other non-acute wards/beds in hospital. • **Residential aged care service:** For clients in a 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.

Assessment information collected from

Assessment information collected from				
Response options	▪ Client ▪ Client's carer ▪ Client's representative ▪ Client's GP ▪ Service provider		▪ Healthcare professional ▪ Aboriginal Liaison Officer ▪ Via interpreter ▪ Other	
Business rules	Mandatory. Select one or multiple option(s).			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	The person(s) or organisation(s) information is collected from at the time of assessment.			

Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Client's carer', 'Client's representative', 'Client's GP', 'Service provider', 'Healthcare professional', 'Aboriginal Liaison Officer', 'Via Interpreter' or 'Other' is selected.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	In the instance it is not the client providing information, record the person(s) name, their relationship to the client and their contact details. It is important that consent is gained to undertake this activity. Consider whether the person(s) should be established as a representative/ relationship on the client's record.			

Considerations for best practice

Context:
This refers to the person(s) or organisation(s) information is collected from at the time of assessment. 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 professional, Aboriginal Liaison Officer, Via Interpreter or other informant.

'Via interpreter' recognises that an interpreter works with spoken language, often translating and mediating between two languages in both directions.

Consider/record:

- In instances that information is not provided by the client, document the name of the person(s) providing the information, their relationship to the client, and their contact details (including what organisation they work for, if applicable).
- If an interpreter is used, the language the interpreter is translating.
- Ensure you have consent from the client for information to be provided on their behalf.
- Consider whether the person(s) should be established as a Representative or Relationship for the client, if they are not already.

Professions of those who participated in the client's assessment

Professions of those who participated in the client's assessment				
Response options	See Appendix A.			
Business rules	Select one or multiple option(s).			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	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 the assessment required a multidisciplinary approach.			
Details				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Other medical practitioners', 'Other nursing professional', 'Other health professional', 'Other social professional' and/or 'Other professional' is selected.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
This 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.

Consider/record:

- The profession of each clinician or professional person, assessment organisation member or non-team member that contributes to the Comprehensive Assessment.
- If more than one contributor belongs to the same professional category, the category should only be recorded once.

Prompts:

- **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).

Reason for Assessment

Introduction

The Reason for Assessment section relates to the reasons the client, or somebody acting on their behalf, has made contact with My Aged Care and been referred for assessment. It also seeks information on the key circumstances triggering assessment.

Circumstances triggering assessment

Circumstances triggering assessment				
Response options	▪ Hospital discharge ▪ Medical condition(s) ▪ Change in care needs ▪ Concern about increasing frailty ▪ Fall(s) ▪ Change in cognitive status		▪ Change in mental health status ▪ Change in caring arrangement ▪ Change in living arrangement ▪ Risk of vulnerability ▪ Other	
Business rules	Mandatory. Select one or multiple option(s).			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The situation or trigger that has led the client to contact 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.			
Specify 'Risk of vulnerability' or 'Other'				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Risk of vulnerability' or 'Other' is selected.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Provide additional information to support the selection of 'Risk of vulnerability' or 'Other'. For example, the type of vulnerability as identified by the client (such as belonging to an at-risk group).			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	The reason the client has contacted My Aged Care and been referred for assessment. Consider and record:			

	• Who made the referral and why • What is concerning the client the most about their current situation • How the client has been managing up until now • Opportunities to support the client to remain independent.

Considerations for best practice

Context:
This aims to categorise the main reason(s) the client is seeking assistance and should include information about the situation or trigger that has led to them contacting My Aged Care.

Considers/record:

- The information provided as part of the referral (e.g. Screening, webform, or other referral information) or from another source such as a representative, carer or friend.
- How the client has been managing with the current issue up until their contact with My Aged Care. 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.
- Any additional general comments and information regarding the reason for contact. The types of comments or information might include:
  - Background information that has led to the circumstance triggering contact.
  - Opportunities to support the client to remain independent.
  - Information that you have obtained that is unable to be documented elsewhere in this section.

Prompts:

- **Hospital discharge:** If the client has had a recent hospitalisation. If hospitalisation is one of the key circumstances triggering assessment, record relevant information in Recent hospitalisation.
- **Fall(s):** If the client has had a fall. If fall(s) are one of the key circumstances triggering assessment, record relevant information in Slips, trips and falls.
- **Medical condition(s):** If the client has medical conditions that are impacting on their ability to undertake day-to-day tasks. If medical condition(s) is one of the key circumstances triggering assessment, record relevant information in Health 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. If change in cognitive status is one of the key circumstances triggering assessment, record relevant information in Cognition or the Psychological Domain.

- **Change in care needs:** If the client needs more (or less) assistance to complete everyday tasks. If change in care needs is one of the key circumstances triggering assessment, record relevant information in Function.
- **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 Physical Domain.
- **Carer burden or illness:** 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 carer burden or illness is one of the key circumstances triggering assessment, record relevant information in the Social Domain.
- **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 change in caring arrangements is one of the key circumstances triggering assessment, record relevant information in the Social and Physical Domain.
- **Change in living arrangements**: If the client has relocated to new accommodation (by choice or forced relocation), is now homeless, has a co-resident carer that moves out of their home or a carer/support person moves into their home. If change in living arrangements is one of the key circumstances triggering assessment, record relevant information in Home and Personal Safety.
- **Sudden change in circumstances**: If there has been an unexpected change in the client's circumstances include the details that have an impact on the client's living arrangements. Sudden changes can include financial hardship, homelessness, a carer passing away, or the impact of environmental disasters like flooding, fire, storms or cyclones.
- **Risk of vulnerability:** If the client has a level of vulnerability, include the details of the type of vulnerability as identified by the client (e.g. such as belonging to an at-risk group). Should a client choose not to disclose information about their situation or lifestyle, this choice should be respected. If risk of vulnerability is one of the key circumstances triggering assessment, record relevant information in Linking Support.
- **Other:** For any responses that are not defined in this guidance. Include relevant information if this response is chosen.

Social Domain – Family, Community Engagement and Support

Introduction

The Family, Community Engagement and Support section relates to the relationships and activities that are important to the client, and how they are maintained.

Family and other support networks

Family and other support networks				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has existing personal and family support networks.			
Details				
Response options	Text (maximum 1500 characters)			
Business rules	Mandatory if '<u>Family and other support networks</u>' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record information relating to the personal and family support networks the client has in place. Consider and record the client's: • Family situation and relationship with close family (partners, children) and extended family • Engagement with social/community groups, clubs etc. Consider and record whether: • There has been any recent changes in the client's family, cultural and social situation • The client is experiencing loneliness and/or social isolation.			

Considerations for best practice
Context: This refers to whether the client has existing personal and family support networks. Having meaningful relationships and social connections is important for clients to achieve and maintain quality of life and prevent social isolation. It is important to understand relationships that are important to a client and how they are maintained. **Consider/record:** • Any key relationships and the current level of interaction. • Family issues (composition, dynamics, coping, interaction). • Family members living interstate or overseas. • If there have been any recent changes in the client's family, cultural or social situation. • Important support networks associated with the client's background and beliefs (e.g. clients who are Aboriginal and/or Torres Strait Islander, culturally and linguistically diverse, religious beliefs). • Whether the relationships identified need to be recorded in the Carer section. **Prompts:** • 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. • Who do you speak to most frequently? • Do you meet up with your friends and family regularly? • Do you know your neighbours?

Activities involved in social and community participation

Activities involved in social and community participation				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is involved in community-based activities or has interests, hobbies, or involvement in special interest groups. Also, whether the client is receiving assistance or supervision of another person in order to participate in community-based or recreational, cultural or religious activities; attending day centres, managing finances and writing letters.			
Support received (formal/informal)				
Response options	Text (maximum 500 characters)			
Business rules	N/A			

Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Includes assistance organised, provided or delivered by agencies or Commonwealth-subsidised aged care services (formal support) or assistance that is provided by family, friends or neighbours (carers) (informal support).			

Considerations for best practice

Context:
This relates to the types of activities the client undertakes, and the assistance they receive in order to complete these activities. Examples of activities include shopping, banking, participating in recreational, cultural or religious activities, attending day centres, managing finances and writing letters.

Consider/record:

- A summary of all activities (social and community) the client participates in, in their usual accommodation setting.
- The support the client receives in regards to accessing social and community participation activities, including:
  - Whether this support is provided informally (for example, by family members, friends, or neighbours) or formally (for example, via a service that is paid for and includes both government-subsidised and/or private services).
  - How long the support has been in place for.
  - The frequency of support.
  - If and/or when the support is due to end.

Prompts:

- 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 activities?
- Does someone take you on outings?
- Do you have any cultural connections?
- Do you prefer participating in individual or group activities?
- What is the next social event that you are looking forward to?
- What activities do you enjoy doing most in the community?
- Is there an activity that you used to do that you would like to do again?
- Are you happy with your current activities?

Social Domain – Carer

Introduction

The Carer section relates to support the client receives from a carer or other person(s). It seeks information on the person providing support; and the type of support they provide to the client.

Client is receiving support from a carer or other persons(s)

Client is receiving support from a carer or other person(s)				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is receiving assistance from a carer, family member(s), friend(s) and/or neighbour(s) not associated with a service provider or paid service.			

Considerations for best practice

Context:
Carers can be a physical and social enabler that is integral to ensuring the quality of life and independence of the older person. In recognition of the vital role that carers play in supporting older people to remain living at home and in the community, a number of carer specific programmes are funded by federal and state and territory governments (such as planned respite services delivered through the Commonwealth Home Support Program). These programmes provide carers with assistance and support to maintain their caring role.

The *Carer Recognition Act 2010* intends to increase recognition and consideration of carers. The Act defines a carer as an individual who provides personal care, support and assistance to another individual who needs it because that other individual:

- Has a disability; or
- Has a medical condition (including a terminal or chronic illness); or
- Has a mental illness; or
- Is frail and aged.

An individual is not a carer in respect of care, support and assistance he or she provides:

- Under a contract of service or a contract for the provision of services; or
- In the course of doing voluntary work for a charitable, welfare or community organisation; or
- As part of the requirements of a course of education or training.

To avoid doubt, an individual is not a carer merely because he or she:

- Is the spouse, de facto partner, parent, child or other relative of an individual, or is

the guardian of an individual; or
- Lives with an individual who requires care.

The Act also includes the Statement for Australia's Carers which sets out ten principles that articulate how carers should be treated and considered.

Details of carer

Details of carer				
Response options	Add 'Details of carer'			
Business rules	Ability to add multiple 'Details of carer' (Name, Relationship to client, Details of carer).			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Record the carer(s) name, their relationship to the client and their details (such as contact information and whether they live with the client). Consider whether the person(s) should be established as a representative/relationship on the client's record. Also, review the client record and see whether there are existing representative/ relationships established, and whether these relationships constitute a caring relationship that should be discussed at assessment.			
Name				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Client is receiving support from a carer or other person(s)' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	✓	Assessment Summary
Help text	See Details of Carer.			
Relationship to client				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Client is receiving support from a carer or other person(s)' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	✓	Assessment Summary
Help text	See Details of Carer.			
Details of carer				
Response options	Text (maximum 300 characters)			
Business rules	Mandatory if 'Client is receiving support from a carer or other person(s)' = Yes.			

Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	See Details of Carer.			

Considerations for best practice

Context:
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 that 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.

Consider/record:

- Details relating to the person(s) providing support to the client.
- If the client has more than one person providing support, identify who is the main/primary carer.
- Establish the person(s) as a Representative, Carer or Support Person.
- Review the Client Record and see whether there are existing Representatives or Relationships established, and whether these relationships constitute a caring relationship that should be discussed at assessment.

Details of support being provided

Details of support being provided				
Response options	Text (maximum 1500 characters)			
Business rules	Mandatory if 'Client is receiving support from a carer or other person(s)' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	Record information relating to the support the client receives from the carer(s). This information may be provided by the client and/or the carer. Consider and record: • The type of care being provided and the frequency of the support • Whether there has been any recent significant changes in carer or family support arrangements • Whether there are any difficulties or concerns with the caring arrangement such as: • Carer – stress and strain, physical exhaustion/ illness/health deterioration, difficulties with specific tasks, factors unrelated to the care situation			

	• Client – increasing needs, other factors. If the carer is involved in the assessment, consider and record: • The support the carer is receiving in their caring role (e.g. from family, friends, community, other organisations) • Whether the carer has other responsibilities (e.g. employment, education, other caring responsibilities) • Whether they are in receipt of a carer payment or allowance • Whether they need to be assessed as a client.

Considerations for best practice

Context:
An assessor should identify and discuss the level of support a person(s) provides to the client, and whether any support is needed for the client or carer. Where possible, in assessing a client and developing a care plan, the assessor should involve the person's carer as they also play an integral part in developing the most suitable care plan.

Consider/record:

- The type of care that the carer provides and how often it is provided. For example, a carer may assist a client with daily showering, weekly shopping, or drive them to medical appointments as required.
- If the assistance is provided by multiple people, state which person provides the support and how often they provide this support.
- Whether there have been any recent significant changes in carer arrangements and if this impacts on the carers' ability to provide ongoing care for the client. For example, a carer 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 choosing not to provide care anymore; or being unable to provide assistance for financial reasons.
- Information to support the addition of service recommendations in the Support Plan. For example, if there is a recommendation made for carer respite, ensure that there is clear information on the client/carer relationship, any difficulties or concerns that are experienced and the sustainability of the relationship.
- Whether the carer would benefit from an assessment of their needs and circumstances as distinct to that of the client.

Social Domain – Client as a Carer

Introduction

The Client as a Carer section relates to support the client is providing to another person(s). It seeks information on the person the client is providing support to; and the type of support the client providers to the persons(s).

Client is providing support to someone else

Client is providing support to someone else				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is supporting or looking after another person, such as assisting with their activities of daily living and/or self-care tasks.			
Considerations for best practice				
Context: This refers to 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. 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.				

Details of person(s) the client is providing support to

Details of person(s) the client is providing support to				
Response options	Add 'Details of person'			
Business rules	Ability to add multiple 'Details of person the client is providing support to' (Name, Relationship to client, Details of person).			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record the person(s) name, the relationship between the client and the person(s), and the person(s) details (such as contact information and whether the client lives with the person they are caring for).			

Name				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Client is providing support to someone else' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Details of person(s) the client is providing support to.			
Relationship to client				
Response options	Text (maximum 100 characters)			
Business rules	Mandatory if 'Client is providing support to someone else' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Details of person(s) the client is providing support to.			
Details of person				
Response options	Text (maximum 300 characters)			
Business rules	Mandatory if 'Client is providing support to someone else' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Details of person(s) the client is providing support to.			
Considerations for best practice				
Consider/record: • Details of the person(s) the client provides support to. • If the client supports more than one person, identify who is the main/primary person the client supports. • Establish the person(s) as a Relationship on the Client Record.				

Details of support the client is providing

Details of support the client is providing				
Response options	Text (maximum 1500 characters)			
Business rules	Mandatory if 'Client is providing support to someone else' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Record information relating to the support the client provides the person(s). Consider and record: • The type of care they provide and the frequency of the support • The support the client is receiving in their caring role (e.g. from			

	family, friends, community, other organisations)
	• Whether there are any difficulties or concerns with the caring arrangement such as:
	  • Carer – stress and strain, physical exhaustion/ illness/health deterioration, difficulties with specific tasks, factors unrelated to the care situation
	  • Client – increasing needs, other factors.

Considerations for best practice

Context:
An assessor should identify and discuss the level of support the client provides to the person(s) identified.

Consider/record:

- The type of care that the client provides and how often it is provided.
- If the client provides assistance to multiple people, what support the client provides to each person.
- If multiple people provide support to the person(s), not just the client.
- The support the client is receiving in their caring role (e.g. from family, friends, community, other organisations)
- Whether there are any difficulties or concerns with the caring arrangement such as:
  - Carer – stress and strain, physical exhaustion/ illness/health deterioration, difficulties with specific tasks, factors unrelated to the care situation
  - Client – increasing needs, other factors.
- Whether there have been any recent significant changes in the caring arrangements and if this impacts on the clients' ability to provide ongoing care for the person.

Social Domain – Sustainability of Caring Relationships

Introduction

The Sustainability of Caring relationships section relates to both the Carer and Client as a Carer section. It seeks information on the sustainability of the caring relationship (the support being provided to the client, and the support being provided by the client); whether the client has accessed respite and whether the client has an emergency care plan in place.

Sustainability of the caring relationships without additional support

Sustainability of the caring relationships without additional support				
Response options	• Yes • No			
Business rules	Mandatory if 'Client is receiving support from a carer or other person(s)' = Yes OR 'Client is providing support to someone else' = Yes. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether carer arrangements are sustainable without additional services or supports. This refers to the sustainability of both the carer in their caring role and the client in their caring role.			
Respite				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is currently receiving, or has been in receipt of respite (informal respite, or community or residential respite) in the past 12 months.			
Details				
Response options	Text (maximum 1000 characters)			
Business rules	Mandatory if 'Sustainability of the caring relationship without additional support' = No.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	Record why carer arrangements aren't sustainable, including any issues identified by the client or carer that are currently impacting on their			

	ability to continue receiving/providing 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. • 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 requires training to develop/improve skills in order to minimise the risk to the carer and/or client. • 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. Also record details relating to the respite received, such as: • The period of time the client received respite. • Whether respite was planned or unscheduled. • Where the client receives respite.

Considerations for best practice

Consider/record:

- Any difficulties or concerns the carer, or client (as a carer), has with the caring arrangement. Consider carer stress and strain; physical exhaustion, illness, or health deterioration; difficulties with specific tasks; factors unrelated to the care situation; and/or if the carer or client has increasing needs or other factors.
- The carer, or client (as a carer) perspective of the sustainability of the caring relationship. Document any issues identified by the carer that are currently impacting on their ability to provide care at a satisfactory/adequate level.
- What supports could be put in place to help the carer or client (as a carer) manage in their caring role. Consider whether the role may be at risk because of the support needs of the carer/client (as a carer).
- Whether the client is currently receiving, or has been in receipt of respite (informal respite, or community or residential respite). Record when the client commenced respite, and where they are receiving it.

Prompts:

- 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/client (as a carer) is available to assist but will not be available to continue for more than a few weeks/months and services/supports need to be in place within a few weeks/months.

- The carer/ client (as a 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/client (as a carer) requires training to develop or improve their skills and capability within their role.
- The carer/client (as a 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/ client (as 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.

Recommendations:

- Assessment of the carer.
- Recommendation/referral to Carer Support Services.

Emergency care plan

Emergency care plan				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether an emergency care plan has been developed in the instance that something should happen to the client in their caring role.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Emergency care plan' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Specify details about the emergency care plan. This may include other family members, people to contact, short-term care and long-term care options or other support options including respite.			

Considerations for best practice
Context: This refers to whether the client has an emergency care plan in place if something should happen to their carer. **Consider/record:** • Details about the emergency care plan. This may include other family members, people to contact, short-term care and long-term care options or other support options including respite. • If the client does not have an Emergency Care Plan in place, whether the client should develop one.

Caregiver Strain Index

Caregiver Strain Index				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A brief, easily administered instrument to identify strain among informal care providers such as spouses, children, relatives, friends and neighbours.			

Considerations for best practice
Context: The Caregiver Strain Index is a brief, easily administered instrument to identify strain among informal care providers such as spouses, children, relatives, friends and neighbours. 'Strain' is defined to mean 'enduring problems that have the potential for arousing threat'. The Index was developed by Dr Betsy Robinson and her research was published in the Journal of Gerontology in 1983. In a related paper it was suggested that health and social service professionals must be aware of the stresses on care givers and take action to reduce these stresses, if possible, with mindfulness that informal support is a key variable in determining whether an older person will remain in the community or be institutionalised. **Instructions and interpretation:** The Index consists of a short-list of questions directed to the carer. Any positive response may indicate a need for intervention in that area. The Index is computed by summing the 'yes' responses for all the items (each 'yes' response is scored as "1", and each 'no' response is scored as "0"). The higher the score, the higher the risk of stress. The Index may need to be administered with consideration that it was largely developed/ tested on the basis of responses from caregivers in America who were caring for elderly ex-

patients, two months after they had been released from hospital following treatments for heart and hip conditions.[1]

Modified Caregiver Strain Index

Modified Caregiver Strain Index				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The Modified Caregiver Strain Index can be a useful method for detecting strain levels among informal caregivers, and is easily administered and scored.			

Considerations for best practice

Context:
The Modified Caregiver Strain Index can be given to family members caring for disabled older adults. It helps to determine their level of strain — a combination of stress and burden that has consequences on caregivers' overall health.

Instructions and interpretation:
The index assesses 13 aspects of physical health, family finances, social interactions, time demands, and employment. By pinpointing the sources and degree of strain, the index can guide in the selection of interventions that might be used to alleviate caregivers' strain and improve the lives of caregivers and care recipients.[2]

[1] Robinson, BC, 1983, 'Validation of A Caregiver Strain Index', *Journal of Gerontology*, 38(3), 344-348.
[2] Onega, LL, 2008, 'Helping Those Who Help Others – The Modified Caregiver Strain Index, *AJN*,108 (9) 62-69.

Physical Domain – Observations

Introduction

The Observations section relates to the observations an assessor makes of the client. It seeks information on what the assessor observed about the client in their environment; and any difficulties the client has with health literacy.

General observations of client

General observations of client				
Response options	Text (maximum 1000 characters)			
Business rules	N/A			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	During an assessment, observation provides an opportunity to note a client's abilities. An assessor can make observations about a client's energy levels, stamina, comprehension, memory, concentration, physical appearance and interpersonal behaviour. The extent to which a client engages in the assessment can indicate how they will engage in interventions or goal setting.			

Considerations for best practice

Context:
This refers to observations the assessor makes of the client.

During an assessment, observation provides an opportunity to note a client's abilities. Observation is not restricted to what you see; it equally applies to what is heard (that is, what and how people communicate with the assessor and others). At assessment, an assessor can make observations about a clients:

- Energy levels, stamina, affect, body language, physical appearance.
- Comprehension, memory, concentration, interpersonal behaviour.

This information can then be used to inform and enhance the development of the client's Support Plan. The extent to which a client engages in the assessment can indicate how they will engage in interventions or goal setting.

Consider/record:

- Is the client participating in the assessment? Are they alert? Drowsy?
- Is the client welcoming of the assessor?
- General appearance; is the client wearing stained or crumpled clothing?
- Is the client appropriately dressed for the weather?
- Are there any obvious odours from the client or environment?

Health literacy difficulties

Health literacy difficulties				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Health literacy is the ability to read, understand and use healthcare information to make informed decisions about health and have the ability to follow treatment instructions where required.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Health literacy difficulties' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record the: • Difficulties the client has with health literacy. • Impact on the client's ability to understand health information. • Support the client has and/or requires in order to understand and interpret health information.			

Considerations for best practice

Context:
This refers to whether the client experiences health literacy difficulties.

Health literacy is the ability of a person to read, understand and use healthcare information to make informed decisions about health, and have the ability to follow treatment instructions where required.

People who have low health literacy skills will experience difficulty with communication, resulting in a poor understanding of their condition, treatment options and choices of care. People with low levels of health literacy are one and a half times more likely to have an adverse health outcome than someone who is health literate.[3]

Health literacy affects a client's ability to:

- Share personal information, such as health history with assessors
- Navigate the healthcare system, including filling out complex forms and locating services or providers.

[3] NSW Government, nd, 'Health Literacy', available at http://www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/person-centred-care/health-literacy, accessed on 26 April 2018.

Consider/record:

- Use plain language (language the client can understand the first time they read or hear it)
- Ensure the client is supported at the assessment by a carer or support person
- Use a translator, interpreter or communication device if required.
- Record details of the difficulties a client experiences.
- Record the support the client has, or the support the client requires to understand and interpret health information.

Prompts:

- Do you need someone to help you read health information?
- Are you able to complete medical forms by yourself?

Physical Domain – Function

Introduction

The Function section relates to the client's ability to complete activities of daily living. It seeks information on the how the client gets to places out of walking distance; goes shopping; prepares meals; undertakes housework; takes medication; handles money; walks; bathes or showers; dresses themselves; eats; transfers; and goes to the toilet. It also seeks information on whether the client requires assistance with these activities; details relating to these activities; and a summary of the client's functional ability.

Get to places out of walking distance

Get to places out of walking distance				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	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 with using public transport, getting to and from places away from home, and driving. Consider cognitive as well as physical reasons for requiring assistance.			

Considerations for best practice

Context:
This refers to whether the client can get to places out of walking distance.

Consider/record:

- **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:** 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.

Prompts:

- How do you manage to access your local community? For example, when did you last visit a GP, have a medical appointment, attend a hairdresser, go shopping, visit friends/family? How did you get there and back?

Go shopping (assuming transportation)

Go shopping (assuming transportation)				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can go shopping for groceries or clothes, assuming 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.			

Considerations for best practice

Context:
This refers to whether the client can go shopping for groceries or clothes, assuming they have transportation to get to the shops.

Consider/record:

- **Without help:** The client can take care of all their shopping needs themselves once they are at the shops. This includes using the 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 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.

Prompts/observations:

- How do you manage to complete your shopping?
- Where do you do your shopping?
- How often do you go shopping?
- How do you manage carrying the groceries?
- Do you get anything home delivered?
- 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).

Prepare meals

Prepare meals				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can prepare their own meals, including the delivery of prepared meals, help with meal preparation and managing basic nutrition. Consider cognitive as well as physical issues. A person with dementia may lack the organisational skills to prepare a meal or is at risk of scalding themselves or leaving the stove on. A person may have difficulty standing to prepare meals or lack the dexterity to cut food.			

Considerations for best practice

Context:
This refers to whether the client can prepare their own meals.

Consider/record:

- **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 preparation.

Prompts/observations:

- 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?
- Observations should be considered. 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.

Undertake housework

Undertake housework				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can do housework. Consider the client's ability to complete household activities including cleaning, vacuuming, washing, ironing, changing bed linen and other general house-keeping tasks.			

Considerations for best practice

Context:
This refers to whether the client can do housework. Consider the client's ability to do cleaning, vacuuming, washing, change bed linen and other general house-keeping tasks.

Consider/record:

- **Without help:** The client can maintain house-keeping 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, washing clothes, cleaning out the fridge etc. Heavy housework includes removing the vacuum from the cupboard, changing the sheets on a bed etc.
- **Completely unable:** The client is unable to participate in any housekeeping tasks.

Prompts/observations:

- How do you manage cleaning 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?
- 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?

Take medicine

Take medicine				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can take their own medication or administer injections. Consider cognitive as well as physical reasons. For example, a client may have a visual impairment and be unable to read labels correctly, or have arthritic hands that cause difficulty opening medication packets/bottles.			

Considerations for best practice

Context:
This refers to whether the client can take their own medication.

Consider/record:

- **Without help:** The client is able to take their medication in the right doses at the right time (self-medicates).
- **With some help:** The client is able to take their medication if someone prepares it for them and/or reminds them to take it i.e. using a dosette box or blister pack. This includes prompting the client to take or dispense medication due to memory difficulties or confusion.
- **Completely unable:** The client is not capable of organising, dispensing or taking their own medication and/or has compliance issues with their medication regime.

Prompts/observations:

- Do you have a pill box or blister pack?
- How do you go about taking your medications?
- Do you have any difficulties using a dosette box/blister pack?
- Observations should be considered. For example, are there loose pills lying on the counter/floor?

Handle money

Handle money				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment

Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
This refers to whether the client can handle their own money.

Consider/record:

- **Without help:** The client manages their own finances. For example, income, banking, bill paying and cheque writing. 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 cheque books, bill paying and major purchases.
- **Completely unable:** The client is not capable of handling money or finances.

Prompts/observations:

- How do you manage day-to-day buying of groceries?
- How do you pay your bills?
- Take note of whether there are unpaid bills lying around the client's home or 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.

Walk

Walk				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can walk. Consider difficulties around the home (indoors and outdoors) or away from home (community mobility).			

Considerations for best practice

This refers to whether the client can walk. Consider difficulties with indoor, outdoor and community mobility.

Consider/record:

- **Without help:** The client walks with no walking aids or is 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 the client is at risk of

falling.
    - Walks with the assistance of one other person and/or uses a walking frame, crutches or 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.
    - Has breathing problems and/or uses oxygen that impacts on and limits their mobility.
    - Uses a wheelchair without the help of others (able to self- propel a manual wheelchair or use an electric wheelchair).
- **Completely unable:** The client is wheelchair bound and is unable to self-propel, is bed bound or needs assistance of more than one person to mobilise.

Prompts/observations:

- Ask the client about their mobility around the house, garden and community.
- 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?
- Do you use any aids to assist with walking? (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?
- Do you limit activity for fear of falling?
- Take note of how the client walks and moves around their home and whether 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 the equipment, for example the height and tip of their walking stick; the sturdiness of their walking frame; the tyres, brakes and seat on their wheelchair; other aids. Is the equipment suitable and safe for the person?

Take a bath or shower

Take a bath or shower				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary

Help text	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 may require prompting by their carer.

Considerations for best practice

Context:
This refers to whether the client can shower, bath or bathe themselves.

Consider/record:

- **Without help:** The client is able to prepare for and shower/dry themselves, including with the 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:** The client needs total assistance with preparing and washing/drying themselves; utilises bed sponges only.

Prompts/observations:

- 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 on yourself?
- Can you clean your teeth/dentures effectively?
- Do you have any difficulties with foot and nail care?
- Take note of whether the shower or bath has been used recently; whether the client's personal appearance and clothing 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 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?

Dressing

Dressing				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client can dress themselves. Consider cognitive as well as physical reasons. A client with dementia may be physically able to dress, but may require prompting to do so, or a carer may also need to physically assist a client who is unable to 'sequence' their dressing tasks.			

Considerations for best practice

Context:
This refers to whether the client can dress themselves.

Consider/record:

- **Without help:** 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.
- **With some help:** 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 on their shoes/socks/stockings etc.
- **Completely unable:** The client is completely unable to dress themselves.

Prompts/observations:

- 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.?
- Is the client dressed in appropriate clothing? Does the outfit match? Are buttons, zips, shoelaces done up appropriately? Does their appearance validate what they have told you?

Eating

Eating	
Response options	• Without help • With some help • Completely unable
Business rules	Mandatory. Select one option.

Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	The client's ability to feed themselves, not issues with swallowing. Consider cognitive as well as physical reasons.			

Considerations for best practice

Context:
This refers to the client's ability to feed themselves, not issues with swallowing.

Consider/record:

- **Without help:** 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.
- **With some help:** The client is able to eat with some assistance. A client with dementia may be physically able to eat, but may require 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).
- **Completely unable:** The client is completely unable to eat without help. This includes clients who are fed via a Percutaneous Endoscopic Gastrostomy feeding tube or a naso-gastric feed.

Prompts/observations:

- Are you able to feed yourself if food is provided 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?
- Take note of whether the client has limited hand or upper limb strength and range of movement; or whether adaptive equipment is in place or present at the dining table or kitchen.

Transfers

Transfers				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	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: • Maintain or change body position • Carry, move and manipulate objects • Get in or out of bed or a chair (including wheelchairs), in/out of a car?

Considerations for best practice

Context:
This refers to whether a client is physically able to move from place to place and includes difficulties with all types of transfers.

Consider/record:

- **Without help:** The client is able to transfer safely without help from a person or aid.
- **With some help:** The client requires assistance with transfers. This includes:
  - Requires verbal or physical prompting from a person to transfer
  - Requires assistance from one or two people to transfer.
  - May use an aid such as a toilet raise; bed stick; chair platform or the use of a hoist, standing and raising aids, handi-lift/walk belt.
- **Completely unable:** 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.

Prompts/observations:

- Do you have difficulty stepping over the bath or getting in to 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?
- 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/bath board, grab rails if present). Do they experience pain 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 the equipment, for example a rusty shower chair or a broken raised toilet seat. Is the equipment suitable and safe for the person to use?

Toileting – Bladder

Toileting – Bladder				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	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 may require prompting. Any issues with incontinence may also be recorded here.			

Considerations for best practice

Context:
This refers to the personal care aspect of toileting (bladder). Any issues with urinary incontinence may also be recorded here.

Consider/record:

- **Without help:** 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
  - Self-managing personal hygiene needs post toileting.
- **With some help:** 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
  - Manage personal hygiene needs post toileting.
- **Completely unable:** The client is completely unable to manage toileting without help.

Prompts/observations:

- Can you wipe yourself effectively after using the toilet?
- Do you need assistance to wipe yourself?
- If the client has a catheter or ostomy insitu, do they manage for themselves?
- 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?

Toileting – Bowels

Toileting – Bowels				
Response options	• Without help • With some help • Completely unable			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	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 may require prompting. Any issues with incontinence may also be recorded here.			

Considerations for best practice

Context:
This refers to the personal care aspect of toileting (bowels). Any issues with faecal incontinence may also be recorded here.

Consider/record:

- **Without help:** 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.
  - Self-managing personal hygiene needs post toileting.
- **With some help:** 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.
  - Manage personal hygiene needs post toileting.
- **Completely unable:** The client is completely unable to manage toileting without help.

Prompts/observations

- Can you wipe yourself effectively after using the toilet?
- Do you need assistance to wipe yourself?
- If the client has an ostomy insitu, do they manage it for themselves?
- 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?

Client requires assistance with this activity

Client requires assistance with this activity				
Response options	• No • Yes – Short term • Yes – Long term • Yes – Short and long term • Yes – Unable to determine			
Business rules	Mandatory if functional activity = 'With some help' or 'Completely unable'. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client requires support to assist with meeting this need. Record 'yes' if this is currently an unmet need, or if support is already being provided (formally or informally). Record 'short term' or 'long term' to indicate the length of time support is required for (e.g. record 'short term' if the client requires support for approximately less than 3 months, 'long term' if the client requires services for 3 months or more). Record 'short and long term' if the client requires a mix of approaches (e.g. short term assistance to regain functional capacity, long term assistance to continue to remain independent).			

Considerations for best practice

Context:
This refers to whether the client requires support to meet the need. It takes in to consideration the support the client may already be receiving, and any additional/new assistance they may require to meet the need.

Consider/record:

- **No:** The client is independent
- **Yes – short term**: The client requires support for approximately less than 3 months
- **Yes – long term**: The client requires services for 3 months or more
- **Yes – short and long term:** The client requires a mix of approaches (e.g. short term assistance to regain functional capacity, long term assistance to continue to remain independent)
- **Yes – unable to determine:** The client requires support and will be undergoing a reablement phase and review.

Details (including support received)

Details (including support received)				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if functional activity = 'With some help' or 'Completely unable'. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record how the client is currently completing this functional activity. Record whether the client is currently receiving assistance or supervision of another person with using public transport, getting to and from places away from home, and driving. Include assistance organised, provided or delivered by agencies (formal support) or assistance that is provided by family, friends or neighbours (carers) (informal support). Record details relating to the support received, such as: • Who provides the support • What support is provided • The period of time the client has received the support for.			

Considerations for best practice

Context:
This refers to how the client is completing the functionality activity.

Consider/record:

- Using a strengths-based approach to assessment, identify what steps a client can and wants to do within a functional activity, rather than only what they have difficulty with.
- Record whether the client is currently receiving assistance or supervision of another person with this activity.
- Include assistance organised, provided or delivered by agencies (formal support) or assistance that is provided by family, friends or neighbours (carers) (informal support).

Summary of Function

Summary of Function				
Response options	Text (maximum 1000 characters)			
Business rules	Mandatory.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary

Help text	A holistic summary of: • The client's level of function. • The impact on activities of daily living. • Any unmet needs. • The services and supports required for the client to remain living independently. • Outcomes of relevant Supplementary Assessment Tools. This summary will pre-populate in to the Assessment Summary.

Considerations for best practice

Context:
This refers to a summary of the client's functionality ability.

Questions relating to a client's function are used to identify the client's strengths and any difficulties they may have in completing activities of daily living. The Summary of Function is an opportunity for assessors to holistically summarise the client's level of functioning and how this impacts on all activities of daily living.

Consider/record:
- The activities the client can do, what activities they receive support with, and whether this support is formal or informal.
- The activities the client requires assistance with in order to fulfil the need.
- Outcomes of relevant Supplementary Assessment Tools used to measure Function.
- The Summary of Function will pre-populate in to the Assessment Summary.

Older Americans Resources and Services (OARS) – Instrumental Activities of Daily Living

Older Americans Resources and Services (OARS) – Instrumental Activities of Daily Living				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	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. It is recommended for the assessment of care needs of older people living in the community and takes about five minutes to administer.			

Considerations for best practice

Context:

The Older Americans Resources and Services – Instrumental Activities of Daily Living (OARS-IADL) 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'.[4] It is recommended for the assessment of care needs of older people living in the community[5] and takes approximately five minutes to administer.[6] The OARS-IADL scale is based on direct or proxy observation and contains seven items:

- Phone
- Transportation
- Shopping
- Meal preparation
- Housework
- Medication management
- Money management.[7]

Instructions and interpretation:

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.[8]

[4] Green J et al., 2006, 'Towards a measure of function for Home and Community Care Services in Australia: Part 2' in *Australian Journal of Primary Health*, Vol 12 (1)
Sansoni J et al., 2008, 'Recent findings: Dementia Outcomes Measurement Suite', Minister's Dementia Advisory Group Meeting, Canberra.

[5] Pearson V, 2004, 'Assessment of function in older adults' in Kane RL and Kane RA (eds.), *Assessing older persons: Measures, Meaning, and Practical Applications*, Oxford University Press.

[6] Burns A et al., 2004, *Assessment Scales in Old Age Psychiatry* (2nd ed.) Martin Dunitz, London.

[7] Fillenbaum GG, Smyer MA, 1981, 'The development, validity, and reliability of the OARS Multidimensional Functional Assessment Questionnaire' in *Journal of Gerontology* 36(4):428-34.

[8] Eagar K et al., 2001, *Towards a national measure of functional dependency for home and community care services in Australia - Stage 1 report of the HACC Dependency Data Items Project*.
Sansoni J et al., 2010, 'Selecting Tools for ACAT Assessment: A Report for the Aged Care Assessment Program (ACAP) Expert Clinical Reference Group', Centre for Health Service Development, University of Wollongong, Department of Health and Ageing, Canberra.

Barthel Index of Activities of Daily Living

Barthel Index of Activities of Daily Living				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A clinical rating scale and contains 10 Activities of Daily Living items looking at personal care or self-care and mobility. The Index should be used as a record of what a patient does, NOT as a record of what a patient could do.			

Considerations for best practice

Context:
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.

It is a clinical rating scale that contains 10 Activities of Daily Living items looking at personal care or self-care and mobility.[9] 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.

Instructions and interpretation:
Scores range from 0 to 1, 2 or 3 for each activity.

Total possible scores range from 0 – 20, with lower scores indicating increased disability (a score less than 4 indicates total dependence). If used to measure improvement after rehabilitation, changes of more than two points in the total score reflect a probable genuine change, and change on one item from fully dependent to independent is also likely to be reliable.

Guidelines for completing the Barthel ADL Index[10]
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

[9] Mahoney F, Barthel DW, 1965, 'Functional evaluation: the Barthel Index' in *Maryland State Medical Journal*,14:61-65.
[10] Wade DT, Collin C, 1988, 'The Barthel ADL Index: a standard measure of physical disability?' in *International Disability Studies*,10(2):64-67.

verbal, however minor and for whatever reason.

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.

Kimberley Indigenous Cognitive Assessment – Activities of Daily Living

Kimberley Indigenous Cognitive Assessment – Activities of Daily Living				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A validated cognitive screening tool for older Indigenous Australians living in rural and remote areas. The KICA-ADL is the daily living skills (ADL and IADL) section of the tool.			

Considerations for best practice

Context:
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.

Instructions and interpretation:
The KICA-ADL is the daily living skills (ADL and IADL) section of the tool.[11] 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.

[11] Stevenson M et al., 2008, *Indigenous Cognitive Assessment-Validation of the KICA-Cog in Far North Queensland*, Queensland Health.

Additional information and training resources

- Kimberley Indigenous Cognitive Assessment
- Instruction Booklet

Revised Urinary Incontinence Scale (RUIS)

Revised Urinary Incontinence Scale (RUIS)				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The RUIS is a short, reliable and valid five item scale that can be used to assess urinary incontinence and to monitor patient outcomes following treatment. When completing the RUIS, respondents select one particular response option from the set of standard response options for each of the five questions. With only 5 items the RUIS is short and simple to use and score. Most patients will only take a minute to complete it.			

Considerations for best practice

Context:
If there are indicators within the assessment that further assessment is required, use the Revised Urinary Incontinence Scale (RUIS) as a follow-up tool.

A National Continence Management Strategy project Refining Continence Measurement Tools 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, this study developed the RUIS and RFIS. These scales improved the assessment of incontinence when compared with the original measures.[12]

Instructions and interpretation:
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.[13]
The scale includes both questions from the Incontinence Severity Index (ISI)[14] and therefore an ISI score can also be calculated. This is done by multiplying the scores from questions 4

[12] Sansoni J et al., 2007, 'Refining Continence Measurement Tools', Centre for Health Service Development, University of Wollongong and the Department of Psychiatry, The University of Melbourne.
[13] Sansoni J et al., 2010, 'Selecting Tools for ACAT Assessment: A Report for the Aged Care Assessment Program (ACAP) Expert Clinical Reference Group', Centre for Health Service Development, University of Wollongong, Department of Health and Ageing, Canberra.
[14] Sandvik H et al., 2000, 'A severity index for epidemiological surveys of female urinary incontinence: comparison with 48-hour pad-weighing tests' in *Neurourol Urodyn*,19(2):137-45.

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.

Additional information and training resources

- Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions
- RUIS Brochure – Summary for assessing and monitoring urinary incontinence.

Revised Faecal Incontinence Scale (RFIS)

Revised Faecal Incontinence Scale (RFIS)				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The RFIS is a short, reliable and valid five item scale that can be used to assess faecal incontinence and to monitor patient outcomes following treatment. 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. With 5 items the RFIS is short and simple to use and score. Most patients will only take a minute to complete it.			

Considerations for best practice

Context:
If there are indicators within the assessment that further assessment is required, use the Revised Urinary Incontinence Scale (RUIS) as a follow-up tool.

A National Continence Management Strategy project Refining Continence Measurement Tools 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, this study developed the RUIS and RFIS. These scales improved the assessment of incontinence when compared with the original measures.[15]

Instructions and interpretation:
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

[15] Sansoni J et al., 2007, 'Refining Continence Measurement Tools', Centre for Health Service Development, University of Wollongong and the Department of Psychiatry, The University of Melbourne.

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.[16]

Additional information and training resources

- Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions
- RFIS Brochure – Summary of assessing and monitoring faecal incontinence.

[16] Sansoni J et al., 2010, 'Selecting Tools for ACAT Assessment: A Report for the Aged Care Assessment Program (ACAP) Expert Clinical Reference Group', Centre for Health Service Development, University of Wollongong, Department of Health and Ageing, Canberra.

Physical Domain – Physical Health

Introduction

The Physical Health section relates to aspects of the client's physical health. It seeks information on taking medication; sensory concerns; communication difficulties; slips, trips and falls; and driving.

Taking medication

Taking medication				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is taking any medication to manage their health conditions. Medications may have been recommended by their doctor, specialist or pharmacist. In some instances, they can also be self-prescribed.			
Number of types of medication				
Response options	Numeric (maximum 2 digits).			
Business rules	N/A			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Specify how many types of medications the client takes.			
Medication details				
Response options	Text (maximum 500 characters)			
Business rules	N/A			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • Current medication(s) (by name) • How the medication(s) are administered • The source of medication information (e.g. direct observation, discharge. summary, GP, pharmacist) • The client's compliance with medication administration • Details on over-the-counter or non-prescription medications used by the client (including eye drops, creams/lotions, inhaled medication, natural therapies, injections etc.).			

Considerations for best practice

Context:
This refers to whether the client is taking any prescribed medication to manage their health conditions.

Medications may have been recommended by the client's doctor, specialist or pharmacist. In some instances, they can also be self-prescribed. Medications may be known by their prescribed name or by a generic brand name.

The effect of drugs on an older person is a significant variable to consider when completing an assessment. It is important for Comprehensive Assessors 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/record:

- How many types of medication the client takes.
- Medication details (Comprehensive Assessors only).
  - Record:
    - All current medications by name.
    - If a medication is self-administered, supervised or given by another person, and why.
    - If an aid is used such as a blister pack or dosette box or other similar devices.
    - The source of the medication information (for example from discharge summary, GP, pharmacist or direct observation of medications).
  - Compare all medications against source of information and the label directions with the 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 medication allergies/adverse reactions.

Prompts:

- 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.
- Check if the client 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 impact on daily activities (e.g. causes lethargy, lack of focus, mobility etc.)?
- Do pain levels fluctuate throughout the day? How do you manage this?
- Have there been any recent changes in your medication?

- 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?

Recommendations:

- Recommendation/referral to GP for a home/residential Medication Review (an Australian Government-subsidised programme).

Sensory concerns

Sensory concerns				
Response options	• Yes • No			
Business rules	Mandatory. Select one option. If 'Yes', mandatory to select 'Vision', 'Hearing' and/or 'Speech'.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has any concerns or difficulties with their vision, hearing or speech. Multiple responses may be appropriate.			
Vision				
Response options	• Low vision • Blindness			
Business rules	Conditionally mandatory if 'Sensory concerns' = Yes. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	See Sensory Concerns.			
Hearing				
Response options	• Poor hearing • Deafness			
Business rules	Conditionally mandatory if 'Sensory concerns' = Yes. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	See Sensory Concerns.			

Speech				
Response options	N/A			
Business rules	Conditionally mandatory if 'Sensory concerns' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Sensory Concerns.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Sensory concerns' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record whether the issue is impacting the client's functioning in terms of activities in the home, moving in the community, engaging in social activities, and connecting with friends and families. Record whether the client has any aids that assist them, and/or whether the client would benefit from assistance of aids.			

Considerations for best practice

Context:
This refers to whether the client has any sensory concerns or difficulties with their vision, hearing or speech. Multiple responses may be appropriate.

VISION
Context:
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'.

Consider/record:

- Whether the client reports they have low vision or blindness
- Details about the client's vision concerns or difficulties. 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 scheduled a vision test
- Whether a client reports they have regular and ongoing vision appointments
- If the client has had recent surgery, such as cataract removal, and whether treatment or follow up is in place
- Whether the client uses aids to facilitate vision (glasses, reading aids, magnifying lenses, large-print items, special papers and writing aids, video enlargement systems, computer display and enlargement systems, adaptive appliances, or speech software for computer systems).

Prompts:

- Do you have difficulty with vision, even with glasses?
- Check that clients with glasses are wearing them, as prescribed to do so
- 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?

Recommendations:

- Recommendation/referral to an optometrist, eye specialist or GP.

HEARING

Context:

Hearing may change as people get older. While some hearing loss is considered normal as you get older, clients are more likely to have problems with their hearing if they are over 55 years of age.

As well as age, hearing may also be affected by other factors such as family history, general health and work history. It is recommended that clients over 65 years of age have their hearing tested every year.

Consider/record:

- 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 or 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 there was recent surgery, such as a cochlear implant, and whether there is follow up in place.
- List hearing aids in use i.e. hearing aid(s), cochlear implant.

Prompts:

- Check that hearing aids have batteries fitted and are 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?
- Can you hear people on the phone?
- How long is it since you had your hearing tested/new hearing aid?
- What different aids or equipment have you tried?
- Does your hearing limit things you would like to do?

Recommendations:

- Recommendation/referral to an audiologist or GP.

SPEECH

Context:

Speech disorders can develop in adults gradually, but they can also develop suddenly, such as in the case of stroke. Disorders can include the loss of ability to express or understand language, problems making certain sounds or words (for example, slurring) and changes to the rhythm or speed of speech. 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 or motor neurone disease.

Consider/record:

- 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 communication aids in use e.g. communication boards, phone attachments, writing aids or speaking aids.

Prompts:

- 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?

Recommendations:

- Recommendation/referral to a speech pathologist/therapist or GP.

Communication difficulties

Communication difficulties				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether there are any barriers in communicating. This includes communicating over-the-phone and face-to-face.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Communication difficulties' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record the type of difficulty (e.g. language, cognitive) and the impact it has. Record whether the client requires assistance or supervision of another person in understanding others and/or making oneself understood by others.			

Considerations for best practice

Context:
This refers to whether the client perceives there are any barriers in communicating. This includes communicating over-the-phone and face-to-face.

Examples of communication difficulties 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.

When communication difficulties are identified, the assessor should have a conversation with the client, their representative or the referrer about using the National Relay Service (NRS) for those who have hearing difficulties or Translating and Interpreting Service (TIS) for those who have English as a second language or do not speak English. Should the client agree, the assessors should facilitate access to NRS or TIS as appropriate.

Consider/record:

- Whether the client uses aids to assist with inter-personal interaction. Aids include phone attachments, writing aids, speaking aids, hearing aids, reading aids or interpreters, use of the NRS or TIS.
- Barriers in communication that are not identified by the client. This should also be recorded to enable communication assistance and awareness for others involved in supporting the client.

Recommendations:

- NRS or TIS (as appropriate).

Slips, trips and falls

Slips, trips and falls				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has had any slips, trips or falls in the past 12 months.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Slips, trips and falls' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The number of falls and/or near misses. • The cause of the falls (e.g. a trip, slip, fainting or dizziness). • Contributing factors to the fall (e.g. vision impairment, injury, feet and footwear etc.). • Where the falls occurred. • Whether the client injured themselves or required medical attention/admission to hospital. • If the client's GP is aware of the falls. • If the client has attended a falls clinic. • Whether the client is afraid of falling.			

Considerations for best practice

Context:
This refers to whether the client has had any slips, trips or falls in the past 12 months.

Research indicates that age-specific rates of fall-related injury increase exponentially from the age of 75 years. Falls may contribute to decreased confidence. Environmental, health and behavioural factors may also contribute to a high risk of falling.

Many falls occur in the home environment and are preventable. Common reasons for falls include medication side effects, poor balance or strength, musculoskeletal disorders, obesity and arthritis which decreased 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 or the positioning of power points and cords.

Consider/record:

- The number of falls in the past 12 months (if known).
- The cause of the falls (e.g. a trip, slip, fainting or dizziness).
- Where the falls occurred.
- If the client injured themselves or required medical attention/admission to hospital.
- Whether the client's GP is aware of the falls.
- If the client has attended a falls clinic.
- Potential hazards inside or outside the home that could put the client at risk of falling or having an accident.
- Whether the client is afraid of falling.
- What day-to-day tasks make the client afraid of falling.

Prompts:

- 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?

Recommendations:

- Falls risk assessment.
- Enrolment in a falls clinic.
- Preparation of a falls prevention plan by a GP or allied health professional.

Driving

Driving				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client drives a motor vehicle.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Driving' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • How frequently the client drives, and over what distance. • Any concerns with the client being able to drive, such as physical ability, impacting health conditions etc.			

Considerations for best practice

Context:
This refers to whether the client drives a motor vehicle.

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.

Factors that may contribute to a client's ability to drive include:

- 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.
- 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 inability 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 driving safely such as hearing emergency sirens or car horns.
- Problems with memory that results in them missing exits that used to be second nature, or finding they are getting lost frequently.

Consider/record:

- Factors that contribute to the client's ability to drive.
- Any concerns in relation to the client being able to drive.

Prompts:

- 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?

Recommendations:

- Recommendation/referral to seek medical advice on the concerns/factors contributing to the client's ability to drive
- Recommendation/referral to an Occupational Therapist for a driving assessment.

Physical Domain – Personal Health

Introduction

The Physical Health section relates to aspects of the client's personal health. It seeks information on oral health; swallowing; appetite, weight loss and nutritional intake; skin conditions; pain; sleep; physical activity; alcohol use; and tobacco use.

Oral health

Oral health				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has any oral health concerns such as problems with their teeth, mouth or dentures.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Oral health' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record whether the client has: • Any concerns with their oral health. • Any problems with their teeth, mouth or dentures. • Pain or sore teeth when they eat. • Seen a dental practitioner recently.			

Considerations for best practice

Context:
This refers to whether a client has any oral health concerns such as problems with their teeth, mouth or dentures. This could include tooth loss, dental cavities, periodontal disease and gingivitis (inflammation of the gums, dry mouth, tooth wear).

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. Many oral problems can be either prevented or effectively treated.

Consider/record:

- Specify details about the client's oral health concerns. For example teeth, mouth or

swallowing problems that make it hard to eat; loose fitting dentures or loose teeth; gum disease or painful gums.

Prompts:

- 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?

Recommendations:

- Recommendation/referral to a dentist, dental practitioner and/or dietitian, as appropriate.

South Australian Oral Health Referral Pad

South Australian Oral Health Referral Pad				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A useful screening tool that is quick and easy to use by any health professional with a minimum of training.			

Considerations for best practice

Context:
The South Australian Oral Health Referral Pad (SA OHRP) is a useful screening tool that is quick and easy to use. It can be used by any health professional with a minimum of training, as contrasted with other tools such as the OHAT which require an oral examination[17].

Instructions and interpretation:
All questions are answered yes / no / don't know. People are classified as high priority for referral if they answer 'Yes' to Q1 and say 'Yes' to any other item dental impact item (e.g. items 2, 3, 4, and 5). People are classified as moderate priority if they answer 'Yes' to 2 or any other dental impact item.[18]

Additional information and training resources

- Clinical Topic: Why oral health care is important for older people
- Clinical Topic: Better Oral Health in Home Care –

[17] Chalmers JM et al., 2005, 'The oral health Assessment tool--validity and reliability', *Australian Dental Journal*, 50(3):191-9.
[18] Sansoni J et al., 2010, 'Selecting Tools for ACAT Assessment: A Report for the Aged Care Assessment Program (ACAP) Expert Clinical Reference Group', Centre for Health Service Development, University of Wollongong, Department of Health and Ageing, Canberra.

Oral Health Assessment Tool (OHAT) for Non-Dental Professionals

Oral Health Assessment Tool (OHAT) for Non-Dental Professionals				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A simple, eight category screening tool to assess residents' oral health, including those with dementia.			

Considerations for best practice

Context:
The Oral Health Assessment Tool (OHAT) was a component of the Best Practice Oral Health Model for Australian Residential Care study. The OHAT provides institutional carers with a simple, eight category screening tool to assess residents' oral health, including those with dementia.

Instructions and interpretation:
The OHAT has eight 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. The OHAT takes approximately 8 minutes to administer.

A Comprehensive 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 Comprehensive Assessors that have been trained in its use and this assessment is usually undertaken by a nurse.

Additional information and training resources

- Clinical Topic: Why oral health care is important for older people–
- Clinical Topic: Better Oral Health in Home Care

Swallowing

Swallowing				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether a client has problems swallowing (dysphagia).			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Swallowing' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record whether the client has: • Problems swallowing food or fluid, for example tea, coffee, water. • Issues with food getting stuck in their throat after chewing and swallowing. • Difficulty swallowing saliva. • A sore throat constantly. • Discussed any issues with their GP or a health professional.			

Considerations for best practice

Context:
This refers to whether the 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.[19]

Consider/record:
- Problems swallowing food or fluid, for example tea, coffee, water.
- Issues with food getting stuck in their throat after chewing and swallowing.
- Difficulty swallowing saliva.
- A sore throat constantly.

[19] 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.

- Discussed any issues with their GP or a health professional.

Prompts:

- 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 saliva?
- Do you constantly have a sore throat?

Recommendations:

- Recommendation/referral to GP or speech pathologist.

Appetite, weight loss and fluid intake

Appetite, weight loss and fluid intake				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has any issues with their appetite, weight loss or fluid intake.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Appetite, weight loss and fluid intake' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • Comments relating to the client's appetite (any recent changes such as eating poorly because of a decreased appetite, special diets, loss of taste). • Practices of food intake (e.g. ability to digest solids, PEG feeding etc.). • Whether the client has lost weight (intentionally or unintentionally) and the reason why. • Any concerns the client has about their weight or nutrition. • Adequate daily fluid intake, or whether they are on fluid restriction and why. • Whether the client has discussed any issues with their GP or a health professional.			

Considerations for best practice

Context:
This refers to whether the client has any issues with their appetite, weight loss and/or fluid intake.

APPETITE
Context:
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.

Consider/record:

- Recent changes to appetite.
- Impact of recent changes to appetite.

Prompts:

- Has your appetite changed recently? If so, what is the reason for this?
- Have you been eating poorly as a result of decreased appetite?
- 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?
- Observe the kitchen – the state of the benches (clean/dirty/unused) and whether there is any food in the fridge and cupboard.

Recommendations:

- Recommendation/referral to GP or dietitian.

WEIGHT LOSS
Context:
Unplanned weight loss happens when someone loses a significant amount of weight, without deliberately being on a weight loss plan. Unplanned weight loss is likely to lower a person's general wellbeing and quality of life. It can also increase their risk of serious health issues such as hip fracture, poor wound healing and malnutrition.

Consider/record:

- Details about the client's weight loss. For example:
  - Weight loss without trying 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 two weeks.
  - Teeth, mouth or swallowing problems that make it hard to eat. Also record in Oral Health and/or Swallowing.
  - Difficulties shopping, preparing food, cooking and/or feeding themselves. Also record in Function.

Prompts:

- 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?
- Have circumstances affected what you eat, how you prepare meals or difficulties with shopping?

Recommendations:

- Recommendation/referral to GP or dietitian.

FLUID INTAKE

Context:

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.

Consider/record:

- Details about the client's fluid intake.
- Reasons for decreased fluid intake (e.g. continence issues, medications, cognitive impairment, fluid restrictions).
- Emphasising the importance of drinking water or fluids regularly to keep hydrated and especially during the hot months.

Prompts:

- Have you had fluids or water today?
- How many glasses of water or fluids would you normally have in a day?
- Have you recently decreased your fluid intake?

Recommendations:

- Recommendation/referral to GP or dietitian.

Mini-Nutritional Assessment (MNA®)

Mini-Nutritional Assessment				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A simple and quick method of identifying elderly persons who are at risk for malnutrition, or who are already malnourished.			

Considerations for best practice
Context: The Mini Nutritional Assessment provides a simple and quick method of identifying elderly persons who are at risk for malnutrition, or who are already malnourished. It identifies the risk of malnutrition before severe changes in weight or serum protein levels occur. The MNA® was developed by Nestlé and leading international geriatricians and remains one of the few validated screening tools for the elderly. It has been well validated in international studies in a variety of settings and correlates with morbidity and mortality. In 2009 the MNA® was validated as a stand-alone screening tool, based on the full MNA®. **Instructions and interpretation:** The MNA® may be completed at regular intervals in the community and in the hospital or long-term care setting. It is recommended to be done annually in the community, and every three months in the hospital or long-term care or whenever a change in clinical condition occurs. The MNA® is an effective tool to help identify patients who are malnourished or at risk of malnutrition. The interpretation of the total screening score (maximum of 14 points) is as follows: • Normal nutritional status: 12 to 14 points • At risk of malnutrition status: 8 to 11 points • Malnourished status: 0 to 7 points. **Additional Information and training resources:** • User Guide and training video

Skin conditions

Skin conditions				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has any major skin conditions.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Skin conditions' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • The skin condition(s) the client has and their impact on day-to-			

	day functioning. • Whether the skin condition(s) require treatment, how frequently, and how it is currently being managed. • Whether a referral is required for nursing/wound management.

Considerations for best practice

Context:
This refers to whether the client has any major skin conditions.

Skin is a person's protective layer. During the ageing process the skin thins and loses elasticity and moisture and is more easily susceptible to injury such as tears, ulcers and dryness. Nutrition, mobility, cognition, falls, pain management and continence are vital to healthy skin integrity.

Clients may not consider skin conditions as potential issues. Therefore, observation at assessment is important.

Consider/record:

- The type of skin condition experienced.
  - **Pressure ulcer:** Signs that a pressure ulcer is beginning to form may include colour changes, temperature changes, changes in consistency of skin or 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.
- Treatment required for the specific skin condition.

Prompts/observations:

- For Comprehensive Assessors:
  - 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 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 a cream that they apply regularly to their skin. Note where they apply the cream.

Recommendations:

- Recommendation/referral to GP or dermatologist.

Pain

Pain				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has experienced any pain or discomfort during the past four weeks.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Pain' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The cause of the pain. • The level of pain. • Where the pain occurs. • What impact the pain has on their ability to complete functional activities or ability to sleep. • Strategies used to manage the pain (e.g. medication, massage, heat/cold pack, changing position on a regular basis, sleeping upright in a chair or attendance at a pain clinic).			

Considerations for best practice

Context:

This refers to 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. Regular pain medication is one strategy that can be effective for a client to manage their day-to-day tasks.

Pain can be divided into five main categories:

- **Nociceptive Pain:**
  - Somatic Pain – this pain is often described as a sharp, aching or gnawing sensation and can be localised. This type of pain can be related to complaints related to skin, muscles or 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 or 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, for example, from a tumour compressing or infiltrating tissue.
- **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.
- **Mixed or unspecific Pain:** This is pain that can be related to unspecified mechanisms such as recurrent headaches or fibromyalgia.

Consider/record:

- The cause of the pain.
- The level of pain.
- Where the pain occurs.
- What impact the pain has on their ability to complete functional activities or ability to sleep.
- Strategies used to manage the pain (e.g. medication, massage, heat/cold pack, changing position on a regular basis, sleeping upright in a chair or attendance at a pain clinic).

Prompts/observations:

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.

Recommendations:

- Recommendation/referral to GP or pain clinic.

Brief Pain Inventory

Brief Pain Inventory				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Allows patients to rate the severity of their pain and the degree to which their pain interferes with common dimensions of feeling and function. Recommended for use in community populations.			

Considerations for best practice

Context:
The Brief Pain Inventory (BPI) has become one of the most widely used measurement tools for assessing clinical pain. The BPI allows patients to rate the severity of their pain and the degree to which their pain interferes with common dimensions of feeling and function.

Initially developed to assess pain related to cancer, the BPI has been shown to be an appropriate measure for pain caused by a wide range of clinical conditions.

Instructions and interpretation:

- **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 pain interference.

Resident's Verbal Brief Pain Inventory

Resident's Verbal Brief Pain Inventory				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	A modification of the BPI for communicative clients in residential care facilities.			

Considerations for best practice

Context:
The Resident's Verbal Brief Pain Inventory (RVBPI) is a modification of the BPI for communicative clients in residential care facilities. 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.

Abbey Pain Scale

Abbey Pain Scale				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
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 Abbey Pain Scale is best used as part of an overall pain management plan.

Instructions and interpretation:
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 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.[20]

Sleep

Sleep				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client experiences any difficulties sleeping.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Sleep' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • The difficulties experienced (e.g. difficulty falling asleep, fragmented sleep, insufficient sleep, pain impacting on sleep). • The cause of the difficulties (e.g. 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 impact of the difficulties.			

[20] Sansoni J et al., 2010, 'Selecting Tools for ACAT Assessment: A Report for the Aged Care Assessment Program (ACAP) Expert Clinical Reference Group', Centre for Health Service Development, University of Wollongong, Department of Health and Ageing, Canberra.

Considerations for best practice
Context: This refers to whether the client experiences any difficulties sleeping. Sleep patterns can often change with age. Sleeping difficulties can be due to diseases such as dementia (constant wandering at night), alcohol use, congestive heart failure, depression, pain, arthritis and urinary problems. **Consider/record:** • 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. • Record the symptoms of sleep problems. For example, difficulty falling asleep, fragmented sleep, insufficient sleep, pain impacting on sleep, difference between night and day and early morning awakening. **Prompts:** • 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? • Have you noticed any changes to your sleep patterns? • 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 or a glass of sherry? **Recommendations:** • Recommendation/referral to GP or sleep clinic.

Physical activity

Physical activity				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client regularly undertakes physical activity (i.e. more than 30 minutes of physical activity that is enough to raise breathing rate).			

Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Physical activity' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The type of physical activity the client participates in. • How frequently the client undertakes physical activity. • The type of physical activity that the client enjoys doing or participating in most. • Whether the client wishes to undertake more physical activity, and what is stopping them from doing it.			

Considerations for best practice

Context:
This refers to whether the client regularly undertakes physical activity (i.e. more than 30 minutes of physical activity that is enough to raise breathing rate).

Regular physical activity can:

- Improve fitness and balance.
- Have a positive impact on health concerns such as osteoarthritis, diabetes, weight management, blood pressure.
- Lift mood, confidence and self-esteem.
- Help deal with negative feelings and bring a sense of wellbeing.
- Improve sleep, which can improve emotional wellbeing.
- Reduce tension levels and feelings of stress or fatigue.
- Increase energy.
- Foster supportive relationships and friendships.

Consider/record:

- The type of physical activity that the client enjoys doing or participating in most. For example, walking, gardening and/or housework.
- Whether the client would like to do more physical activity. Specify the details of the type of physical activity the client would like to do, 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.
- What is stopping the client from doing physical activity.

Prompts:

- 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?

Alcohol use

Alcohol use				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client's alcohol use negatively impacts on their health and wellbeing, or puts the client at harm.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Alcohol use' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • The level of alcohol use (i.e. how often the client has six or more standard alcoholic drinks on any one occasion). • The impact of alcohol use (such as on medication use, physical health and medical history, functional abilities, psychological wellbeing and age). • Whether alcohol use is causing problems for the client (e.g. accidents, adverse interactions with medications, financial hardship, relationship breakdown, legal issues, dependence). • Relevant history relating to alcohol use.			

Considerations for best practice

Context:
This refers to whether the client drinks 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.

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

- Exploring the 'good' and 'less good' things about the use of alcohol.
- Avoiding confrontation or argument.
- Assessing the person's level of concern.
- Assessing the person's readiness to change.
- Developing discrepancy between the person's ideal self and actual self.

- Referral, with consent, to an alcohol service.
- Supporting the person in any decision to change their behaviour.
- Acceptance that not all people will want to change their alcohol use.[21]

An assessor may identify concerns that are not identified by the client and this may require further investigation / discussion with the client, client's family/carer. Similarly the client's family / carer may raise issues that the assessor should investigate further.

Consider/record:

- Whether the client drinks alcohol and how much
- Whether the client is concerned with how much alcohol they drink. Specify details of the concerns.
- Whether alcohol consumption is causing problems for the client. 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.

Prompts:

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

Recommendations:

- Recommendation/referral to GP.

Alcohol Use Disorders Identification Test

Alcohol Use Disorders Identification Test				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Developed by the World Health Organization as a measure of alcohol consumption, alcohol dependence, and alcohol related problems.			

Considerations for best practice

Context:
The Alcohol Use Disorders Identification Test (AUDIT Scale) was developed by the World Health Organization as a measure of alcohol consumption, alcohol dependence, and alcohol related problems. It has reported that the AUDIT was better than other related measures at being able to differentiate between problem and non-problem drinkers.

Instructions and interpretation:
The AUDIT has 10 items, with both interviewer administered and self-report versions

[21] Department of Health,2011, *Strengthening Assessment and Care Planning: A Guide for HACC Assessment Services in Victoria.*

available.

The scoring guide below outlines recommendations for the health professionals. Where the client's AUDIT score is:

- Between 8 and 15, it is recommended that the client is provided advice on reduction of hazardous drinking
- Between 16 and 19, it is recommended that the client is provided with brief counselling and continued monitoring
- 20 and above, it is recommended that the client is referred to a specialist for diagnostic evaluation and possible treatment for alcohol dependence.

Additional information and training resources

- Alcohol Use Disorders Identification Test (AUDIT) Guidelines

Tobacco use

Tobacco use				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client currently smokes daily or frequently.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Tobacco use' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • How many cigarettes the client smokes, and how frequently • The impact of tobacco use (such as on medication use, physical health and medical history, functional abilities, psychological wellbeing and age) • Whether tobacco use is causing problems for the client • Whether the client wishes to quit smoking • Relevant history relating to tobacco use.			

Considerations for best practice

Context:
This refers to whether the client currently smokes daily or frequently.

According to health experts, smoking affects all body organs and functions. It contributes to diseases such as cancer, heart disease and respiratory disease and it may also affect cognitive functioning.

Consider/record:

- Whether the client currently smokes
- The number of cigarettes the client states they smoke per day
- Whether the client wishes to quit smoking
- If the client has previously smoked, record when they ceased smoking.

Recommendations:

- Recommendation/referral to Quit Smoking program.

Medical Domain – Healthcare Connections

Introduction

The Healthcare Connections section relates to the healthcare services the client regularly or recently visited. It seeks information on recent GP visits and health checks; clinical services; and recent hospitalisation.

Recent GP visits and health checks

Recent GP visits and health checks				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has regular contact with a GP and/or has regular health checks (including cancer screening, mammograms, flu vaccinations etc.).			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Recent GP visits and health checks' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Provide details of: • The client's GP and how frequently they see them. • Who conducts the client's regular health checks, how often and for what reason.			
Considerations for best practice				
Context: This refers to whether the client has a GP that they have recently seen, and whether they undertake any regular health checks. GPs are an important link in the continuity of care for clients and can be advocates for goal setting, achieving wellness and improving quality of life. **Consider/record:** • Whether the client regularly sees a GP, and how frequently. • Why a client doesn't regularly see a GP or have health checks. • Use language the client understands to identify if they have had checks such as blood pressure, medication review, continence matters, flu.				

- Advocate the value in regular GP check-ups, particularly after a hospital admission.

Recommendations:

- Recommendation/referral to GP, including for a health assessment (over 75 health check).

Clinical services

Clinical services				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether the client currently accesses any short-term or ongoing clinical services. Includes services such as palliative care, mental health services and diabetes education, and ongoing services through specialist clinics, such as pain clinics and exercise programmes.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Clinical services' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Provide details of the clinical service(s) received, including: • Who the services are provided by • How frequently the client accesses these services.			

Considerations for best practice

Context:
This refers to whether the client is currently accessing clinical services.

Consider/record:

- The clinical services the client receives, the frequency of these services, and the provider of these services.
- Whether the services have been put in place for a short period of time post a hospital admission.

Recent hospitalisation

Recent hospitalisation				
Response options	• Yes • No • Currently in hospital			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has been in hospital in the past three months.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Recent hospitalisation' = 'Yes' or 'Currently in hospital'.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record the details of the hospital admission (e.g. date of admission, reason for admission [scheduled, unplanned, visit to the emergency department], information about the hospital stay and date of discharge).			

Considerations for best practice

Context:
This refers to whether the client has been discharged from hospital in the past three months.

It is important to know whether the client has had any recent admissions to hospital which could be the reason for the referral for an assessment. Collecting vital information relating to hospital admission provides assessors with an understanding as to what occurred as a result of the hospital stay.

In the event an assessment is undertaken in the hospital setting information can be collected from the client, family, the client's medical record, nursing staff or other health professionals involved in the clients admission.

Consider/record:

- How many times a client has been admitted over the past 12 months, including if they have had recent admissions in the past three months.
- The reason for these admissions.
- The outcome of the admissions.
- Any significant inpatient events.
- Whether the hospital admission resulted in health professional assessments such as Occupational Therapy assessment for home safety; physiotherapy assessment for aids; or continence assessment. Note the outcomes of these assessments, such as if

equipment was supplied or if the client was referred to a provider outside of the hospital.

- Whether aids/equipment were recommended as a result of the hospital stay. 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 or hand held showers etc.
  - Support and mobility aids such as splints, hospital beds, cushions/pillows, crutches, walking sticks, walkers or wheelchairs etc.
  - Communication aids such as phone attachments, writing aids, speaking aids or hearing aids.
  - Reading aids such as magnifying / reading glasses, braille books, reading frames or talking books etc.

Medical Domain – Health Conditions

Introduction

The Health Conditions section relates to the health conditions the client experiences, which have an impact on their activities of daily living and social participation. It seeks information on the health condition(s); their diagnosis status; the impact of health conditions and the support the client is receiving to manage them; and allergies and sensitivities.

Health condition

Health condition				
Response options	See Appendix B.			
Business rules	Mandatory to add at least one 'Health condition'. Ability to add multiple health conditions.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✓	Assessment Summary
Help text	Whether the client has any health conditions, including 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 or pre-existing conditions.			
Primary health condition				
Response options	See Appendix B.			
Business rules	**Home Support Assessment:** Ability to select one 'Primary health condition'. **Comprehensive Assessment:** Mandatory to select one 'Primary health condition'.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	The health condition with the greatest impact on the person's need for assistance with activities of daily living and social participation.			
Diagnosis status				
Response options	• Client reported • GP confirmed • Hospital confirmed • Other health practitioner diagnosis			
Business rules	Mandatory per 'Health condition' selected.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether the health condition has been diagnosed, and by whom.			

Considerations for best practice

Context:
This refers to whether the client has any health conditions that impact on their daily activities, identifying the client's primary health condition, and for Comprehensive Assessors, recording the diagnosis status of the health condition.

As people age, they are more likely to experience multiple, and more complex health conditions that impact on how they complete day-to-day activities.

For Comprehensive Assessors, it is important to note that:

- A complete history may be obtained from a number of sources (e.g. GP, client, carer, hospital staff and patient notes or specialists).
- Medical history must contain current problems, past medical conditions, operations, fractures, including any past or current psychiatric diagnosis.

Consider/record:

- A client may not provide the actual name of the condition. For example, 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 their difficulties are 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. Document the information that is provided by the client.
- Review the information included by the referrer (such as a GP or other health professional).
- Record comments relating to the health condition, such as specific information on the cause of the health condition, the length of time the client has had the health condition, the specific impact it has on the client, and any treatment or medical specialist oversight of the condition.
- In instances that the client does not have any health condition select 'no health conditions present' from the list.

Prompts:

- Assist the client/carer to recall past problems using a systematic method such as a head to toe scan (start at the head and work down).

Impact of health conditions and support being received to manage them

Impact of health conditions and support being received to manage them				
Response options	Text (maximum 1000 characters)			
Business rules	Mandatory.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment

Pre-population	✖	Add in Support Plan	✓	Assessment Summary
Help text	Consider and record the impact the health condition(s) have on the client's ability to carry out day-to-day personal, household or social activities, and the type of support the client is receiving help to manage their health condition(s). Specify details about how the condition impacts their ability to complete such tasks, and details about the type of help they are receiving to help manage the condition(s).			

Considerations for best practice

Context:
This refers to how the client's health conditions impact on their ability to carry out day-to-day tasks.

Consider/record:

- Specify details about how the condition impacts on their ability to complete such tasks. For example, a client who:
  - Becomes breathless and fatigued due to heart disease and 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 and may no longer be able to catch a bus to their doctor.
  - Has arthritis in their hands and may no longer be able to prepare their own meals due to their inability to cut or chop ingredients.
  - Has undergone back surgery and 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 and 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 and may be forgetting to take their medication.
  - Has had a leg amputation and 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.
- Record the support being received to manage health conditions. This could take the form of medication, allied health appointments, socialisation activities.

Prompts:

- What do your good days looks like? How do you cope on the bad days? e.g. exacerbation of breathlessness due to weather changes.
- Are you able to get out and about in your community? What helps you? What stops you?

Allergies and/or sensitivities

Allergies and/or sensitivities				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has and/or has had allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities.			
Source				
Response options	▪ Client reported ▪ Health professional reported			
Business rules	Select one or multiple option(s).			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record whether the allergies and/or sensitivities have been reported by the client or by a health professional.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Allergies and/or sensitivities' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Should a client have allergies and or sensitivities to environment, medication or food, specify details of the identified allergies and/or sensitivities.			

Considerations for best practice

Context:
This refers to whether the client has any allergies or sensitivities.

Consider/record:

- Record a client's allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities.
- Record the reactions the client may have if they come in contact with the allergens and/or sensitivities and whether they have a severe reaction or one that they manage themselves.

Prompts:

- Have you had a reaction to a medication? Food? Something in the environment? E.g. developed a rash, itchiness, vomiting, fainting, lumps or bumps?

Psychological Domain – Cognition

Introduction

The Cognition section relates to changes the client has experienced in relation to their cognition. It seeks information on changes in memory and thinking; changes in personality; changes in behaviour; and assistance with decision making.

Changes in memory and thinking

Changes in memory and thinking				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has experienced any changes in their memory and thinking over a short or long period of time.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Changes in memory and thinking' = Yes.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	Consider and record: • The changes experienced by the client (e.g. recall, repetition, recognition, trouble with fine motor skills). • When the changes occurred (e.g. gradually or sudden onset). • The impact of the changes on day-to-day tasks and the client's quality of life. • Whether the client is receiving assistance to manage these changes, and from whom. • Who this information was collected from (if not the client).			
Considerations for best practice				
Context: This refers to whether the client has had any changes in their memory and thinking. Cognitive decline can have a major impact on a client's functional abilities and can lead to a loss of autonomy and capacity to function independently. Clients experiencing cognitive decline have greater difficulty making decisions, and can be more vulnerable if they do not have someone who can advocate for them, on their behalf. They may also be more vulnerable if there is significant change to carer or family arrangements that will affect the support they receive.				

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 injury or stroke.
- Mental health issues that may limit self-care capacity including:
  - Major depression.
  - Post-Traumatic Stress Disorder (PTSD).
  - Psychosis, schizophrenia or bipolar disorder.

Changes in memory and thinking can be a sensitive issue for clients. In some instances, the client's support networks will notice a client's change in memory and thinking before the client does, and are more open to having a conversation about it.

An assessor should use gentle, persistent questions and encourage the client to engage in the conversation. It may be necessary to revisit the information that has been discussed during the assessment to ensure the client's needs have been considered with regard to their cognition.

If the client does appear to become upset, redirect the conversation to put the client at ease. It may be necessary to speak to the family or carer separately if the client is upset by the discussion.

Consider/record:

- Any changes in memory and thinking the client may have experienced or any concerns reported by a carer or family. 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 within a few minutes.
  - Losing the ability to read or recognise 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.
  - Trouble with fine motor skills such as using silverware, buttoning clothes, or walking.

Prompts:

- How are changes to memory and thinking impacting on the client and their carer's day-to-day tasks?
- Is the client aware of time, place and person?
- 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?

Changes in personality

Changes in personality				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has experienced any changes in their personality.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Changes in personality' = Yes.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The changes experienced by the client (e.g. aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations, delusions). • When the changes occurred. • The impact of the changes on day-to-day tasks and the client's quality of life. • Whether the client is receiving assistance to manage these changes, and from whom. • Who this information was collected from (if not the client).			

Considerations for best practice

Context:
This refers to whether the client has experienced any changes to their 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.
- Infections, such as meningitis, encephalitis, and human immunodeficiency virus (HIV) infection that involves the brain (HIV-associated encephalopathy), Parkinson's disease, seizure disorders or stroke.
- System disorders that can affect the brain: kidney failure, liver failure, low blood

sugar (hypoglycaemia), systemic lupus erythematous or thyroid disorders.

Consider/record:

- Record information related to changes experienced by the client as reported by themselves or family or carer. Changes can include aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations and delusions.
- Consider the impact the changes have had on the client's quality of life. For example, does the client now experience sudden outburst of anger or rudeness, when usually/previously, they have been an easy-going individual?

Prompts:

- Have you noticed any changes in how you think or feel?
- Do you notice the changes regularly or as a result of anything in particular? E.g. time of day; before, during or after certain activities?
- Have the family reported any unusual behaviour?
- What behaviours have been present throughout life?
- Are there any situations you try and avoid?

Changes in behaviour

Changes in behaviour				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has experienced any changes in their behaviour.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Changes in behaviour' = Yes.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	✓	Assessment Summary
Help text	Consider and record: • The changes experienced by the client (e.g. aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations, delusions). • When the changes occurred. • The impact of the changes on day-to-day tasks and the client's quality of life. • Whether the client is receiving assistance to manage these changes, and from whom. • Who this information was collected from (if not the client).			

Considerations for best practice
Context: This refers to whether the client has experienced any changes in behaviour. 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. **Consider/record:** • Changes in behaviour can be evidenced by whether the client presents as agitated, aggressive, suspicious, repetitive or inappropriate. • Any indications that a client's behaviour has changed. Changes can include aggression, wandering, inappropriate exposure, hoarding, agitation, hallucinations and delusions. • Details of the changes and the impact it is having, including on the client's quality of life. For example, aggression, wandering, sun-downing, shadowing, inappropriate exposure, hoarding, agitation, sexual dis-inhibition, calling out, apathy or insomnia. • Details of the assistance the client is receiving. For example medications, day respite attendance or behaviour management. • Whether the behaviours have been assessed by a geriatrician, psychiatrist or mental health team. **Prompts/observations:** • 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 or apparent lack of sleep.

Assistance with decision making

Assistance with decision making				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has anyone that assists them in making health or lifestyle and/or financial decisions.			

Assistance with decision making				
Response options	▪ Health or Lifestyle ▪ Financial			
Business rules	If 'Assistance with decision making' = Yes, select one or multiple options.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	See Assistance with decision making.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Assistance with decision making' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record the name of the person(s) who assists and the types of decisions they provide assistance with. Consider whether the person(s) should be established as a representative for the client. Also, review the client record and see whether there are existing representative/relationships established, and whether these relationships provide assistance with decision making.			

Considerations for best practice

This refers to whether the client has assistance from someone else in order to make decisions.

Context:
Assessors should presume that a person has the capacity to make all decisions for themselves, and should not assume that a person lacks capacity based on appearances, age, disability, behaviour or other conditions or characteristics. A client's capacity to make decisions is separate to whether they make good or bad decisions – a client cannot be assessed as lacking capacity simply because they make a decision you think is unwise, reckless or wrong.

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).

Capacity is decision-specific and it is inappropriate to state that a client 'lacks capacity' without further reference to the type of capacity task. A client's capacity can vary in different circumstances, at different times and even within domains for different types of decisions.

Consider/record:

- 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.

Standardised Mini-Mental State Examination

Standardised Mini-Mental State Examination				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
The Standardised Mini-Mental State Examination (SMMSE) 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.

Some client's may not be able to undertake the SMMSE. For example, client's with permanent physical disabilities, language difficulties, severe speech problems, low education or education in a language other than English.

Instructions and interpretation:
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.

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.

Ask each question a maximum of three times. If the person does not respond, score zero. 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. 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'.

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.

The following equipment is required to administer the instrument: A watch, a pencil, reverse of 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.

Additional Information and training resources

- Guidelines for administration and scoring instructions

Rowland Universal Dementia Assessment Scale

Rowland Universal Dementia Assessment Scale				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	A short cognitive screening instrument designed to minimize the effects of cultural learning and language diversity on the assessment of baseline cognitive performance. When administering the RUDAS it is important that the respondent is encouraged to communicate in the language with which they are most competent and comfortable.			

Considerations for best practice

Context:
The Rowland Universal Dementia Assessment Scale (RUDAS) is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance.

Instructions and interpretation:
General Guidelines for the Administration:

- **Test Anxiety**: Make sure the client 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 client can hear clearly. It is important to identify at the beginning of the assessment if the client has impaired hearing and accommodate for this as much as possible by speaking slowly and clearly. Encourage the client 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 clients with severe hearing impairment.
- **Vision:** Ensure that the client is using reading glasses where necessary and that there is sufficient light in the room.

- **Seating**: Sit opposite the client. 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 client.
- **Recording Responses**: It is important to record the client's full response to each item.
- **Physical Disability**: For clients 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).

Informant Questionnaire on Cognitive Decline in the Elderly (short version)

Informant Questionnaire on Cognitive Decline in the Elderly (short version)				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A brief questionnaire which uses information provided by an informant to assess a person's change in cognitive functioning over the previous ten years. This assessment is directed at the client's carer, family member or friend and is designed for them to complete. Generally, this test is completed without interference by a doctor or nurse, but it can be talked through with them if they need clarification. It usually takes around 10-20 minutes to complete.			

Considerations for best practice

Context:
The Informant Questionnaire on Cognitive Decline in the Elderly (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.

The IQCODE should be used to supplement the other patient administered tools, e.g. the SMMSE; to increase sensitivity and specificity or used in situations where the patient is unable to complete the assessment.

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.

Instructions and interpretation:

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.

Additional Information and training resources:

- Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Kimberley Indigenous Cognitive Assessment

Kimberley Indigenous Cognitive Assessment				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
The Kimberley Indigenous Cognitive Assessment (KICA – COG) 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 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.

Instructions and interpretation:
The KICA-COG requires 5 common items – a comb, pannikin/cup, box of matched, plastic bottle (with top), and a watch/timer. A set of pictures are required to be presented to the client in order to assess visual naming, free recall and cued recall. Since language skills are being assessed, a trainer interpreter is recommended.

The KICA-Cog is out of 39. A score of 33 or below indicates possible dementia and a referral to a GP is recommended.

Additional information and training resources

- Kimberley Indigenous Cognitive Assessment
- Instruction Booklet

Psychological Domain – Psychosocial

Introduction

The Psychosocial section relates to the client's mental health and social wellbeing. It seeks information on feelings of nervousness or depression; and feelings of loneliness or social isolation.

Feelings of nervousness or depression

Feelings of nervousness or depression				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has recently (i.e. within the last four weeks) had feelings of nervousness or depression.			
Type				
Response options	▪ Nervousness ▪ Depression			
Business rules	If 'Feelings of nervousness or depression' = Yes, select one or multiple.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Feelings of nervousness or depression.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Feelings of nervousness or depression' = Yes.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The feelings of nervousness experienced by the client (e.g. feeling anxious, worried, edgy, jumpy, panicky, uneasy) • The feelings of depression experienced by the client (e.g. feeling unhappy, 'blue', down, miserable, dejected, low, disheartened,			

	sad). • Over what timeframe the feelings have been experienced. • How frequently these feelings are experienced. • The impact of these feelings on day-to-day tasks and the client's quality of life. • Whether the client is receiving assistance to manage these feelings, and from whom.

Considerations for best practice

Context:
This refers to whether the client experiences feelings of nervousness or depression.

- Feelings of nervousness can be expressed as feeling anxious, worried, edgy, jumpy, panicky or uneasy.
- Feelings of being depressed can be expressed as feeling unhappy, 'blue', down, miserable, dejected, low, disheartened or sad.

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 with daily activities, and the frequency of this support.

Consider/record:
- The feelings experienced by the client.
- The frequency of the feelings (a little of the time, some of the time, all of the time).

Prompts/observations:
- Ask further questions to investigate statements that a client might make regarding nervousness, feeling sad and lonely. These feelings 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.

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.

Feelings of loneliness or social isolation

Feelings of loneliness or social isolation				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment

Pre-population	✓	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has recently (i.e. within the last four weeks) had feelings of loneliness or social isolation.			

Type				
Response options	▪ Loneliness ▪ Social isolation			
Business rules	If 'Feelings of loneliness or social isolation' = Yes, select one or multiple.			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	See Feelings of loneliness or social isolation.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Feelings of loneliness or social isolation' = Yes			
Assessment level	✓	Home Support Assessment	×	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record: • The feelings of loneliness experienced by the client (e.g. feeling lonesome, alone, deserted). • The feelings of social isolation experienced by the client (e.g. isolation from family, friends, their community). • Over what timeframe the feelings have been experienced • How frequently these feelings are experienced • The impact of these feelings on day-to-day tasks and the client's quality of life • Whether the client is receiving assistance to manage these feelings, and from whom.			

Considerations for best practice

Context:
This refers to whether the client experiences feelings of loneliness or social isolation.

- Feelings of loneliness can be expressed as feeling lonesome, alone, deserted or isolated from friends/family/ their community. 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?
- Social isolation is a major and prevalent health problem among older adults living in the community. It 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.' Examples of social 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.
- Where a person's capacity to live at home is at risk due to their geographic isolation and associated difficulties with effective service provision.

Consider/record:

- The feelings experienced by the client
- The frequency of the feelings (a little of the time, some of the time, all of the time)
- Positive indicators of social isolation. For example, behavioural habits, cognitive changes or physiological changes.

Prompts/observations:

- When was the last time you went on an outing?
- What hobbies have you enjoyed doing? Do you still do them?
- Have there been any changes to your usual daily routine?
- Do you have a group of friends that you see regularly?
- Observe whether the client is exhibiting signs of withdrawal, stress or loneliness, such as through facial expressions, or hoarding/squalor.

Kessler 10 (K10)

K10				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			

Considerations for best practice

Context:
The Kessler 10 (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.

Instructions and interpretation:
The 10 item scale has five response categories and the score is the sum of those responses. 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).

- Scores of under 20 are likely to be well
- Scores of 20-24 are likely to have a mild mental disorder
- Scores of 25-29 are likely to have moderate mental disorder
- Scores of 30 and over are likely to have a severe mental disorder.

KICA-Carer: Cognitive Informant Report

KICA-Carer: Cognitive Informant Report				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	The KICA-Carer is an informant questionnaire given by the interviewer. It is the informant cognitive subsection of the Kimberley Indigenous Cognitive Assessment (KICA) that was developed and validated in the Kimberley region of Western Australia.			

Considerations for best practice

Context:
Cognitive assessment of Aboriginal Australians aged over 45 years can be undertaken using in the KICA-COG. In the instance that the client is not assessed directly, assessors could use the KICA-Carer with an informant.

Instructions and interpretation:
A cut-off score of ≥3/16 should be used.

Additional information and training resources

- Kimberley Indigenous Cognitive Assessment
- Instruction booklet

Psychological Domain – Psychological

Introduction

The Psychological section relates to the cognitive, behavioural and psychological signs, symptoms and conditions the experiences. It seeks information on memory problems; judgement; delirium; behaviour; agitation; hallucinations; wandering; disturbed sleep; anxiety; symptoms of depression; apathy; loneliness; social isolation; confusion and disorientation.

Short term memory problems

Short term memory problems				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	When a client experiences short term memory loss he or she can remember incidents from 20 years ago but are unable, for example, to remember details of events that happened 20 minutes ago. Each client may have different time deficits.			

Long term memory problems

Long term memory problems				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	In contrast to short term memory problems a person is able to remember events/details within a short time period but is unable, for example, to remember events/details from their childhood. Each client may have different time deficits.			

Impaired judgement

Impaired judgement				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary

Help text	This condition results in a person not being able to make good decisions due to underlying medical problems.

Delirium

Delirium				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	An acute change in mental status characterised by a disturbance of consciousness, attention, cognition and perception that can develop hours to a few days.			

At risk behaviour

At risk behaviour				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Behaviours that put the client or others at risk of harm.			

Aggressive behaviour – Verbal

Aggressive behaviour – Verbal				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Where a client yells, screams and/or threatens.			

Aggressive behaviour – Physical

Aggressive behaviour – Physical				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Where a client hits, scratches, bites, pushes, shoves, throws things or			

	uses weapons.

Resistive behaviour

Resistive behaviour				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Where a client resists/opposes or withstands help or caregiving tasks such as taking medication, eating or self-feeding.			

Agitation

Agitation				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Extreme emotional disturbance.			

Hallucinations/delusions

Hallucinations/delusions				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Hallucinations can occur in any sensory modality: auditory, visual, olfactory, gustatory and tactile. Delusions are false or erroneous beliefs that usually involve a misinterpretation of perceptions or experiences.			

Wandering

Wandering				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	To move about without a definite destination or purpose.			

Disturbed sleep/insomnia

Disturbed sleep/insomnia				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Persistent difficulty in initiating or maintaining sleep.			

Anxiety

Anxiety				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Unpleasant state of inner turmoil, often accompanied by nervous behaviour such as pacing back and forth, somatic complaints and rumination.			

Symptoms of depression

Symptoms of depression				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Depressive symptoms include physical symptoms, long periods of feeling lonely, overwhelming feelings of being unable to keep going or regular tears.			

Apathy

Apathy				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Absence or suppression of passion, emotion or excitement.			

Loneliness

Loneliness				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Loneliness can be expressed as feeling lonesome, alone, deserted or isolated from friends/family/ their community.			

Social isolation

Social isolation				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Where a client lacks engagement with others, has a minimal number of social contacts and is deficient in fulfilling quality relationships.			

Confusion

Confusion				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	This behaviour can come on quickly or slowly over time depending on the cause.			

Disorientation – time

Disorientation – time				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Unable to identify the time, day, date or year.			

Disorientation – place

Disorientation – place				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Unable to identify where they live or where they are currently placed.			

Disorientation – people

Disorientation – people				
Response options	See Psychological – Scale.			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Unable to identify person(s) such as family or friends.			

Psychological – Scale

Scale				
Response options	• Unable to determine • Never • Occasionally • Regularly • Always			
Business rules	Mandatory. Select one option.			
Assessment level	×	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	These questions record whether the client exhibits the following cognitive/behavioural/psychological signs and symptoms. Each sign or symptom should be recorded using the following scale: • Unable to determine: This response should only be chosen due to the client being unable to communicate that they are exhibiting the behaviours or others are unable to quantify this type of behaviour. • Never: There is no evidence that 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 e.g. one			

	or more times during a week • Always: A client exhibits behaviours daily.

Psychological – Details

Details				
Response options	Text (maximum 1500 characters)			
Business rules	N/A			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✓	Assessment Summary
Help text	A detailed description of the psychological conditions/signs and symptoms identified at assessment effecting a client's ability to undertake activities of daily living and instrumental activities of daily living. The descriptions can include such matters as: decision making, ability to recognise family and friends, or any behaviours of concern. Record outcomes of relevant Supplementary Assessment Tools.			

Considerations for best practice

Context:
This refers to a summary of the frequency of the signs, symptoms and conditions recorded in the Psychological Domain.

Consider/record:

- The signs, symptoms and conditions experienced by the client, and the frequency of these experiences.
- Any associated diagnoses, and the diagnosis date.
- The impact of the signs, symptoms and conditions.
- The impact of health conditions on the signs and symptoms.
- The use of Supplementary Assessment Tool(s) and the result, including any area of concerns or follow-up.

Prompts/observations:

- Observe the client's ability to discuss and answer questions relating to these signs, symptoms and conditions – do they change the topic? Do they become tangential? Are they aware of time and place?
- Does the client perseverate, confabulate, have word finding difficulties?
- Does the client get confused? Lack the ability to plan and implement tasks?
- Does the client present with memory loss, disorientation, disordered thought patterns?
- Is the client able to participate in the assessment process? Is the information being provided accurate and reliable? Seek information/confirmation from the client's carer or representative, where appropriate.

Geriatric Depression Scale

Geriatric Depression Scale				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	A depression assessment tool specifically designed for older people.			

Considerations for best practice

Context:
The Geriatric Depression Scale (GDS) (15 point version) is a depression assessment tool specifically designed for older people. 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. Some items in the GDS may not be appropriate at all times for all cultural groups.

Instructions and interpretation:
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. 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?

Home and Personal Safety

Introduction

The Home and Personal Safety section relates to a client's safety in their usual accommodation setting. It seeks information on the home environment; home safety; home maintenance (including gardening); and personal safety.

General observations of the home environment

General observations of the home environment				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if '[Assessment Setting]' = 'Client's home'.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	During an assessment, observation provides an opportunity to note a client's home environment. An assessor can make observations about the client's safety in their home, including how they: • Negotiate stairs (internal and external) and uneven flooring • Access cupboards, the garden, clothesline, letterbox, driveway • Move freely around the home. Observe whether: • There is clutter present. • The garden is neat and tidy or overgrown. • Light globes (inside and outside) are working, and there is adequate natural lighting. • The home is in need of general maintenance and repairs.			

Considerations for best practice

Context:
This refers to the general observations an assessor can make of the client's home environment.

During an assessment, observation provides an opportunity to note a client's home environment.

Consider/record:

- How the client is able to negotiate internal and/or external stairs and uneven/different floor surfaces
- Whether the client can access cupboards, the garden, the clothesline, the letterbox, the 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 inadequate natural lighting
- If the home is in need of general maintenance and repairs.
- If there is clutter present and whether a client is able to move freely around the home.

Home safety

Home safety				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether there are any risks, hazards or concerns to a client in their home. This may include access issues (broken steps, uneven footpath or overgrown lawns/garden), presence of pets, or signs of clutter or hoarding. Also record whether the client has a smoke alarm; personal alarm; personal emergency plan in case of fire, heat wave or flood; or uses other technology to ensure home safety.			
Type				
Response options	▪ Smoke alarm ▪ Personal alarm ▪ Personal emergency plan ▪ Other technology			
Business rules	If 'Home safety' = Yes, select one or multiple.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	See Home safety.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Home safety' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • The type of risks, hazards or concerns • The impact it has on the client			

	• Any barriers to the client's independence. Also consider and record: • Whether the client's smoke alarm(s) are in good working order, have recently been checked, or whether the client is in need of additional smoke alarm(s) • The client's familiarity with their emergency plan • Whether the client would benefit from having a personal emergency plan developed • What other technologies the client utilises in order to ensure home safety, and how the client maintains these.

Considerations for best practice

Context:
This refers to the safety of the client in their home, and whether there are any risks, hazards or concerns.

Clients need to feel safe in their own homes; and their home has to be safe for them. Safety can be ensured in a number of different ways. Technologies to assist with home safety include:

- **Smoke alarms**: Smoke alarms are vital in ensuring lives are protected. They are designed to alert residents to smoke or fire, in time to act or evacuate. 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.
- **Personal alarm:** A personal alarm is a safety device that allows a user to call for assistance in an emergency. It 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; or an Emergency Pendant.
- **Personal emergency plans:** Plans that are developed to outline what actions the client would take in the event 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 plan should be developed in collaboration with the people and and/or groups that they intend to utilise in an emergency.

Consider/record:

- Any risks, hazards or concerns in the home environment. This may include access issues (broken steps, uneven footpath or overgrown lawns/garden), presence of pets, or signs of clutter or hoarding
- Whether the client has a smoke alarm, whether it has been checked in the last year, and whether the client requires more than one smoke alarm. For example, where there is a high level of hoarding, or for a client who smokes in their home.
- Whether the client has a personal alarm, and whether it has been checked in the last

year
- Whether the client has a personal emergency plan in place, or would benefit from developing one.

Prompts/observations:
- Do you have any concerns about risks or hazards in your home?
- Do you wear your personal alarm at all times? What happens if you have a fall or need assistance?
- When checking/testing the personal alarm, does the client know how to operate it?

Recommendations:
- Recommendation/referral to state and territory specific programmes that assist older people to install, maintain and/or replace smoke alarms.

Home maintenance (including gardening)

Home maintenance (including gardening)				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client is able to keep their home in a safe and habitable condition, for example, changing light bulbs and basic gardening.			
Support received (formal/informal)				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Home maintenance (including gardening)' = yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • Activities the client undertakes to maintain their home, and how frequently they undertake these activities. • Any assistance or supervision of another person with basic maintenance and repair of the person's home, garden or yard.			

Considerations for best practice

Context:
This refers to whether the client is able to keep their home in a safe and habitable condition, for example, changing light bulbs and basic gardening.

Consider/record:
- Activities the client undertakes to maintain their home, and how frequently they undertake these activities.

- Any assistance or supervision of another person with basic maintenance and repair of the person's home, garden or yard.

Prompts:

- 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?
- 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?

Personal safety

Personal safety				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has any issues with personal safety, including family violence (including physical danger or other threats), abuse (including physical, emotional, financial), presence of weapons, other reported issues etc.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Personal safety' = yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Consider and record: • The issues the client has with maintaining personal safety. • The impact it has on the client. • Any barriers to the client's independence. • Whether information should be recorded in a sensitive attachment. Also consider and record: • Whether the client's personal alarm(s) are in good working order, have recently been checked, or whether the client is in need of additional personal alarm(s). • Whether the client wears their personal alarm at all times. • What other technologies the client utilises in order to ensure personal safety, and how the client maintains these.			

Considerations for best practice

Context:
This refers to whether the client has any issues with personal safety, including family violence, abuse, presence of weapons, or other reported issues.

For some clients, they are at a vulnerable stage in life. Personal safety is important, and there are many factors and influences that can contribute to a client feeling safe – or unsafe – when engaging with people, including those who they trust.

Consider/record:

- Details provided by the client relating to personal safety concerns
- The impact the concerns are having on the client.
- Whether information should be recorded in a sensitive attachment.

Prompts/observations:

- Be aware of sudden and unusual behaviour patterns in the client, not only in the home but also in other situations and settings.
- Observe the behaviour the 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
  - Lacking interest
  - Presenting as helpless, hopeless or sad
  - Being afraid of one or more persons.

Linking Support

Introduction

Linking support is designed to assist clients who have issues or circumstances that may impede their access to aged care services. Linking support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support or care, to the extent that the client is willing or able to access aged care services.

The assessment assists to identify the complexity of a client, and their risk of vulnerability, indicating a potential need for linking support. Assessor judgment also plays a significant role, as the presence of the same risk in different people may signify varying degrees of vulnerability.

More information on linking support is available in the My Aged Care Assessment Manual.

Complexity Indicators

Client 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

Client 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				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A.			
Considerations for best practice				
Context: This indicator reflects people: • **Living in inadequate housing:** Such as sub-standard dwellings, poor sanitation, squalor, or unsafe/unsuitable housing for the person's level of functioning. • **With precarious tenure or who have imminent loss of ownership or accommodation rights:** Where there is a likelihood of having to move because of increased rental and/or unsuitable accommodation that does not meet their needs. • **Living in unstable housing:** Such as boarding and lodging, public housing, and staying with friends and/or relatives. • **Who are homeless:** Those 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). Homeless people have an increased risk of adverse health-related outcomes. Those having experienced long term homelessness are more likely to have risk factors such as alcohol and drug misuse and higher rates of mental and physical illness.

Consider/record:

- Relevant information in Home Safety or Support Considerations.

Prompts:

- 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.

There is risk of, or suspected or confirmed abuse

There is risk of, or suspected or confirmed abuse				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✖	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This indicator reflects people who are at risk of suspected abuse or there is confirmed abuse. The harm may be intentional or unintentional and may be caused by another person with whom the person has a relationship of trust.

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.

Consider/record:

- Relevant information in Personal safety or Support Considerations.

Prompts:

- The types of abuse can include physical abuse, sexual abuse, psychological abuse and financial abuse (including lack of control of finances).
- It can also involve neglect or failure to provide necessary food, shelter, clothing, medical care or emotional support.
- Other issues that may play a role include carer stress, difficulties accepting care due to health status, family violence or conflict, isolation, dependency, psychological problems and addictive behaviours in the abuser.

Client has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support

Client has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This indicator reflects clients 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 may lead to periods of rapid deterioration. Poor mental health may impact on a person's social relationships and risk of 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.

Consider/record:

- Relevant information in Health Conditions, Psychosocial, Psychological or Support Considerations.
- The impact of the client's emotional or mental health issues, and how frequently it is experienced (intermittent or ongoing).
- Whether the client is current receiving support to manage their emotional or mental health issues.
- How the client can be supported to establish a meaningful, accepted place in the community.

Prompts:

- How are you coping day-to-day? Do you find yourself motivated to look after yourself? To participate in your community?

Recommendations:

- Recommendation/referral to a GP, mental health services, psychiatrist.

Client is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support

Client is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This indicator reflects people who are without ongoing financial support as a result of circumstances including debt, unemployment, age or a disability. This may be 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. Financial issues may also include gambling issues and an inability to pay for services needed (such as private medical bills incurred by people ineligible for Medicare).

Consider/record:

- Relevant information in Support Considerations.

Prompts:

- Impacts of financial disadvantage may include not having the available resources to purchase healthy food, afford appropriate housing, pay for utilities and services or cover medical and dental costs.

Client 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

Client 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				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✖	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This indicator reflects people who have experienced adverse effects of institutionalisation and/or systems abuse, and are refusing assistance or services when these 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.

Consider/record:

- Relevant information in Support Considerations.

Client is exposed to risks due to drug and/or alcohol related issues and likely to cause harm to themselves or others

Client is exposed to risks due to drug and/or alcohol related issues and likely to cause harm to themselves or others				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✖	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This indicator reflects people exposed to risks due to drug and/or alcohol issues and who are likely to cause harm to themselves or 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.

Consider/record:

- Relevant information in Physical Health, Personal Health or Support Considerations.

Recommendations:

- Recommendation/referral to local drug and alcohol services.

Client is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others

Client is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✖	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
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 (including living in squalor).

People who may be susceptible include those who are socially isolated and/or lacking carer

support or have a cognitive impairment lacking insight into their day to day activities of daily living.

Consider/record:

- Relevant information in Personal safety or Support Considerations.
- Signs of self-neglect, shown through the client's living conditions (e.g. appropriate heating/cooling, sanitation, need for repairs, hoarding, animal or insect infestation), health and nutrition concerns (e.g. illness, injury, dehydration and malnutrition, poor personal hygiene) and behaviour (e.g. changes in behaviour, hallucinations, delusions).

Prompts:

- Are you looking after yourself? What stops you from looking after yourself?

Client has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support

Client has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support				
Response options	• Yes • No			
Business rules	Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
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. This includes people with mild cognitive impairment to those with severe dementia.

Limitations in self-care capacity relates to the impact of the condition on the person's ability to perform self-care 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.

Relevant information in Health Conditions, Cognition, Psychological or Support Considerations.

Prompts:

- See Changes in memory and thinking.

Risk of Vulnerability

Risk of Vulnerability – Cohort

Cohort				
Response options	▪ Aboriginal or Torres Strait Islander ▪ Veteran ▪ Change in family/carer support arrangements ▪ Refugees, asylum seekers or recent migrants without support ▪ Lesbian, Gay, Bisexual, Transgender, Intersex or other gender diverse individuals ▪ Culturally and linguistically or ethnically diverse individual ▪ Socially isolated individual			
Business rules	Select one or multiple.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This question asks whether the client belongs to a population cohort who is at risk of vulnerability.

Vulnerable older people often need additional support and short-term management to access services. The assessment process is designed to identify vulnerable people and refer them to the appropriate pathway for support.

Consider/record:

- If the client is at risk of vulnerability associated with belonging to one of the cohorts identified.

Prompts:

- Some of the complex issues these vulnerable cohorts may experience include homelessness, mental health issues, drug and alcohol issues, older people and systems abuse, neglect, financial disadvantage and cognitive decline.

Linking Support

Does the client have one or more complexity indicators that impact on their ability to live independently in the community?

Does the client have one or more complexity indicators that impact on their ability to live independently in the community?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option. Should one or more Complexity Indicators = Yes, 'Yes' will be pre-selected.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has one or more complexity indicators that impact on their ability to live independently in the community.			

Considerations for best practice

Context:
This question asks whether the client has one or more areas of complexity that impact on their ability to live independently in the community.

Consider/record:

- The information collected in Complexity Indicators.

Prompts:

- Review the information collected at assessment, the complexity indicators identified and whether the client is at risk of vulnerability.
- Consider whether the clients' complexity is impacting on their ability to complete daily activities, and live independently in the community.

Does the risk or issue warrant urgent intervention and/or support to minimise deterioration?

Does the risk or issue warrant urgent intervention and/or support to minimise deterioration?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether the identified complexity warrants urgent intervention and/or support to minimise deterioration.			

Considerations for best practice
Context: This question asks whether the risk or issues needs to be immediately addressed in order to prevent further deterioration. **Consider/record:** • Whether the client's level of complexity needs to be addressed urgently. **Prompts:** • How long has the client experienced the risk or issue? Is it a new or emerging issue? • How is the risk or issue currently being managed? • What factors are likely to contribute to – or inflate – the risk or issue?

Does the client present with indicators that impede access to delivery of aged care services?

Does the client present with indicators that impede access to delivery of aged care services?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether 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. Reasons for their refusal may include a lack of insight due to cognitive, memory, mental health or substance abuse issues, or extreme levels of independence. 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 from 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.			

Considerations for best practice
Context: This question asks if the client's level of complexity is impacting on their ability to access aged care services. This can include clients who refuse assistance required to maintain safety and wellbeing at home. Reasons for their refusal may include a lack of insight due to cognitive, memory, mental health or substance abuse issues, or extreme levels of independence. 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 from being

carried out.

Consider/record:

- What is impacting on the client's ability to access aged care services and why (e.g. cognitive impairment, history of experiences).

Prompts:

- It is important to clarify what if anything the person wants to happen, and to acknowledge their ambivalence in a respectful manner.

Support Considerations – Client Motivations

Introduction

The Client Motivations section relates to understanding what is important for the client. It seeks information on what is important and why; what is important in relation to their support; how satisfied the client is with their level of independence; and what they hope will change if they were able to receive support.

What is most important to you right now? Why?

What is most important to you right now? Why?				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	This question asks the client to share what is important to them. Have the client consider what is: • **Important to them:** What makes them happy/content/fulfilled and improves their sense of wellbeing? • **Important for them:** What is required to ensure their health and safety, develop a positive perception of themselves and optimise their community connections? • **Important for us:** What makes the client happy when key persons within their life are happy/content and feeling supported.			

Considerations for best practice

Context:
This question asks what is most important to the client, and why.

It is important to understand what is important to a client, at the time they are seeking support. Collecting this information directly from the client helps to inform the client's goals and recommended supports.

Consider/record:

- Encourage the client to speak openly if they feel comfortable.
- Ask the client to consider what is important to them, for them, and for us.
- Ask open-ended questions.
- Be specific – find out about the specific elements of the role, activity or issues that are important.
- Aim for balance – recognise what is important to remain healthy and safe as well as what makes the client happy.

Prompts:

- 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?

Is there anything important to you in relation to the support you may receive?

Is there anything important to you in relation to the support you may receive?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	This question asks whether the client has identified any important supports.			
Comments				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Is there anything important to you in relation to the support you may receive?' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Record the identified supports the client has indicated are important.			

Considerations for best practice

Context:
This question asks the client what is important to them if regards to the support they may receive.

It is important to have a shared understanding of the desired outcomes of the client, and where relevant, other family members. For example, in culturally and linguistically diverse communities, extended families play a key role in goal setting, agreeing on priorities and providing support.

Consider/record:

- The important supports the client has identified.
- The reason why it is important for the client.

Prompts:

- What is the most important aspect of your life?
- What would assist you to have more good days?

- What is important for others to know about you?

How satisfied are you with your current level of independence?

How satisfied are you with your current level of independence?				
Response options	• 1 • 2 • 3 • 4 • 5 • Unable to determine			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	How satisfied the client is with their current level of independence on a scale from 1 (not at all satisfied) to 5 (very satisfied). 'Unable to determine' may be used in instances where the assessor cannot elicit this information from the client.			
Details				
Response options	Text (maximum 300 characters)			
Business rules	N/A			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record information relating to what is contributing to the client's current level of satisfaction with their independence.			

Considerations for best practice

Context:
This question asks the client how satisfied they are with their current level of independence.

Understanding a client's level of satisfaction with their independence will help inform the goal setting process, including how motivated the client is to achieve their goals, and the level of support they might wish to receive.

Consider/record:

- How satisfied the client is with their current level of independence, where 1 indicates that they are not at all satisfied, and 5 indicates that they are very satisfied.
- The reasons for the client's level of satisfaction with their independence.

Prompts:

- How do you think you are managing?
- Are you happy with how you are going?
- How do you feel?

- Are you happy with how independent you are? Would you like to be more independent?

What do you hope will change if you are to receive support?

What do you hope will change if you are to receive support?				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	This question asks the client what they hope to change by receiving support. Empower the client to make suggestions and contributions. This provides them with the opportunity to take the lead, set the direction and reinforces your commitment to collaborative planning.			

Considerations for best practice

Context:
This question asks the client to consider what they hope will change if they were able to receive support.

By asking this question, the client will feel empowered to make suggestions and contributions to the support planning process. It gives the client the opportunity to lead and set the direction of the conversation, and reinforces the commitment to collaborative care planning.

Consider/record:

- The activities the client wishes to continue to undertake.
- The activities the client wishes to have support with and how they would like to receive that support.
- The outcomes the client would like to achieve.

Prompts:

- 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?

Support Considerations – Support Considerations

Introduction

The Support Considerations section relates to understanding what is important for the client in regards to how support is provided. It seeks information on whether the client has any cultural and/or religious values and beliefs; gender identity or sexual orientation/sexuality or experience of discrimination; history of childhood experiences; or other information that providers should be aware of.

Does the client have any cultural and/or religious values or beliefs that are important to know or would affect services being provided?

Does the client have any cultural and/or religious values or beliefs that are important to know or would affect services being provided?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Does the client have any cultural and/or religious values or beliefs that are important to know or would affect services being provided?' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record the client's specific cultural and/or religious needs for consideration during assessment and service delivery. Be as accurate as possible when documenting what the client states about their cultural and/or religious values and the beliefs important to them. Ensure you have the client's consent to record this information.			

Considerations for best practice
Context: This question asks the client whether they have any cultural and/or religious values or beliefs that are important to know, or would affect services being provided. 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, and the recommendations in which they action. **Consider/record:** • The information provided by the client. • Specific information relevant to previous experiences with service provision. **Prompts:** • Are there any cultural considerations I should know about to serve your health needs? • 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 or 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? • Are there certain healthcare procedures and tests which your culture prohibits?

Does the client have a gender identity or sexual orientation/sexuality or experience of discrimination that is important to know or would affect services being provided?

Does the client have a gender identity or sexual orientation/sexuality or experience of discrimination that is important to know or would affect services being provided?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	This question asks whether the client has a gender identity or sexual orientation/sexuality or experience of discrimination that may affect services to be provided.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Does the client have a gender identity or sexual orientation/sexuality or experience of discrimination that is important to know or would affect services being provided?' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment

Pre-population	✖	Add in Support Plan	✖	Assessment Summary
Help text	Consider and record the information provided by the client with regard to their gender identity and/or sexual orientation. 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. Ensure you have the client's consent to record this information.			

Considerations for best practice

Context:
This question asks the client whether they have a gender identify or sexual orientation/sexuality, or experience discrimination that may affect services being provided.

Clients who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) 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 their 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 disclose and have their identity recognised and embraced. Others may not have any choice about disclosing – which can often be the case for transgender or intersex people.

It is important for those assessing clients 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.

Consider/record:

- The information provided by the client.
- Specific information relevant to previous experiences with service provision.

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 affect services being provided?

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 affect services being provided?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	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.			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if '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 affect services being provided?' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record specific events or experience in the client's past history for consideration during assessment and service delivery. Ensure you have the client's consent to record this information.			

Considerations for best practice

Context:
This question asks the client whether they have a history of childhood experiences that is important to know about or 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.

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.

Consider/record:

- The information provided by the client.
- Specific information relevant to previous experiences with service provision.

Is there any further information that provider(s) should be aware of?

Is there any further information that provider(s) should be aware of?				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Whether the client has provided any further information that would impact on service delivery or should be known by service provider(s).			
Details				
Response options	Text (maximum 500 characters)			
Business rules	Mandatory if 'Is there any further information that provider(s) should be aware of?' = Yes.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	×	Add in Support Plan	×	Assessment Summary
Help text	Consider and record the information provided by the client. This may include specific information relevant to how support is provided to the client. Ensure you have the client's consent to record this information.			

Considerations for best practice

Context:
This question asks the client if there is any further information the provider should be aware of, should they be referred for services.

By identifying what is important to the client in regards to the delivery if services will help build trust, promote information sharing, and also alert service providers of any issues related to service provision.

Consider/record:

- The information provided by the client.

Attachment

Attachment				
Response options	• Yes • No			
Business rules	Mandatory. Select one option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✗	Assessment Summary
Help text	Whether the client has provided information of a sensitive nature that needs to be recorded. Enter information provided by client in the attachment, and attach to the client record as a 'Sensitive attachment'. This attachment will be visible to the My Aged Care contact centre and assessors, and an alert will be provided to service providers who accept a referral for the client that sensitive information is available. Providers will be instructed to contact the assessor or contact centre to access this information. In the attachment, assessors should record who should have access to the information and whether certain information should be restricted and to whom.			

Considerations for best practice

Context:
This refers to whether there is information of a sensitive nature that has been included as an attachment added to the Client Record.

A template is available which enables assessors to record information that is of a sensitive nature, and attach it to the Client Record. Assessors also have the ability to record information in Sensitive Notes.

Assessors are strongly encouraged to have open conversations with clients and record the outcomes of those conversations within the assessment.

Consider/record:

- The information the client has provided that is sensitive.
- Who that information can – and cannot – be provided to.
- Whether the issue(s) identified need to be discussed with a Team Leader/Manager or reported (as per local processes).
- Whether the issue(s) identified may impede access to services.

Prompts/observations:

- **Concern with financial situation**
  - 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.
- **Concern with living arrangements**
    - If the client is living in squalor
    - The client's appearance and how well maintained their home is, especially if they have a carer who is meant to be assisting with these tasks
    - If the client presents as nervous, worried or scared about something. Take note of how they respond to your questions
    - Whether there are concerns about the behaviour of the representative, carer, family member, or other persons present
    - 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 you and your carer/family or between the carer and your family?

- **Afraid of someone who hurts, insults, controls, or threatens them**
    - 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
    - Document the details provided by the client, including whether it is becoming worse or happening for frequently; and whether the client is scared for their safety.
- **Legal issues that may affect services (e.g. AVO)**
    - Document the dteials provided by the client. 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 making a will?
        - Need help or advice with the administration of finances and legal decisions?
        - Need help or advice with an Enduring Power of Attorney or Guardianship issues?
        - Fear for their safety from family, friends or other persons?
- **Other relevant information**
    - **Document any additonal general comments provided by the client that may be sensitive in nature. Comments might relate to:**
        - The client driving a car
        - The client's personal emergency plan
        - Assistance required to maintain the client's safety and wellbeing at home
        - Information that you have obtained from the conversation or referral that is unable to be documented elsewhere.

Support Plan – Identified Needs

Introduction

The Identified Needs section of the Support Plan provides a snapshot of information from the assessment. It displays the assessment summary; and the client's identified needs (functional needs, other considerations, and complexity indicators).

Assessment Summary

Assessment Summary				
Response options	Text (maximum 5000 characters)			
Business rules	Ability to pre-populate from completed assessment information.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✗	Add in Support Plan	✓	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
The assessment summary can be pre-populated based on the information an assessor records in the assessment. A list of the assessment fields that will populate in to the assessment summary is at Appendix C.

The assessment summary should follow the ISBAR format:

- Introduction
- Situation
- Background
- Assessment
- Recommendations.

The assessment summary needs to be written in language the client can understand. It can also be used to inform the client's representative(s), healthcare professionals and service providers of the assessment findings and outcomes. It is also a useful tool that informs ongoing discussion, monitoring and review.

Functional Needs

Functional Needs	
Response options	▪ Transport – [Client requires assistance with this activity] ▪ Shopping – [Client requires assistance with this activity] ▪ Meals Preparation – [Client requires assistance with this activity] ▪ Housework – [Client requires assistance with this activity] ▪ Medicine Management – [Client requires assistance with this activity] ▪ Money Management – [Client requires assistance with this activity]

	▪ Walking – [Client requires assistance with this activity] ▪ Showering – [Client requires assistance with this activity] ▪ Dressing – [Client requires assistance with this activity] ▪ Eating – [Client requires assistance with this activity] ▪ Transfers – [Client requires assistance with this activity] ▪ Toileting (bladder) – [Client requires assistance with this activity] ▪ Toileting (bowels) – [Client requires assistance with this activity]			
Business rules	Functional need displayed based on selected 'Address in Support Plan' option and associated response to 'Client requires assistance with this activity'.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This refers to where information relating to a client's functional needs is populated from the assessment into the Support Plan.

It is important for an assessor to ensure all identified needs are considered as part of the goals, considerations and recommendations included in the Support Plan.

Other Considerations

Other Considerations	
Response options	▪ Social and community participation ▪ Carer sustainability ▪ Respite ▪ Health literacy ▪ Sensory concerns ▪ Communication difficulties ▪ Slips, trips and falls ▪ Driving ▪ Oral health ▪ Swallowing ▪ Appetite, weight loss and fluid intake ▪ Skin conditions ▪ Pain ▪ Sleep ▪ Physical activity ▪ Alcohol use ▪ Tobacco use ▪ Recent hospitalisation ▪ Health conditions ▪ Allergies and/or sensitivities

	▪ Changes in memory and thinking ▪ Changes in personality ▪ Changes in behaviour ▪ Feelings of nervousness or depression ▪ Feelings of loneliness or social isolation ▪ Psychological considerations ▪ Home safety ▪ Home maintenance (including gardening) ▪ Personal safety			
Business rules	Other considerations displayed based on selected 'Address in Support Plan' option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✖	Assessment Summary
Help text	N/A.			

Considerations for best practice

Context:
This refers to where information relating to a client's other considerations is populated from the assessment into the Support Plan.

It is important for an assessor to ensure all identified needs are considered as part of the goals, considerations and recommendations included in the Support Plan.

Complexity Indicators

Complexity Indicators	
Response options	▪ Client 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 ▪ There is risk of, or suspected or confirmed abuse ▪ Client has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support ▪ Client is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support ▪ Client 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 ▪ Client is exposed to risks due to drug and/or alcohol related issues and likely to cause harm to themselves or others ▪ Client is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others ▪ Client has a memory problem or confusion that significantly limits

	self-care capacity, requires intensive supervision and/or frequent changes to support			
Business rules	Other considerations displayed based on selected 'Address in Support Plan' option.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Pre-population	✓	Add in Support Plan	✗	Assessment Summary
Help text	N/A			

Considerations for best practice

Context:
This refers to where information relating to a client's complexity indicators is populated from the assessment into the Support Plan.

It is important for an assessor to ensure all identified complexity indicators are considered as part of the goals, considerations and recommendations included in the Support Plan.

Support Plan – Goals & Recommendations

Introduction

The Goals and Recommendations section of the Support Plan provides a snapshot of information from the assessment. It displays the assessment summary; and the client's identified needs (functional needs, other considerations, and complexity indicators).

Area of concern

Area of concern				
Response options	Text (maximum 255 characters)			
Business rules	N/A			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: Areas of concern should capture key information about the client's life, interests, abilities and challenges. It is not a list of the client's problems, or a list of the services they wish to receive. Ask the client to prioritise their areas of concern. **Consider/record:** • Short and simple areas of concerns that can be addressed through one or more of the client's goals.				

Goal

Goal				
Response options	Text (maximum 255 characters)			
Business rules	Record per identified Area of concern.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: Goal setting with the client enables assessors to have a clear focus on the priorities for the client, to be addressed through the client's Support Plan. 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 needs to be followed by goals, strategies and				

solutions to address the issues identified.

Throughout the assessment, it is likely that the person will have referred to various goals but they are not seen as, or called, 'goals'. An assessor should identify these goals and have a conversation with the client about them.

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 is it 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.

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 be 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 etc.

Assessors need to ensure that they maintain an empowering, strengths-based approach that values the individual needs and preferences of the client. This is particularly important 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), has limited or no English language skills, is from a culturally and linguistically diverse background, has a terminal condition and/or is receiving palliative care and/or limited motivation or is resistant to care.

Prompts:

- What's working well for you at the moment that we could build on?
- What do you do well?
- What are the things that you're managing well with 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 strengths and abilities in relation to this goal?

What are the client's current strengths and abilities in relation to this goal?				
Response options	Text (maximum 255 characters)			
Business rules	Record per identified Goal.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: A strengths-based and solution-focused approach to assessment and support planning requires the assessor to identify the person's strengths, talents, capabilities and resources 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.				

What are the client's current areas of difficulty or activities where the client needs support in order to achieve this goal?

What are the client's current areas of difficulty or activities where the client needs support in order to achieve this goal?				
Response options	Text (maximum 255 characters)			
Business rules	Record per identified Goal.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: Having a client identify their areas of difficulty and/or the supports they need assists the client to understand their current limitations that need to be further developed in order to achieve their goal. Having this conversation helps to ensure that 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.				

Motivation to achieve

Motivation to achieve				
Response options	▪ 1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10			
Business rules	Record per identified Goal.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: It is important to understand a client's motivation to achieve each of their goals. This enables assessors to discuss and prioritise recommendations and supports associated with each goal. **Consider/record:** • The client's motivation to achieve each goal on a scale from 1 (not motivated) to 10 (extremely motivated). This rating is to be made by the client, not by the assessor.				

Goal status

Goal status				
Response options	▪ In progress ▪ Achieved ▪ No longer relevant			
Business rules	Record per identified Goal.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				
Context: 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. Assessors can: • Edit or remove goals or concerns from a client's Support Plan. These may be goals				

and/or concerns that have been recently added, or added by a previous assessor.
- Edit or remove recommendations in some instances. This will depend on the status of any associated referrals.
- View the history of goals, concerns and recommendations by viewing the Support Plan history.

General Recommendations

Recommendation				
Response options	Text (maximum 255 characters)			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
General recommendations relate to 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 engage in an activity that they wish to undertake.

Assessors can add general recommendations to a client's Support Plan, identifying whether there is an action to be taken by the assessor, client and/or someone else

A general recommendation can be associated to one or more of the client's goals.

Service Recommendations

Service type	
Response options	▪ **Allied Health and Therapy Services** – ATSI Health Worker; Dietitian or Nutritionist; Diversional Therapy; Exercise Physiologist; Hydrotherapy; Occupational therapy; Ongoing Allied Health and Therapy Services; Other Allied Health and Therapy Services; Physiotherapy; Podiatry; Psychologist; Restorative Care Services; Social Work; Speech Pathology. ▪ **Assistance with Care and Housing** – Advocacy – Financial, Legal etc.; Assessment – Referrals etc.; Hoarding and Squalor. ▪ **Case Management**. ▪ **Centre-based Respite** – Centre Based Day Respite; Community Access – Group; Residential Day Respite. ▪ **Client Care Coordination**. ▪ **Cottage Respite** – Overnight Community Respite. ▪ **Domestic Assistance** – General House Cleaning; Linen services; Unaccompanied Shopping (delivered to home).

	▪ **Flexible Respite** – Flexible Respite; Host Family Day Respite; Host Family overnight Respite; In-home Day Respite; In-home Overnight Respite; Mobile Respite; Other planned respite. ▪ **Goods, equipment and assistive technology** – Car Modification; Communication aids; Medical care aids; Other goods and equipment; Reading aids; Self-care aids; Support and mobility aids. ▪ **Home maintenance** – Garden Maintenance; Major Home Maintenance and Repairs; Minor Home Maintenance and Repairs. ▪ **Home modifications**. ▪ **Meals** – At Centre; At Home. ▪ **Multi-Purpose Service** – Residential – Shared room + Ensuite; Shared room + no bathroom or Ensuite; Shared room + shared Bathroom; Single room + Ensuite; Single room + no bathroom or Ensuite; Single room + shared Bathroom. ▪ **National ATSI Aged Care Program**. ▪ **Nursing**. ▪ **Other Food Services** – Food Advice, Lessons, Training, Food Safety; Food Preparation in the Home. ▪ **Personal Care** – Assistance with client self-administration of medicine; Assistance with Self-Care. ▪ **Social Support Group**. ▪ **Social Support Individual** – Accompanied Activities e.g. Shopping; Telephone/Web Contact; Visiting. ▪ **Specialised Support Services** – Client Advocacy; Continence Advisory Services; Dementia Advisory Services; Hearing Services; Other support services; Vision Services. ▪ **Transport** – Direct (driver is volunteer or worker); Indirect (through vouchers or subsidies).			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
Service recommendations can be added to a client's Support Plan e.g. Commonwealth Home Support Program services.

Consider/record:

- The relevant service type and (where required) service sub-type.
- The priority to be associated with the referral to the service type.
- Recommended frequency and intensity of the service, if discussed with the client.
- 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 goals within six weeks and a review should then 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, client and/or someone else.
- Whether the service recommendation is associated to one or more of the client's goals.

Assessors can:
- Edit or remove recommendations in some instances. This will depend on the status of any associated referrals.
- View the history of recommendations by viewing the Support Plan history.

Recommend a period of linking support

Recommend a period of linking support				
Response options	▪ Short term assistance to access aged care services ▪ Short term assistance to access support outside aged care ▪ Urgent intervention to address risks or issues ▪ Interim support to access specialist linking service ▪ Interim support to access ongoing case management service ▪ Supplementary support to access services in addition to Assistance with Care and Housing ▪ Assistance with Care and Housing unavailable in region ▪ Other			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment
Help text	**What is linking support?** Where a client's complex circumstances may be a barrier to accessing aged care services, providing linking support can assist the client to access various services they require. The level of linking service support offered in My Aged Care is time limited, and is not designed to provide ongoing support services. If linking support is required, the assessor can provide: Short term case management to address the barriers impeding access to aged care services. This includes information provision and tailored advice, guided referral, case conferencing/service coordination and advocacy activities. A referral to Assistance with Care and Housing in CHSP (where it is available in the local area), for clients who have insecure housing arrangements or are homeless. Where Assistance with Care and Housing is not available, RAS are to provide linking support to this client. Non-aged care support to assist the client to access services outside of			

	aged care.

Considerations for best practice

Context:
Where an older person's complex circumstances may impede their access to aged care services, linking support will assist in linking the client to various services they require in order to live in the community with dignity, safety and independence.

Linking support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support, to the extent that the client is willing or able to access aged care services.

The level of linking service support offered in My Aged Care is time limited, and is not designed to provide ongoing support services.

Assessors can add periods of linking support to a client's Support Plan, nominating the start date, recommended end date, reason for the period of support, and any associated comments. At the end of individual periods of linking support, assessors are to indicate the end date, the outcome of the period of support and add any associated comments.

More information on linking support is available in the My Aged Care Assessment Manual.

Recommend a period of reablement

Recommend a period of reablement				
Response options	▪ Rebuild confidence and independence in mobility ▪ Support the development/relearning of daily activities ▪ Task simplification and energy conservation for managing housework ▪ Promote social contact, community access and integration ▪ Skills development in using public transport ▪ To supporting independence through assessment for appropriate aids and equipment ▪ Training in the use of assistive technology ▪ Helping people to manage personal finances ▪ Other			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment
Help text	**What is reablement?** Reablement involves time-limited interventions that are targeted towards a client's specific goal(s) or desired outcome to adapt to some function loss, or regain confidence and capacity to resume their activities. Supports could include training in a new skill, modification to a client's home environment or having access to equipment or assistive technology. If a client is suitable and agrees that short-term reablement support is appropriate, the assessor should include service solutions			

	within the support plan which promote their independence, assist them to maintain and/or strengthen their capacity to undertake daily activities, and maintain social and community connection.

Considerations for best practice

Context:
Reablement involves time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.

If a client is suitable and agrees that short-term reablement support is appropriate, the assessor should include service solutions within the Support Plan which:

- Promote their independence
- Assist them to maintain and/or strengthen their capacity to undertake daily activities
- Maintain social and community connections.

Supports could include training in a new skill, modification to a client's home environment or having access to equipment or assistive technology.

Assessors can add periods of reablement to a client's Support Plan, nominating the start date, recommended end date, reason for the period of support, and any associated comments. At the end of individual periods of reablement, assessors are to indicate the end date, the outcome of the period of reablement and add any associated comments.

More information on reablement is available in the My Aged Care Assessment Manual.

Recommend for Comprehensive Assessment

Recommend for Comprehensive Assessment				
Response options	Add recommendation for Comprehensive Assessment			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✗	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
From Home Support Assessment, a client may be recommended to have a Comprehensive Assessment.

An assessor is to identify:

- The reason that a Comprehensive Assessment is required
- The priority to be associated with the referral to the ACAT
- That client consent has been provided for a referral to be sent to an ACAT.

In order to send a referral for Comprehensive Assessment, the Home Support Assessor will

need to add the recommendation for Comprehensive Assessment. Once the Assessment is finalised, the assessor will be able to issue a referral for Comprehensive Assessment to the selected ACAT.

Add recommended long term living arrangement

Add recommended long term living arrangement				
Response options	• Private residence • Independent living within a retirement village • Supported community accommodation • Residential aged care service • Hospital • Other institutional care • Other community			
Business rules	Select one option.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
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 list of accommodation settings.

Prompts:

- **Private residence:** Includes private residences such as houses, flats, units, caravans, mobile homes, boats and 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 listed as 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 government-regulated Supported Residential Services/Facilities); 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

Add a care type for Delegate Decision				
Response options	▪ Home Care Package Level 1 ▪ Home Care Package Level 2 ▪ Home Care Package Level 3 ▪ Home Care Package Level 4 ▪ Residential Permanent ▪ Residential Respite High Care ▪ Residential Respite Low Care ▪ Short-Term Restorative Care ▪ Transition Care ▪ No Care Approval ▪ No Change to Existing Approvals			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
Care type recommendations relate to care types under the Act which require approval by an ACAT Delegate. More information is available in the My Aged Care Assessment Manual.

Consider/record:

- 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.

Add 'No care type under the Act'

Add 'No care type under the Act'				
Response options	▪ Client withdrew application ▪ Client hasn't applied for care			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✗	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
Where a Comprehensive Assessment has occurred, however, the client has withdrawn their Application for Care or not applied for care, a recommendation of 'No care type under the Act' can be added to the Support Plan. This enables an assessor to finalise the assessment and Support Plan, without needing to submit it to the ACAT Delegate for approval.

Support Plan – Associated People

Introduction

The Associated People section of the Support Plan provides assessors with the opportunity to identify the people who will be helping the client to meet their goals, or who may be assisting in providing support.

People associated with support plan				
Response options	Add person			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			

Considerations for best practice

Context:
This refers to who is involved in the Support Plan.

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.

Consider/record:

- The person(s) name, their relationship to the client and their contact details.
- Whether the person has been involved in the support planning process.
- Whether the client has consented to giving the person a copy of their Support Plan.
- Whether they have been provided with a copy of the Support Plan.

Support Plan – Review

Introduction

The Review section of the Support Plan provides assessors with the opportunity to identify when the client would benefit from a review of their Support Plan.

Schedule a Review				
Response options	DD/MM/YYY			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Reason for review				
Response options	Text (maximum 1000 characters)			
Business rules	See Assessor Portal/myAssessor app.			
Assessment level	✓	Home Support Assessment	✓	Comprehensive Assessment
Help text	N/A			
Considerations for best practice				

Context:
This refers to the date the assessor intends to review the client's Support Plan.

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.

Consider/record:

- The date a review of the client's Support Plan should occur.
- The reason for scheduling a review of the client's Support Plan.

Appendices

Appendix A

Professions of those who participated in the client's assessment

Medical practitioners

- Generalist medical practitioner
- Geriatrician
- Psychogeriatrician
- Psychiatrist
- Rehabilitation specialist
- Other medical practitioners

Nursing Professionals

- Nurse manager
- Nurse educator and researcher
- Registered nurse
- Registered mental health nurse
- Registered development disability nurse
- Other nursing professional

Health Professionals

- Occupational therapist
- Physiotherapist
- Speech pathologist/therapist
- Podiatrist
- Pharmacist
- Aboriginal health worker
- Other health professional

Social Welfare Professionals

- Social worker
- Welfare and community worker
- Counsellor
- Psychologist
- Other social professional
- Interpreter
- Other professional

Appendix B

Health conditions

Category	Code	Condition
No health conditions present	0000	No health conditions present
Certain infectious & parasitic diseases	0101	Tuberculosis
	0102	Poliomyelitis
	0103	HIV/AIDS
	0104	Diarrhoea & gastroenteritis of presumed infectious origin
	0105	Chronic viral hepatitis
	0199	Other infectious & parasitic diseases n.o.s or n.e.c (includes leprosy, listeriosis, scarlet fever, meningococcal infection, septicaemia, viral meningitis)
Neoplasms (tumours/cancers)	0201	Head & neck cancer
	0202	Stomach cancer
	0203	Colorectal (bowel) cancer
	0204	Lung cancer
	0205	Skin cancer
	0206	Breast cancer
	0207	Prostate cancer
	0208	Brain cancer
	0209	Lymphoma
	0210	Leukaemia
	0211	Other malignant tumours n.o.s or n.e.c
	0212	Liver cancer
	0213	Gynaecological cancer (includes ovarian, endometrial/uterine, cervical cancers)
	0214	Kidney cancer
	0215	Bladder cancer
	0216	Pancreatic cancer
	0217	Myeloma (includes multiple myeloma)
	0299	Other neoplasms (includes benign tumours & tumours of uncertain or unknown behaviour)
Diseases of the blood & blood forming organs & immune mechanism	0301	Anaemia (includes pernicious anaemia)
	0302	Haemophilia
	0303	Immunodeficiency disorder (excluding AIDS)
	0399	Other diseases of blood & blood forming organs & immune mechanism n.o.s. or n.e.c (includes hemochromatosis, scleroderma)

Category	Code	Condition
Endocrine, nutritional & metabolic disorders	0401	Disorders of the thyroid gland (includes iodine-deficiency syndrome, hypothyroidism, hyperthyroidism, thyroiditis)
	0402	Diabetes mellitus—Type 1 (IDDM)
	0403	Diabetes mellitus—Type 2 (NIDDM)
	0404	Diabetes mellitus—other specified/unspecified/unable to be specified
	0405	Malnutrition
	0406	Nutritional deficiencies
	0407	Obesity
	0408	High cholesterol
	0499	Other endocrine, nutritional & metabolic disorders n.o.s or n.e.c (includes hypoparathyroidism, Cushing's syndrome, Addison's disease)
Mental & behavioural disorders	0500	Dementia in Alzheimer's disease
	0501	Dementia in Alzheimer's disease with early onset (<65 yrs)
	0502	Dementia in Alzheimer's disease with late onset (>65 yrs)
	0503	Dementia in Alzheimer's disease, atypical or mixed type
	0504	Dementia in Alzheimer's disease, unspecified
	0510	Vascular dementia
	0511	Vascular dementia of acute onset
	0512	Multi-infarct dementia
	0513	Subcortical vascular dementia
	0514	Mixed cortical & subcortical vascular dementia
	0515	Other vascular dementia
	0516	Vascular dementia—unspecified
	0520	Dementia in other diseases classified elsewhere
	0521	Frontotemporal dementia
	0522	Dementia in Creutzfeldt-Jakob disease
	0523	Dementia in Huntington's disease
	0524	Dementia in Parkinson's disease
	0525	Dementia in human immunodeficiency virus (HIV) disease
	0526	Dementia in other specified diseases classified elsewhere
	0530	Other dementia
	0531	Alcoholic dementia
	0532	Unspecified dementia (includes presenile & senile dementia)
	0540	Delirium
	0541	Delirium not superimposed on dementia
	0542	Delirium superimposed on dementia
	0543	Other delirium
	0544	Delirium–unspecified
	0550	Psychoses & depression/mood affective disorders
	0551	Schizophrenia

Category	Code	Condition
	0552	Depression/Mood affective disorders
	0553	Other psychoses (includes paranoid states, hallucinations)
	0560	Neurotic, stress related & somatoform disorders
	0561	Phobic & anxiety disorders (includes agoraphobia, panic disorder)
	0562	Nervous tension/stress
	0563	Obsessive-compulsive disorder
	0564	Other neurotic, stress related & somatoform disorders
	0570	Intellectual & developmental disorders
	0571	Mental retardation/intellectual disability
	0572	Other developmental disorders (includes autism, Rett's syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific developmental disorder of motor function (e.g. dyspraxia))
	0580	Other mental & behavioural disorders
	0581	Mental and behavioural disorders due to alcohol & other psychoactive substance use (includes alcoholism, Korsakov's psychosis (alcoholic))
	0582	Adult personality & behavioural disorders
	0583	Speech impediment (i.e. stuttering/stammering)
	0584	Lewy Body dementia
	0585	Cognitive impairment n.o.s
	0586	Post-traumatic stress disorder
	0599	Other mental & behavioural disorders n.o.s or n.e.c (includes harmful use of non-dependent substances e.g. laxatives analgesics, antidepressants, eating disorders e.g. anorexia nervosa, bulimia nervosa, mental disorders not otherwise specified)
Diseases of the nervous system	0601	Meningitis & Encephalitis (excluding 'viral')
	0602	Huntington's disease
	0603	Motor neurone disease
	0604	Parkinson's disease (includes Parkinson's disease, secondary Parkinsonism)
	0605	Transient cerebral ischaemic attacks (T.I.A.s)
	0606	Brain disease/disorders (includes senile degeneration of brain n.e.c, degeneration of nervous system due to alcohol, Schilder's disease)
	0607	Multiple sclerosis
	0608	Epilepsy (includes seizures)
	0609	Muscular dystrophy
	0610	Cerebral palsy

Category	Code	Condition
	0611	Paralysis—non-traumatic (includes hemiplegia, paraplegia, quadriplegia, tetraplegia & other paralytic syndromes, e.g. diplegia & monoplegia; excludes spinal cord injury code1699)
	0612	Chronic/post-viral fatigue syndrome
	0613	Shingles (Zoster) and/or postherpetic neuralgia
	0614	Peripheral Neuropathy
	0615	Normal pressure hydrocephalus
	0699	Other diseases of the nervous system n.o.s or n.e.c (includes dystonia, migraines, headache syndromes, sleep disorders e.g. sleep apnoea & insomnia, Bell's palsy, myopathies, dysautonomia, progressive supranuclear palsy, restless legs syndrome)
Diseases of the eye & adnexa	0701	Cataracts
	0702	Glaucoma
	0703	Blindness (both eyes, one eye, one eye & low vision in other eye)
	0704	Poor vision (low vision both eyes, one eye, unspecified visual loss)
	0705	Macular degeneration
	0799	Other diseases of the eye & adnexa n.o.s or n.e.c (includes conjunctivitis, dry eyes)
Disease of the ear & mastoid process	0801	Ménière's disease (includes Ménière's syndrome, vertigo)
	0802	Deafness/hearing loss
	0899	Other diseases of the ear & mastoid process n.o.s or n.e.c (includes disease of external ear, otitis media, mastoiditis and related conditions, myringitis, otosclerosis, tinnitus)
Diseases of the circulatory system	0900	Heart disease
	0901	Rheumatic fever
	0902	Rheumatic heart disease
	0903	Angina
	0904	Myocardial infarction (heart attack)
	0905	Acute & chronic ischaemic heart disease (includes Coronary Artery Bypass Grafting (CABG))
	0906	Congestive heart failure (congestive heart disease)
	0907	Other heart diseases (acute pericarditis, acute and subacute endocarditis, cardiomyopathy, cardiac arrest, heart failure – unspecified)
	0910	Cerebrovascular disease
	0911	Subarachnoid haemorrhage
	0912	Intracerebral haemorrhage
	0913	Other intracranial haemorrhage
	0914	Cerebral infarction
	0915	Stroke (CVA)—cerebrovascular accident unspecified

Category	Code	Condition
	0916	Other cerebrovascular diseases (includes embolism, narrowing, obstruction & thrombosis of basilar, carotid, vertebral arteries and middle, anterior, cerebral arteries, cerebellar arteries not resulting in cerebral infarction)
	0920	Other diseases of the circulatory system
	0921	Hypertension (high blood pressure)
	0922	Hypotension (low blood pressure)
	0923	Abdominal aortic aneurysm
	0924	Other arterial or aortic aneurysms (includes thoracic, unspecified, aneurysm of carotid artery, renal artery, unspecified)
	0925	Atherosclerosis
	0926	Atrial fibrillation
	0927	Venous thromboembolism (VTE) (includes deep vein thrombosis (DVT), pulmonary embolism)
	0928	Heart valve disorders (includes aortic stenosis, mitral valvular disorder)
	0999	Other diseases of the circulatory system n.o.s or n.e.c (includes other peripheral vascular disease, arterial embolism & thrombosis, other disorders of arteries & arterioles, diseases of capillaries, varicose veins, haemorrhoids, giant cell arteritis, raynaud's)
Diseases of the respiratory system	1001	Acute upper respiratory infections (includes common cold, acute sinusitis, acute pharyngitis, acute tonsillitis, acute laryngitis, upper respiratory infections of multiple & unspecified sites)
	1002	Influenza & pneumonia
	1003	Acute lower respiratory infections (includes acute bronchitis, bronchiolitis & unspecified acute lower respiratory infections)
	1004	Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)
	1005	Chronic lower respiratory diseases (includes emphysema, chronic obstructive airways disease (COAD), chronic obstructive pulmonary disease (COPD), asthma)
	1006	Tracheostomy
	1099	Other diseases of the respiratory system n.o.s or n.e.c
Diseases of the digestive system	1101	Diseases of the intestine (includes stomach/duodenal ulcer, abdominal hernia (except congenital), enteritis, colitis, vascular disorders of intestine, diverticulitis, irritable bowel syndrome, diarrhoea, constipation)
	1102	Diseases of the peritoneum (includes peritonitis)

Category	Code	Condition
	1103	Diseases of the liver (includes alcoholic liver disease, toxic liver disease, fibrosis and cirrhosis of liver)
	1104	Gastrointestinal stoma (includes gastrostomy, jejunostomy (PEG/PEJ), ileostomy, colostomy)
	1199	Other diseases of the digestive system n.o.s or n.e.c (includes diseases of oral cavity, salivary glands and jaws, oesophagitis, gastritis and duodenitis, cholecystitis, other diseases of gallbladder, pancreatitis, coeliac disease, reflux)
Diseases of the skin & subcutaneous tissue	1201	Skin & subcutaneous tissue infections (includes impetigo, boil, cellulitis)
	1202	Skin allergies (dermatitis & eczema)
	1299	Other diseases of the skin & subcutaneous tissue n.o.s or n.e.c (includes wounds, urticarial, erythema, radiation-related disorders, disorders of skin appendages, leg ulcers, pressure areas/ulcers)
Diseases of the musculoskeletal system & connective tissue	1301	Rheumatoid arthritis
	1302	Other arthritis & related disorders (includes arthrosis, Paget's Disease)
	1303	Deformities of joints/limbs—acquired
	1304	Back problems—dorsopathies (includes scoliosis, sciatica)
	1305	Other soft tissue/muscle disorders (includes rheumatism, lupus, polymyalgia rheumatica)
	1306	Osteoporosis
	1307	Osteoarthritis
	1308	Gout
	1399	Other disorders of the musculoskeletal system & connective tissue n.o.s or n.e.c (includes osteomyelitis)
Diseases of the genitourinary system	1401	Kidney & urinary system (bladder) disorders (includes nephritis renal failure, cystitis; excludes urinary tract infection & incontinence)
	1402	Urinary tract infection
	1403	Stress/urinary incontinence (includes stress, overflow, reflex & urge incontinence)
	1404	Urinary diversion (ileal conduit), urostomy
	1499	Other diseases of the genitourinary system n.o.s or n.e.c (includes prostate, breast and menopause disorders, vaginal prolapse, benign prostatic hypertrophy)
Congenital malformations, deformations & chromosomal abnormalities	1501	Spina bifida
	1502	Deformities of joints/limbs—congenital
	1503	Down's syndrome
	1504	Other chromosomal abnormalities
	1505	Congenital brain damage/malformation
	1599	Other congenital malformations & deformations n.o.s or n.e.c

Category	Code	Condition
Injury, poisoning & certain other consequences of external causes	1601	Injuries to the head (includes injuries to ear, eye, face, jaw, acquired brain damage)
	1602	Injuries to arm/hand/shoulder (includes, dislocations, sprains & strains)
	1603	Injuries to leg/knee/foot/ankle/hip (includes dislocations, sprains & strains)
	1604	Amputation of the finger/thumb/hand/arm/shoulder—traumatic
	1605	Amputation of toe/ankle/foot/leg—traumatic
	1606	Fracture of neck (includes cervical spine & vertebra)
	1607	Fracture of rib(s), sternum & thoracic spine (includes thoracic spine & vertebra)
	1608	Fracture of lumbar spine & pelvis (includes lumbar vertebra, sacrum, coccyx, sacrum)
	1609	Fracture of shoulder, upper arm & forearm (includes clavicle, scapula, humerus, radius, ulna)
	1610	Fracture at wrist & hand level
	1611	Fracture of femur (includes hip (neck of femur))
	1612	Fracture of lower leg & foot
	1613	Poisoning by drugs, medicaments & biological substances (includes systemic antibiotics, hormones, narcotics, hallucinogens, analgesics, antipyretics, antirheumatics, antiepileptic, antiparkinsonism drugs, includes overdose of the above substances)
	1614	Non-traumatic amputation (includes surgical amputation)
	1699	Other injury, poisoning & consequences of external causes n.o.s or n.e.c (including all other injuries to the body, spinal cord injury, multiple fractures, unspecified dislocations, sprains, strains, fractures, burns, frostbite, toxic effects of substances of nonmedical source, complications of surgical & medical care, joint replacements, THR/TKR)
Symptoms & signs n.o.s or n.e.c	1701	Abnormal blood-pressure reading, without diagnosis
	1702	Cough
	1703	Breathing difficulties/shortness of breath
	1704	Pain
	1705	Nausea & vomiting
	1706	Dysphagia (difficulty in swallowing)
	1707	Bowel/faecal incontinence
	1708	Unspecified urinary incontinence
	1709	Retention of urine
	1710	Jaundice (unspecified)
	1711	Disturbances of skin sensation (includes pins & needles, tingling skin)

Category	Code	Condition
	1712	Rash & other nonspecific skin eruption
	1713	Abnormal involuntary movements (includes abnormal head movements, tremor unspecified, cramp & spasm, twitching n.o.s)
	1714	Abnormalities of gait & mobility (includes ataxic & spastic gait, difficulty in walking n.e.c)
	1715	Falls (frequent with unknown aetiology)
	1716	Disorientation (confusion)
	1717	Amnesia (memory disturbance, lack or loss)
	1718	Dizziness & giddiness (light-headedness, vertigo n.o.s)
	1719	Restlessness & agitation
	1720	Grief and loss
	1721	Irritability & anger
	1722	Hostility
	1723	Physical violence
	1724	Slowness & poor responsiveness
	1725	Speech & voice disturbances (includes aphasia, dysphasia)
	1726	Headache
	1727	Malaise & fatigue (includes general physical deterioration, lethargy and tiredness)
	1728	Blackouts, fainting, seizure
	1729	Oedema n.e.c (includes fluid retention n.o.s)
	1730	Symptoms & signs concerning food & fluid intake (includes loss of appetite, excessive eating & thirst, abnormal weight loss & gain)
	1799	Other symptoms & signs n.o.s or n.e.c (includes gangrene, haemorrhage from respiratory passages, reflux, disturbances of smell & taste, enlarged lymph nodes, illness n.o.s)
	1899	Has other health condition not elsewhere specified

Appendix C

Assessment Summary

The follow fields will be pre-populated in to the assessment summary.

Location	Profile	Field	Assessment summary location
Client Record		Title	Introduction
		First name	All sections
		Last name	Introduction
		Estimated age	Introduction
		Lives with	Background
		Accommodation type	Background
		Services in place	Background
		Current care approvals	Recommendations
Assessment	Assessment Details	Mode	Introduction
		Date of assessment	Introduction
		Assessment setting	Introduction
		Assessment information collected from	Introduction
	Reason for Assessment	Details	Introduction
	Carer	Details of Carer – Name	Background
		Details of Carer – Relationship to client	Background
		Details of support being provided	Background
	Sustainability of Caring Relationships	Details	Assessment
	Function	Summary of Function	Assessment
	Health conditions	Health condition	Situation
		Impact of health conditions and support being received to manage them	Assessment
	Cognition	Changes in memory and thinking *Home Support Assessment only*	Assessment
		Changes in behaviour *Home Support Assessment only*	Assessment
	Psychological	Details *Comprehensive Assessment only*	Assessment
Support Plan	Review	Review Date	Recommendations
		Reason for Review	Recommendations

Staff Profile		First name	Recommendations
		Last name	Recommendations
		Role *Home Support Assessor or Comprehensive Assessor*	Recommendations
		Assessment Outlet	Recommendations
		Assessment Organisation	Recommendations
		Outlet Phone Number	Recommendations

Appendix D

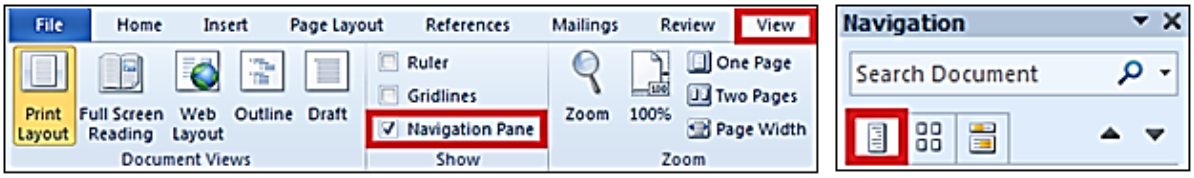
Navigating the User Guide

The User Guide has also been designed to support use via Microsoft Word and Adobe Reader, and as a hard-copy printed version. The following hints and tips may assist users navigating the document. Screenshots are taken using Microsoft Word 2010 and Adobe Reader XI. The hints and tips may not apply to all versions of Microsoft Word and Adobe Reader.

Microsoft Word

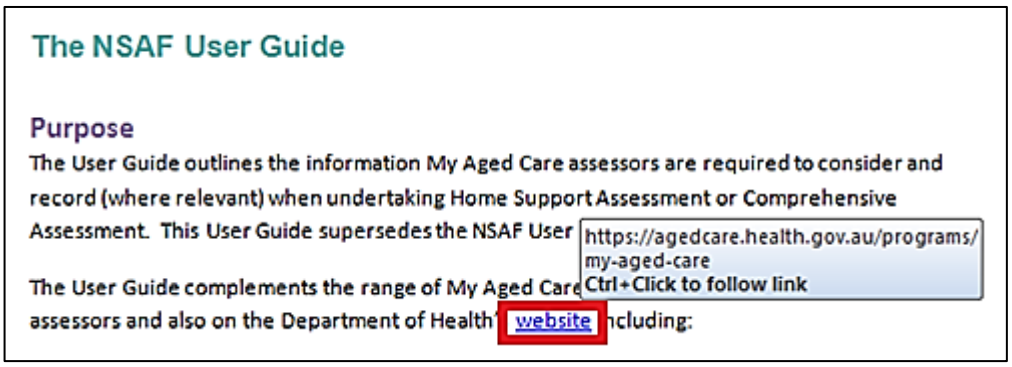
1. Display the navigation pane to:
    - See an overview of the User Guide
    - Move easily between sections of the User Guide
    - Search for specific text or graphics.

    To display the navigation pane, select the 'View' tab and 'Navigation Pane'. Alternatively, select 'CTRL + F' and navigate to the first tab.



2. Use hyperlinks to:
    - Navigate between related sections
    - Navigate to relevant appendices.

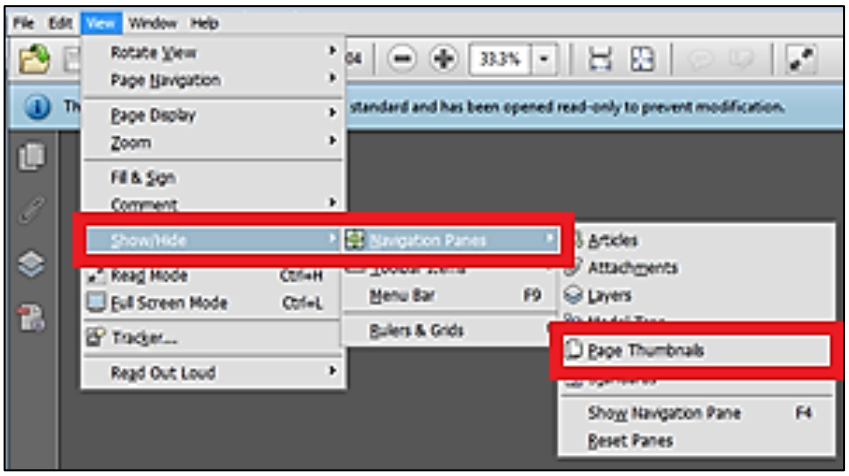
    To use hyperlinks, hover over hyperlinked text (Blue underlined text) and press 'CTRL + click'.



Adobe Reader

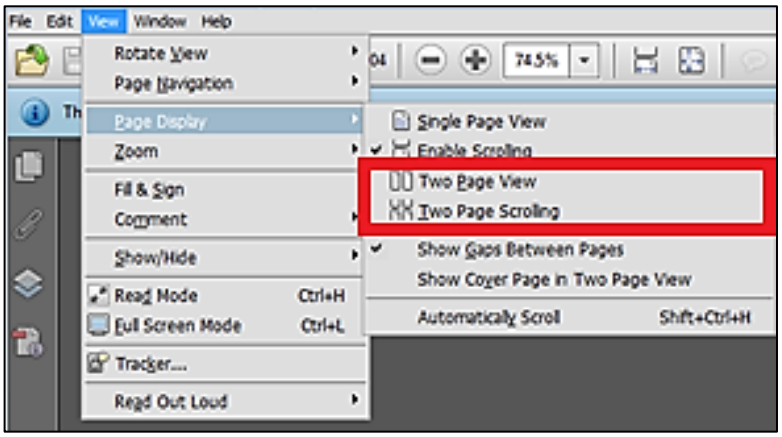
1. Display the navigation pane to:
    - View thumbnail images of each page
    - Navigate to the page displayed in the thumbnail image.

    To display page thumbnails, select the 'View' tab, 'Show/Hide', 'Navigation Panes' and 'Page Thumbnails'.



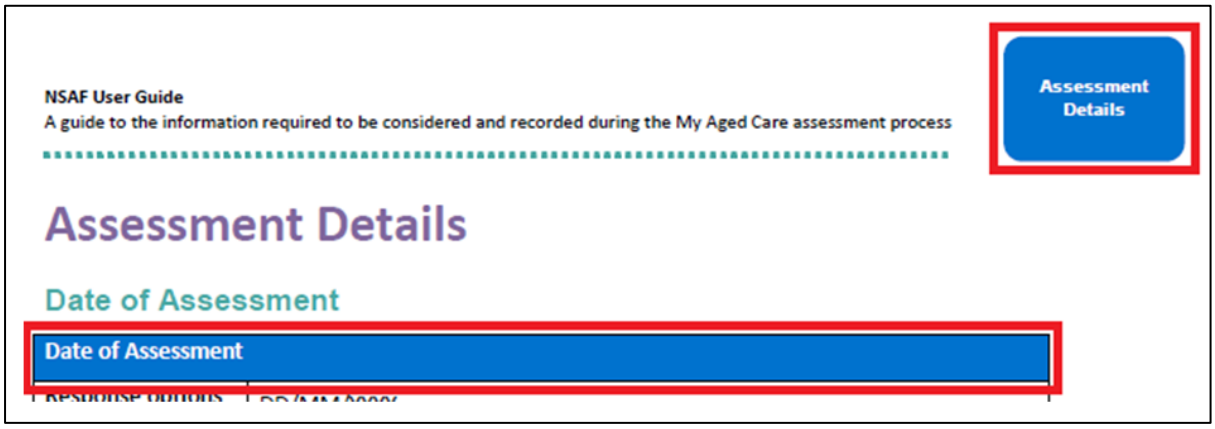
2. Display two pages in one view to:
    - See page information side-by-side.

    To display two pages in one view, select the 'View' tab, 'Page Display' and 'Two Page View' or 'Two Page Scrolling'.



Printed version

Each section (typically a Profile or Domain) can be identified by the coloured tab in the Header. The Questions in each section are also presented in this colour. An overview of the colours associated with each section can be found at NSAF structure.



This colour theme also appears on the printed NSAF and blank assessment forms.