PLANNED ACTIVITY GROUPS

Make it meaningful:
Assessment and care planning guidelines and tools

Participate, engage and enjoy!

June 2015

Acknowledgements

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This document may be downloaded from the Department of Health & Human Services website at: http://www.health.vic.gov.au/hacc/assessment.htm

Frequently asked questions

What is this document about?	This document describes the guidelines for assessment and care planning for Home and Community Care (HACC) funded Planned Activity Groups (PAGs) in Victoria.
Why should I read this?	Anyone involved in assessment or care planning for clients who may be interested in attending a PAG, should read these guidelines. This will ensure that your assessment and care planning practice meets current requirements, reflects the active service model and is consistent with quality standards.
Am I funded to do this?	Yes, the unit price for PAGs incorporates assessment and care planning.
Is use of the PAG service specific assessment template and care planning template in this document mandatory?	The PAG service specific assessment template and the PAG goal directed care plan template contained within these guidelines have been specifically designed for PAGs to support good practice and to meet goal directed care planning audit criteria. The templates are not mandatory. It is recommended that agencies compare and contrast their current PAG templates with those shown, before deciding whether to use the templates in these guidelines or amend their existing ones.
Are the templates available electronically?	The PAG assessment and care planning templates will be available as electronic forms (with expandable boxes) on the department's website, and can be adapted for use by each organisation.
With the transition to the Commonwealth Government will these guidelines become redundant?	These guidelines have been prepared prior to the transition of the HACC program to the Commonwealth Home Support Programme (CHSP). The guidelines are based on a philosophy of wellness that builds on the strengths, capacity and goals of individuals. A wellness approach is embedded into these assessment and care planning guidelines and is congruent with the philosophy of the CHSP.
Do the templates meet quality standards?	Yes. The PAG assessment template and the PAG care plan template included in these guidelines meet the Community Care Common Standards (and the future Home Care Standards).
How will this benefit clients?	Good assessment and care planning is fundamental to a person's participation in a PAG. By making sure you provide high quality assessment and care planning, you will increase the likelihood of successful outcomes.

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Abbreviations

ASM	Active Service Model
CALD	Culturally and linguistically diverse
CCCS	Community Care Common Standards (to be replaced by the Home Care Standards)
LGBTI	Lesbian, gay, bisexual, transgender and intersex
HACC	Home and Community Care
HAS	HACC Assessment Service
HCS	Home Care Standards
LAHA	Living at home assessment
PAG	Planned Activity Group
SCTT	Service coordination tool templates

Terminology

Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander.

'Diversity' encompasses the range of special needs groups who are specified in Victoria's current HACC review agreement with the Commonwealth, which specifically names people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples, people with dementia, financially disadvantaged people and people in remote or isolated areas. Diversity characteristics include, but are not limited to, diversity of age, sexual orientation, gender identity, faith and spirituality and socio-economic status.

The term 'care plan' is used in this document to describe the individual plan, based on a persons' assessed needs, that lists the person's goals and how the PAG will assist the person to achieve their goals. The care plan may also be called a support plan, service plan or similar term. The key principle is that the plan describes the person's goals and the actions to be taken, and meets the audit criteria for a care plan.

Living at home assessment refers to a holistic assessment as conducted by a HACC assessment service.

1 About this guide

This document provides practice guidelines for service specific assessment and care planning for Home and Community Care (HACC) funded Planned Activity Groups (PAG).

High quality assessment and care planning are essential to a person's successful participation in a PAG and achieving positive outcomes from their participation.

The guidelines include 'how to' assessment and care planning information, and examples to promote person centred, individualised approaches. These assessment and care planning guidelines support an active, healthy approach to ageing on the basis that being healthy, physically active and socially engaged has many benefits.

These service specific assessment and care planning practice guidelines meet the Victorian HACC program requirements as described in the *Victorian Home and Community Care program manual 2013* and provide the flexibility for individual funded agencies to adapt them to their own organisational requirements.

Implementation of these guidelines will assist organisations to meet the Community Care Common Standards and Commonwealth Home Care Standards (that are substantially the same as the Community Care Common Standards) that will be used in future and the expected outcomes in relation to assessment and care plan development.

Who is this guide for?

There are around 279 HACC funded agencies in Victoria that deliver PAGs. These guidelines have been written primarily for PAG managers, coordinators and staff who will be conducting assessments and developing care plans.

Some agencies may already have PAG assessment and care planning practices that meet these guidelines. However, all HACC funded agencies providing PAGs should become familiar with these guidelines and ensure that the guidelines are reflected in their policies and procedures for PAG assessment and care planning.

The assessment and care planning templates reflect a psycho-social model rather than a medical model. It is acknowledged that some clinically based organisations that deliver PAGs, such as Health Services, may also use a range of validated clinical tools where relevant.

Whilst PAGs support frail older people, younger people with a disability and their carers, the focus of this guide is on assessment and care planning for adults attending PAGs. Whilst some PAGs support children with a disability, the prompting questions and templates in these guidelines are designed for adults and therefore will have limited applicability to children. (For example, the assessment questions are adult-orientated and would need to be adjusted for use with a child and family).

The guidelines should also be read by HACC assessment services and assessors.

HINT

Give this guide to all PAG activity staff, support staff and volunteers to read and discuss. This will contribute to their understanding about assessment, care planning and the Active Service Model within PAGs.

Development of the guidelines

These guidelines were developed based on existing resources and PAG assessment and care planning practices, used by the sector in Victoria and more broadly. Development of the guidelines included significant input from experienced PAG providers and other key stakeholders.

The guidelines extend and complement the information contained in the:

- Planned Activity Group Information Bulletin 2014
- Victorian Home and Community Care program manual 2013
- Goal Directed Care Planning Toolkit 2013
- Supporting volunteers to take an Active Service Approach 2013
- Strengthening assessment and care planning: A guide for HACC assessment services in Victoria 2011

Links to these documents are available on the department's website at http://www.health.vic.gov.au/hacc/index.htm

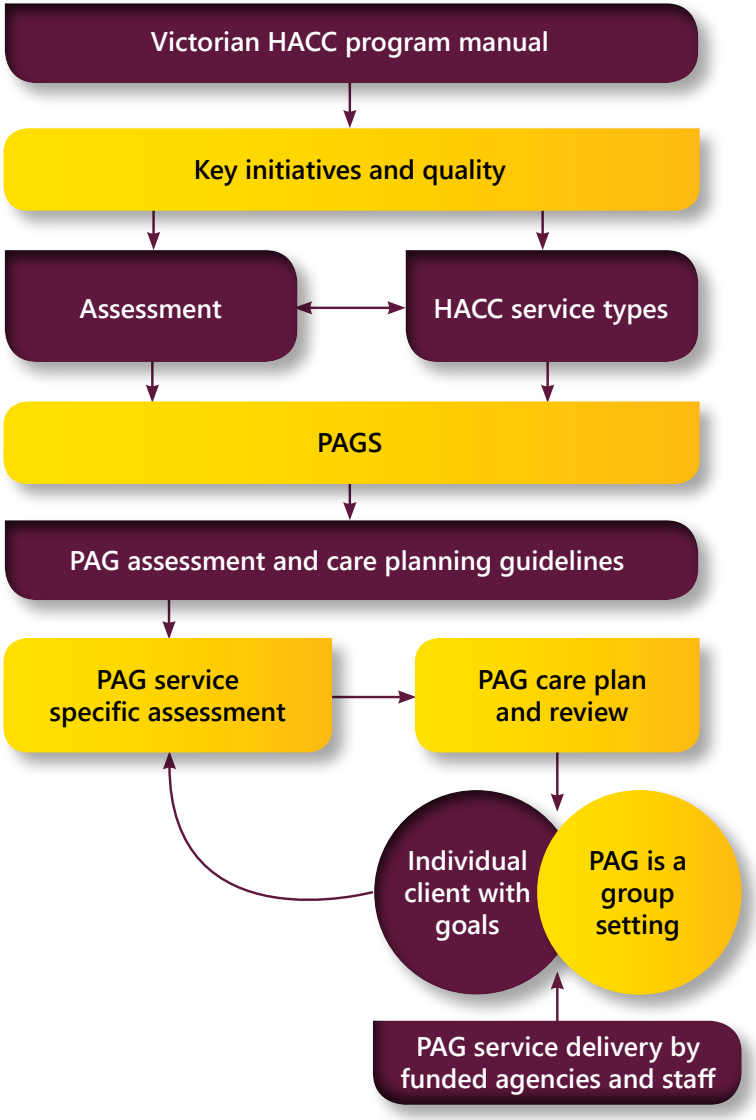
What's included

These guidelines describe the practice required for service specific assessment and care planning for PAGs in Victoria. The scope of the guidelines is limited to assessment and care planning, and does not cover other aspects that are important in providing PAGs. For example, the guidelines do not include PAG service delivery models, frameworks, program design or activity planning. The guidelines have been written to reflect an Active Service Model (ASM) approach and encourage a wellness approach with individual, person centred practice and capacity building in response to each individual and their diverse characteristics.

The guide also includes text boxes of consumer thoughts - these are designed to reinforce person centred thinking and the appreciation of each PAG participant as a unique individual.

The diagram below illustrates how key elements of HACC statewide policy, quality initiatives, assessment and care planning practice flow through to PAG service delivery.

Diagram 1:
PAG assessment and care planning in the broader HACC context



Victorian HACC program manual

This is the overarching document for all HACC services in Victoria See http://www.health.vic.gov.au/hacc/prog_manual/

Following the transition of the Victorian HACC program to the Commonwealth Government in the future, HACC services for older people will be part of the Commonwealth Home Support Programme.

Key initiatives and quality

These include the: HACC Assessment Framework, Active Service Model, Diversity Planning and Practice, Service Coordination, and the Community Care Common Standards (and future Home Care Standards). Links to these are available on the department's website at http://www.health.vic.gov.au/hacc/index.htm

HACC service types

There are many different HACC service types, such as PAG, domestic assistance, allied health, nursing, delivered meals, respite, access and support, property maintenance, etc. For a full list see the Victorian HACC Program Manual (as above).

PAGs

PAGs are one type of social support provided by HACC; another example is café style support.

PAG assessment and care planning guidelines

These guidelines (this document) describe how agencies funded to deliver HACC PAGs should conduct and document PAG service specific assessments and care plans.

PAGs are a group setting

PAGs:

- work with individuals primarily in a group setting, to achieve their goals
- support links to carers, family, friends and community
- plan for transition and exit.

2 Purpose and benefits

PAGs are one of the activities (also called service types) funded though the HACC program.

The purpose of a PAG is to support people to remain living in the community as independently as possible, by providing a range of enjoyable and meaningful activities that enhance or maintain their skills. By participating in the activities, people can enhance, practice or maintain their skills, enjoy social interaction with others and participate in the community. PAGs can assist to link and integrate the person into community activities. For people with carers, PAGs also support the care relationship.

Importantly, PAGs are designed to contribute to both the physical and emotional wellbeing of participants, thus contributing to their ability to live as independently as possible.

The activities provided by PAGs are designed with this in mind. PAG service models and activities are specially designed to offer the opportunity for, and benefits of:

- physical activity
- cognitive and intellectual stimulation
- good nutrition
- social interaction
- emotional and peer support community participation
- care and safety
- appreciation and acknowledgement of each person and their diverse characteristics
- new experiences and something to look forward to.

Together these can contribute and provide a range of benefits to each person's physical and emotional wellbeing, and thus contribute to their capacity to live as independently as possible.

PAGs also provide an important function of monitoring, review and referral to other services as required.

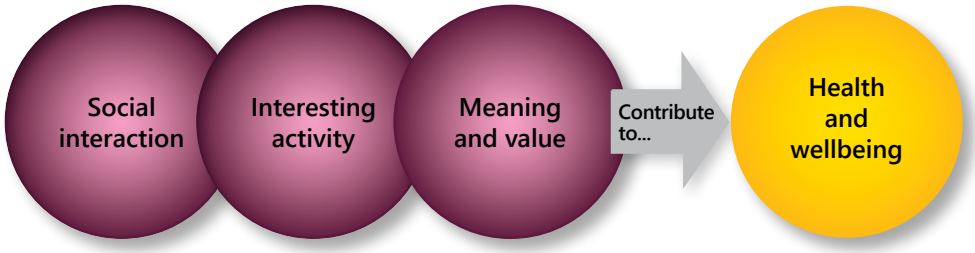
A consumer perspective

Older people may become socially isolated as their social networks reduce over time. One response to this may be attending a group activity such as a PAG. Consumer feedback has indicated that in attending a PAG, people tend to be seeking social activity, enjoyment and meaning in a safe, friendly and caring environment, as summarised below.

- The opportunity for social interaction – an enjoyable experience with other people, that appreciates and accepts individuality and diversity, and includes laughter and conversation.
- Activity – an interesting activity in which the person can participate, even in a small way, and which supports their health and wellbeing (physical, social, emotional or cognitive).
- Meaning – the activity, people or experience has an intrinsic benefit, value or meaning to the person.

For people with carers, a PAG can provide a break from their care role and the confidence that the person is safe and participating in an activity that they enjoy.

Diagram 2:
Why do people choose to attend a PAG?



These considerations are therefore integral to the PAG assessment and care planning process, and how PAGs are designed and delivered by funded agencies.

What I like about PAG
Firstly, there's the friendly atmosphere, the camaraderie between the staff and clients, the understanding and helpful staff and the welcome one receives.
Until I discovered PAG, I was just sitting around at home with nothing to do, no car and housebound.
My life has changed, so that I no longer live like a recluse, but have such a lot of good friends. You shouldn't stop enjoying life because you grow old. No! You grow old because you stop enjoying life.
Believe me, it is the wonderful changes to my lifestyle, due to my association with PAG, that enables me to put my fingers to the keyboard to express my sincere thanks in this way to all I have come to know in this organisation.
Luv ya all.

These reasons fit with a wellness approach and the HACC program's objective of supporting and maintaining people's ability to remain living in the community as independently as possible, as shown below.

Diagram 3:
How these perspectives come together in service delivery

PAGs support the person to live independently by providing:		What it means to the person (I statement)
Opportunities and encouragement for physical activity and informal exercise in a safe, supervised environment.	⇨	I get an opportunity to increase or maintain my physical capacity.
Meals that contribute to good nutrition.	⇨	I have an enjoyable, tasty and nutritious meal in a social setting.
An expanded or extended social network and interaction with others.	⇨	I enjoy the company of, and conversation with, like-minded others.
Emotional support and meaning in a way that makes sense to the person and contributes to their enjoyment.	⇨	I have the opportunity to actively participate and have a good time. I feel satisfied and have a sense of belonging to the group and community. My cultural beliefs and needs are respected.
Support for the care relationship.	⇨	My carer has a break from their care role. My carer can attend the PAG if they want to.
All of the above in a safe, friendly, supervised and supportive environment.	⇨	I get support for my specific health, safety and personal needs.

HINT

Always think about how communication can be improved - will the person benefit from an interpreter, Auslan (sign language), audio, large print or other communication aid or technique? Whilst this may take time to organise, it will contribute to better outcomes and demonstrates person centred practice.

3 Service specific assessment

Holistic assessments such as those provided by a HACC assessment service, cover the broad domains of a person's needs, whereas a service specific assessment is focussed on a single HACC service type such as a PAG. Assessment for a particular type of service is known as a service specific assessment.

There are multiple reasons why a service specific assessment for PAG is necessary and of value. The PAG coordinator should be able to explain these reasons to the person so that there is a shared understanding of the purpose and importance of the PAG service specific assessment, and how it will influence decisions about what types of activities might suit the person and their goals.

Assessment for PAG is necessary to:

- find out about the person, diversity characteristics, interests, likes and dislikes, aspirations
- find out about the person's independence, health and wellbeing (e.g. need for support)
- find out about the care relationship and carer's needs (if the person has a carer)
- build on the information available through the holistic assessment (if available) and the person's broader goals
- find out why the person is interested in the PAG, and what has changed recently to prompt the interest
- consider whether the support available through the PAG is appropriate to the person's care and safety needs (e.g. communication, mobility, personal care, medication etc)
- find out about the outcomes they are seeking from their participation
- think about other options and opportunities that might meet the person's social needs (e.g. Neighbourhood House or community centre)
- consider what support the person might need to attend and participate
- think about whether, on balance, a PAG is a good option for the person and is likely to contribute to their independence and wellbeing
- form the foundation for the person's care plan and agreed goals
- meet the national Community Care Common Standards (and future Home Care Standards): *All people using a HACC service are required to participate in an assessment and in the development of a care of service plan.*

Not all PAGs have the capacity to assess the person prior to the person's commencement. Assessment is a process that may occur over time as PAG staff members get to know the person, and the person gets to know and trust PAG.

For example, only basic information may be available about new people attending a monthly bus outing - such as information gained as a result of a telephone contact. This information can be added to over time as the person becomes more involved.

HINT

The service specific assessment may take place at the person's home or in a private area within the PAG building or other appropriate setting.

4 PAG assessment pathways

There are two choices for how assessment for attending a PAG occurs.

The assessment can be conducted by either the (see diagram 4):

- HACC assessment service as one part of a Living at home assessment or
- PAG coordinator or other appropriately trained staff member as a **service specific assessment.** A service specific assessment is an assessment that is specific to the particular HACC funded activity. See *Strengthening assessment and care planning* about service specific assessment (page 127) at http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf

Regardless of which pathway is used, assessment is always a two way 'guided' conversation between the assessor and the person.

If the person has a carer, the carer's input will also be essential. In some instances, such as for a person with dementia, the carer may be the main spokesperson (depending on the person's stage on the dementia pathway).

The amount of information already available may depend on the source of the referral. For example, if a Living at home assessment or assessment by an ACAS has been conducted, there will already be a significant amount of information available that should be used.

The possible outcomes from the assessment are that the person:

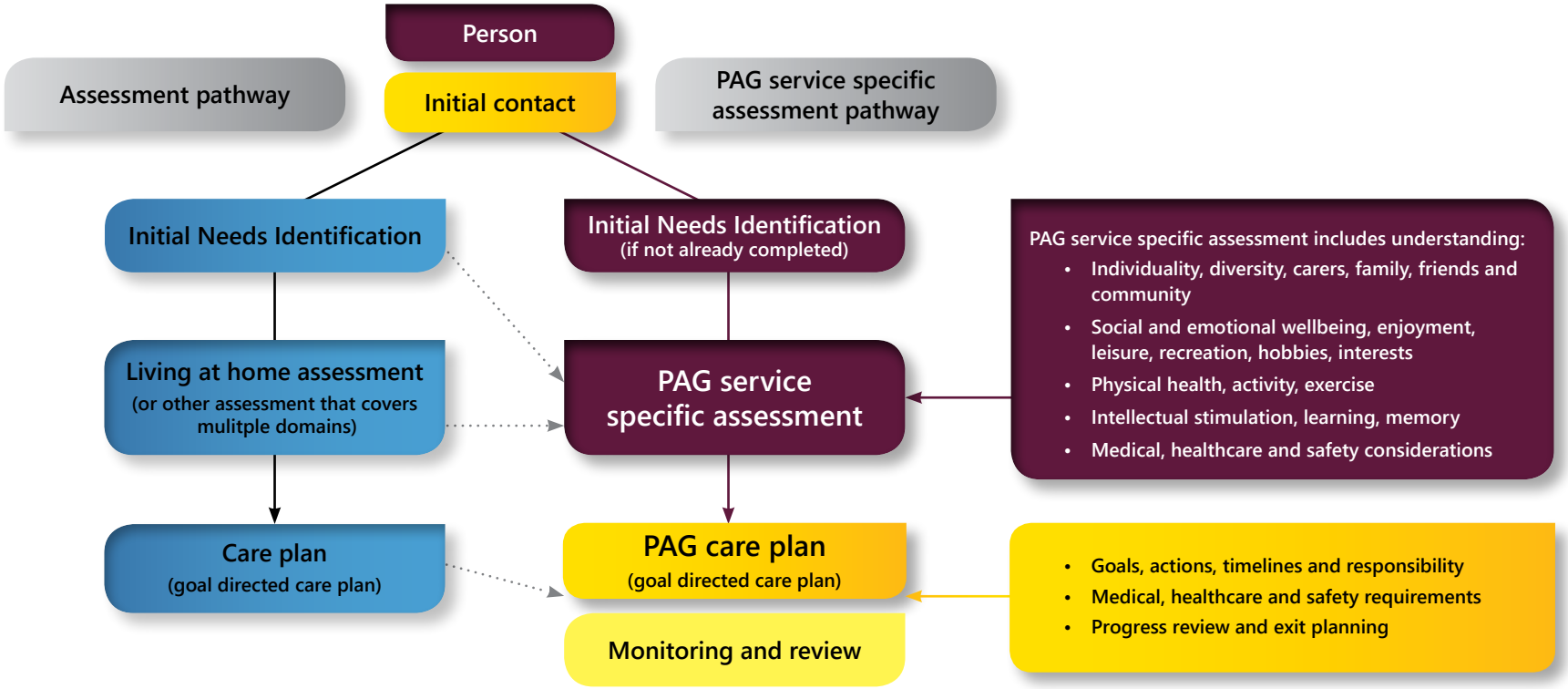
- *is* interested in trying or attending a PAG – this then proceeds to the care plan
- *is unsure* about PAG, in which case they may wish to attend a trial or 'meet and greet' session before deciding
- *is not* interested, or their needs are not likely to be met through a PAG. This may result in the provision of information about other social options (such as community activities and interest groups), and/or a referral back to a HACC assessment service or another service as relevant.

The information in this guide focuses on a **PAG service specific assessment** only.

HINT

Remember to ask the person if they would like a family member, community member, or Access and Support worker to be present during the assessment conversation.

Diagram 4:
Assessment pathway



HINT

For further information about assessment in the HACC program see *Strengthening assessment and care planning: A Guide for HACC assessment service in Victoria at http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf*

PAGs turn 'cant's' into 'cans' and aspirations into plans....

5 Assessment is more than a conversation

Whilst the assessment **process** necessitates asking questions and guiding the conversation, it is most effective when it is a two-way conversation with the person to elicit information, rather than a question and answer approach. It requires engagement, listening, understanding and thinking.

Good assessment is about building rapport and exploring and finding out about the person and listening to what is important to them. It is reliant on the conversational and observational skills, insights and experiences of the assessor and direct care staff, as well as the ability of the person and their carer to express and communicate their situation and wishes. For people from a CALD background who have English as a second language, the use of an interpreter may be essential to understanding one another.

A good assessment process uses conversational skills (talking and guiding the conversation) and observational skills (seeing and observing the person, their facial expressions, body language, functioning and environment) to do the following.

- Collect information – by chatting, asking questions, observing and using tools
- Appreciate, engage, listen and clarify – the person's unique character, diverse characteristics and values, skills and strengths (both past and current) by encouraging them to identify their interests and clarify their wishes
- Interpret information – from a PAG perspective what might be possible or gained though attendance at PAG (or not)
- Develop a plan together - care planning, including practical arrangements
- Monitor and review - how well the plan is working and changing the plan as needed.

Diagram 5:
PAG assessment process

Collect information

Collecting assessment information - what and why?

Every aspect of a person's life influences their state of wellbeing. A service specific assessment for PAG includes the exploration of areas of the person's health and wellbeing that are particularly relevant to their participation in a PAG.

It includes understanding how the PAG can add value to the social and emotional wellbeing of the person and support them to be part of their community.

The assessment is not performed from a clinical perspective to develop a treatment plan, but rather from the perspective of what opportunities a PAG can provide for the person to improve their health and wellbeing.

How much information?

The short answer is as much as is needed to gain an understanding of the person's goals and their healthcare and safety whilst at PAG.

Clients should have their core information recorded on the Service Coordination Tool Templates (SCTT) Consumer information form, and may also have one or more of the SCTT Initial Needs Identification (INI) forms completed as part of the screening and assessment processes. In some cases the person will also have information from a recent assessment (for example, from a HACC assessment service).

It is essential to use and build on the existing information (i.e. available SCTT and assessment information) rather than duplicate it.

The depth and level of detail explored in the assessment should be relevant to the person's presenting situation and potential participation in PAG. For example, the assessment conversation with a person attending a six week i-pad course, or a monthly bus outing, may potentially be less detailed than that required for a person attending a PAG on a more frequent basis, however this will depend on each individual and their goals and needs.

Likewise, the person may approach a PAG with a particular group in mind (such as a gentle exercise class). Understanding this will assist the assessor to tailor the type of information and level of detail discussed in the assessment. If a person approaches a PAG with a particular group in mind, further assessment information can be gained over time to consider other goals and opportunities for PAG to contribute to the person's health and wellbeing.

It is important that PAG coordinators use their professional judgement in considering the appropriate level of discussion to gain a good understanding about the person and their goals and support needs.

The type of information

The assessment includes collecting a combination of:

- information in order to understand the person's diversity characteristics, social and emotional wellbeing (e.g. personality, what is most important to the person, likes, dislikes, preferences, aspirations etc) and the type of social and emotional support they might enjoy and benefit from whilst attending the PAG
- relevant health related information in order to understand the person's general health capacity and the type of assistance and care they would require whilst attending (e.g. mobility, personal care, transport, medication, cultural dietary considerations etc).

HINT

If the person has a recent assessment (from another source) it is important not to duplicate the information. Read the assessment and use as much information as relevant to gain an understanding of the person.

6 What to assess

There are a range of different assessment tools and templates that collect some or all of the relevant assessment items.

Many PAGs have developed their own PAG service specific assessment tools. Some tools for example, have a dementia focus and use clinical terminology and rating scales, whilst other tools are text based in how they collect and record this information (e.g. open-ended questions), whilst many use of a combination of both approaches.

These guidelines include a list of PAG assessment areas and items (see Table 2) and an example of a tool that includes them.

Each HACC funded agency should use a tool that is suitable to their organisation. The assessment and care planning templates included in this guide reflect a psycho-social model rather than a medical model. It is acknowledged that some health based organisations that deliver PAGs, such as Health Services, use clinically validated tools (for example in relation to nutritional risk or falls risk). Regardless of which tools are used they should at a minimum, include consideration of the items listed in Table 2.

Dear PAG,

I am an only child and was quite isolated growing up in a rural area. I consider myself as being quite shy and have always been quite content with my own company and my dog.

So being part of a group is still an experience I am getting used to. I'm enjoying the company of the other people in the group and sharing stories about our pets and the mischief they get up to. I'm looking forward to going to the show this year with the group and seeing all the animals.

Appreciate the person, engage, listen and clarify

Appreciating and seeking to understand the person, their life story, diverse characteristics, values and preferences is essential to building rapport and showing respect. A PAG coordinator or staff member conducting an assessment shows that they value communication with the person and their carer, by taking the time to listen and understand.

For example, the assessment conversation may reveal that the person:

- is feeling lonely and would like social contact in a friendly atmosphere
- is bored, wants something to do or to 'get out of the house'
- their carer is seeking a break from their care role.

Using feedback and an active listening technique, and reflecting back an understanding of what the person has said, assists to clarify their meaning and ensure that the assessor has understood correctly. For example: 'So what you are saying is ...,' 'Is this what you mean?'

Clarifying the person's point of view will assist the assessor to understand the person's situation, aspirations and preferences, and thus better enable them to achieve their individual aims and aspirations. It will help the person clarify what they would like to gain from attending the PAG, and what choices may be suitable.

The information to be collected may include a combination of screening information (as per SCTT tools listed below) plus assessment items, as relevant to each person's situation.

Table 1:
PAG screening information

Service Coordination Tool Templates	Screening items to collect to inform the assessment (As relevant and if not already provided with the referral or through a recent assessment)
Consumer information	SCTT Consumer information form (as per HACC MDS requirements).
Accommodation and safety arrangements	SCTT Accommodation and safety arrangements (includes living arrangements and personal emergency planning). This is a screening tool – for PAG assessment purposes you will need to collect additional information as relevant to the person's situation and their participation in PAG.
Need for assistance with activities of daily living	SCTT Need for assistance with activities of daily living. This is a screening tool – for PAG assessment purposes you will need to collect additional information as relevant to the person's situation and their participation in PAG. Note: If a full functional assessment is required refer to a HACC assessment service.
Other SCTT as relevant	For example: SCTT Care relationship, family and social network.

The assessment information builds on the screening information to provide an understanding of the person's health and wellbeing that are relevant to their participation in a PAG.

Table 2:
Examples of PAG assessment areas, items and focus

PAG assessment area	Items to collect – As relevant and if not already provided or collected	PAG focus How can we (the PAG) assist you to...
Individuality, social and emotional wellbeing	• Diversity characteristics • Communication • Cultural and spiritual considerations • Neighbours, friendships, clubs • Interests, hobbies, aspirations, wants, wishes, goals	...be respected and valued, feel comfortable in a group, interact with other people the way that you prefer, contribute in a way meaningful to you, have a sense of belonging?
Being active, physical activity, exercise	• Mobility, transfers • Lifestyle, leisure activities, games, excursions, sports • Exercise (formal, informal) • Supervised, allied health input	...be active, maintain strength and balance, stay agile, participate in supervised (formal and informal) exercise?
Cognitive and intellectual stimulation	• Cognition, comprehension • Memory • Behaviour support	...exercise your thinking, memory and brain, by learning new things, or capturing your interest?
Eating well, good nutrition	• Meals (culturally appropriate), nutrition, hydration • Dental, dentures	...eat well, have a balanced diet, contribute to meeting your nutritional requirements?
Participating in the community	• Community connections and participation • Social interaction, cultural events • Transport	...feel part of, and connected to other people in the community, through social connections and outings? ...have some fun and an enjoyable time in the company of others?
Medical, healthcare and safety	• Vision, glasses, hearing, aids and equipment • Personal care, continence • Health conditions, chronic disease, disability • Allergies, alerts • Medication, self-administration • (If relevant: pain management, skin integrity, oxygen use, palliative care)	...be supported and safe when at the PAG (e.g. environment, mobility, aids and equipment, personal care, medication)?
Carer support	• Family and carer support	...support the care relationship?

Table 3:
Typical domains for PAG service specific assessment template

A PAG service specific assessment should document the following information	Included ✓
Administrative information	
The consumer's name, DOB, sex, unique identifier	
Who the PAG assessment was conducted by - name of the assessor, their position and agency	
Who else had input	
Whether the person has had a recent assessment (such as a Living at home assessment or similar) and if so the date of the assessment	
Other current support services if known	
The date of the PAG assessment	
Interpretation of assessment information and the next steps/actions arising from the assessment e.g. care plan, referral/links	
Provision of information e.g. fees, other information provided	
Individuality, social and emotional wellbeing	
Care relationship, family, friends, significant others, neighbours, recent bereavement – and implication for PAG support	
Individuality and diversity characteristics: cultural, religious/spiritual, communities of interest, groups that identify with – interest, goals, implication for PAG	
Individuality and emotional wellbeing: enjoyment, personal accomplishment, previous valued work and volunteer roles, interests, strengths and capacities, aspirations – interest, goals, implication for PAG	
Social preferences: communication preferences, style of support, personal favourites – interest, goals, implication for PAG	
Recreation/leisure and keeping healthy: hobbies, sports, physical activity, allied health – interest, goals, implication for PAG	
Brain health and cognition: thinking, learning, memory, mental health, behaviour support – interest, goals, implication for PAG	
Medical, health, safety and care – as relevant to PAG	
Communication, vision, hearing, aids/equipment, type of assistance (if) required	
Mobility, transport, aids/equipment, falls, type of assistance (if) required	
Personal care	
Food / nutrition, dietary requirements	
Health conditions, medication, allergies, alerts, other	

Interpret the assessment information

Important to, or important for?

Assessment is a conversation that seeks to engage with the person to understand the person's goals, in their own words, and the implications for their attendance in a PAG. It is necessary for person centred practice and the ability to offer each person (and their carer) choice about the kind of support that suits them best.

The assessment process inevitably collects a lot of information.

The assessor and the person are required to sift and interpret this information in the context of how it applies to a PAG and how the PAG activities can assist the person to maintain their independence, as well as identify any referrals to other service providers that may be needed and/or information about other community activities that may be relevant to their interests or needs.

Other HACC service types would interpret the same information in the context of how it applies to another particular service type.

One way to interpret the information is to separate what is important **to** the person, and what is important **for** the person's safety and care, and the combination of both. (See helen sanderson associates at http://www.helensandersonassociates.co.uk/about/)

Table 4:
Important to and important for

To or for?	Description	What PAG can do (Action)
Important to the person	What really matters to the person, from their perspective as an individual with a life history and diverse characteristics and values. For example: leading the type of life they wish to, their future ambitions, the importance of helping others.	Link and reflect these in the person's goals and actions whilst at PAG.
Important for the person	Things that are important for the person's health, safety and care, such as medication, use of a walking aid, eating gluten free food, supply of continence aids.	Respond as necessary for safety, duty and quality of care.

Table 5:
Example - Important to Harry and important for Harry

To or for?	Description	Provide opportunities for participants to engage in conversations and share interests with other participants
Important to Harry	Eating gourmet food (Harry has been a 'foodie' all his life) and watching TV cooking shows. Talking and joking with his mates. Following the local footy team. Wearing his old but very comfortable shoes. Getting birthday cards from his grandkids. Feeling appreciated because he can fix things – having his 'tool bag' handy. Getting to the airshow every two years if possible.	Discuss the winning contestants and their recipes. Always ask on a Monday how the footy team went. Ask Harry for advice about how to fix things and get him to assist (e.g. provide advice, hold things, pass tools etc). Investigate outing to the airshow using companion cards.
Important for Harry	Good nutrition and diabetic monitoring. Batteries in hearing aids. Monitoring and prompting for foot and nail care.	Insulin levels at 12.00 each day. Check batteries every Monday. Reminders about podiatry visits.

Both the 'important to' and 'important for' understandings are needed to be able to find a balance supporting the social and emotional needs of the person whilst ensuring safety and care, and enhancing or maintaining their capacity for independent living.

Assessment outcome

The outcome of a PAG assessment is that the assessor has:

- an understanding about the person, their unique life story, diversity, ambitions and aspirations (wants and wishes)
- an understanding about the carer's needs and wishes and how the PAG can support them and the care relationship
- information about the types of activities that the person enjoys
- an understanding about how the PAG can help the person to maintain their independence
- an understanding of the person's medical, health and safety needs as relevant to PAG
- enough information to develop a care plan with the person.

In relation to a person with dementia, the assessor should also have gained an understanding of where the person is on the dementia pathway, the person's behaviours and support strategies, and how to support the care relationship.

The Chinese New Year celebration

中國新年慶祝活動

For those fortunate to attend our group, a most surprising and wonderful day was spent on Friday 3rd December. Starting with a morning tea of spring rolls and mini dim-sims with second helpings a-plenty. Then rummy cup or carpet bowls, etc. until lunchtime. And what a delightful meal lunch was. A real Chinese stir-fry with fried rice, followed by an equally nice dessert, again of Chinese cuisine all prepared by our very own Josh. Josh, we all say a big "Thank You" for your effort in presenting us with these beautiful dishes that we all enjoyed so much.

The day didn't end here. Oh no! Suddenly there was the sound of drums heralding the arrival of a colourful and fearsome dragon who pranced around us in his most ferocious manner, chasing away all the evil spirits. Presented so capably by members of The Chinese Youth Society of Melbourne. Yes, it was a most remarkable day which will be remembered by all present for a long time and we extend our most grateful thanks to all who helped to make this day so unforgettable.

HINT

Request a copy of the assessment and the care plan from the HACC assessment service or ACAS.

Example of PAG assessment template

Below is a suggested service specific assessment template for use by HACC PAGs. The prompting questions are designed to be part of a conversation with the person to gain an appreciation about them and the type of activities they would like to pursue. The emphasis is on discovering how the person can be supported to do the things they would like to do (rather than just fitting them in to current groups) and how they can do this within the context of PAG.

This assessment approach assumes that basic information has already been collected using the Service Coordination Tool Templates (SCTT) Consumer Information form or similar. The assessment form **does not** duplicate basic information included on SCTT forms, such as contact details and personal emergency planning (see SCTT Accommodation and safety arrangements), activities of daily living (see SCTT Need for assistance with activities of daily living) or detailed questions about carer support needs (see SCTT Care relationship, family and social networks).

The assessment form is divided into three parts. This is to enable a distinction between the social questions which are important to understanding what is important to the person and their social wellbeing, from the person's healthcare and safety requirements whilst at PAG.

- Part 1 is about the person and their individuality, social and emotional wellbeing.
- Part 2 is about the person's medical, healthcare and safety considerations while they at PAG.
- Part 3 provides a summary and the action to follow from the assessment.

Always use professional judgement about the presenting situation as to which prompting questions to include in the conversation. Remember that assessment information may be built up over time as rapport is developed between the person and the PAG staff.

Agencies can adjust and modify the template depending on individual organisational needs and requirements. For example, add the agency name and logo, or additional categories as relevant to the organisation or a group (e.g. younger people with a disability, people with dementia, bus outings).

HINT

It is suggested that each organisation compare the questions and items in the PAG assessment tool to their existing assessment tool. This will determine where you may make improvements to your existing assessment tool or whether to use this assessment tool.

7 Service specific template and instructions

These instructions apply to the PAG service specific template shown on the next pages. It is assumed that core client information has already been collected on the SCTT Consumer information form (e.g. carer information, general practitioner contact details, need for an interpreter or assistance with communication etc). Do not duplicate information that is already available on the SCTT forms or from other recent assessments.

Part 1: Individuality, social and emotional wellbeing

Use this section to guide a conversation with the client and their carer. The conversational prompts are designed to assist to discover information about the person (it is not a checklist of questions). Use your professional judgement about which prompts to use as not all prompts will be relevant to all clients or the presenting situation. You may wish to laminate the prompt questions as a separate sheet to use as a reminder during assessment.

Record the person's responses in the 'Response' column. Consider the implications of this information in relation to their participation in PAG activities and note this in the 'Interpretation for PAG' column. List any actions or referrals required as a result of the information and your interpretation (e.g. if a referral is required for something outside of the PAG's scope).

Part 2: Medical, healthcare and safety

Use this section to discuss the person's medical, healthcare and safety needs whilst at PAG. Use the prompt questions and the tick boxes in the 'Response' column to identify and document the person's specific needs in relation to mobility, nutrition, vision, hearing, personal care, health conditions, disability and medication whilst at PAG. (Note that it is not the responsibility of PAGs to maintain a complete, current medication list for each participant. The role is to be aware of the medication the person needs to take whilst at the group and who to contact with questions.)

Use the 'Care requirement at PAG' column to describe how the person's identified needs will be met when they are at PAG. List any actions or referrals required as a result of the information (e.g. when a referral is required).

Part 3: Summary and action

Use this section to summarise the assessment, the action arising and record administrative information.

HINT

A blank template as included in Appendix 1, with the prompt questions on a separate page. The electronic forms available on the department's website will have expandable boxes with additional space for responses.

Affix consumer label / unique identifier (repeat on each page)

Template 1: PAG Service specific assessment template

Name:		Date of birth:		With input by carer:	
Likes to be called:				With input by other:	
Has the person had a recent assessment:	☐ No ☐ Unsure ☐ Yes: If yes, agency and date:	Other current support services (if known):			

Part 1: Individuality, social and emotional wellbeing					
Conversation starter: I would like to understand more about you as a person so we can work out together what might suit and interest you. Can you tell me a bit about yourself....					
Category	**Areas**	**Prompts** (Use your professional judgement and the presenting situation as to which prompts and questions to use).	**Response**	**Interpretation for PAG**	**Action or referral**
About you	Carer, family members, history Significant others, friends, diversity	Tell me about you and your family...and who is most involved in your life... Do you have a carer or a person who helps you...Are these arrangements working well for you... What about friends and significant others...who do you like to keep in touch with... Have you had any recent bereavements or losses... Do you have any lifestyle considerations, cultural, religious values or beliefs that we should be aware of... Are there any events, outings or festivals that you would like to attend...or connections to make... What is most important to you in your life at present...		Hint: The blank template in the Appendices has the 'Prompts' removed so there is more space to write.	
What you enjoy (Consider past, present, future)	Enjoyment, work, volunteering, hobbies, interests, good/bad days, opportunities	What would you describe as the highlights of your life and your personal accomplishments... What sort of work did you do...and what aspects of this did you enjoy most... What sort of things do you enjoy doing, what are you good at...what makes you happy... What do you like to do in your spare time...has this changed over time and if so how... Do you have any hobbies at present...or that you hope to try but haven't yet... Is there anything in particular you want to achieve... What are your personal favourites e.g. favourite food, fruit, music, sport, book, movie, craft... How would you describe a 'good day' for you...			
Your social preference	Communication, socialising preferences	How do you like to communicate...(e.g. preferred language, assistance, aids, understanding)... Can you tell me about how you like to interact or socialise with others... What makes you feel comfortable or 'belong' in a group setting...(e.g. big or small groups, a particular community, type of group, boisterous or quiet/relaxed)... Do you belong to any groups or clubs...or would you like to... How would you describe the ideal social outing for you...			
Keeping healthy	Physical health, fitness, likes, opportunities	I would also like to hear about what you do at present to keep healthy. Can you tell me about what types of exercise or sport do you most enjoy doing (or watching)...are you currently doing this... Do you have an exercise program at present...what is the most energetic thing you do at present... Are you interested in something to help you stay physically fit and healthy...do you have any ideas about what...do you have a physio or coach...			
Brain health	Learning, thinking, memory, mental health, opportunities	How is your memory these days...do you need help remembering things...if so what... For a person with memory loss, dementia, brain injury, or intellectual disability: Discuss with the person and/or their carer whether a specific response is required. (e.g. does the person get anxious or agitated, triggers, positive behaviour support and reinforcement strategies, whether a behaviour support plan is required etc)			

Part 2: Medical, healthcare and safety – Only ask for information that is not already available from other sources				
Conversation starter: I would like to understand about your healthcare needs so that if you decide to come to PAG we can assist you in the way you prefer.....				
Category	**Prompts**	**Response**	**Care requirement at PAG** (Description)	**Referral / information required**
Mobility	How do you go moving around at home - inside and outside Or about in the community... Any falls in the last 6 months...	☐ Walks independently ☐ Supervised ☐ Uses aids/equipment: stick, frame, wheelchair, scooter ☐ Can sit to stand independently ☐ Requires assistance ☐ Assistance required to get in/out of vehicle ☐ Drives ☐ Uses public transport ☐ Fall within last 6 months – is a falls assessment needed? ☐ Has existing link to physio/other		
Eating well	Do you have any particular dietary requirements...	What are your favourite foods___ ☐ Normal diet ☐ Diabetic ☐ Vegetarian ☐ Gluten free ☐ Traditional/bush tucker ☐ Religious ☐ Other dietary requirement (cut up, soft food) ☐ Aids/equipment ☐ Uses dentures ☐ Other:		
Vision	How is your vision...	☐ Glasses for reading ☐ Glasses for distance ☐ Assistance to clean glasses ☐ Other visual aids (e.g. contact lenses, prosthesis, glass eye)		
Hearing	How is your hearing...	☐ Hearing aid right ear ☐ Hearing aid left ear ☐ Requires batteries check ☐ Other		
Personal care	How do you manage in the bathroom and toilet...	☐ Independent ☐ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Incontinent ☐ Indwelling catheter ☐ Uses aids/equipment (e.g. pads): describe		
	And with dressing/grooming...	☐ Independent ☐ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Uses dressing/grooming aids/equipment: describe		
Health conditions	Do you have any health conditions we should be aware of that might affect your participation at the PAG...	☐ Dementia - Note behaviours, triggers, management strategies ☐ Diagnosed conditions / pre-existing conditions ☐ Chronic diseases: describe ☐ Recent illnesses or hospital admissions: describe ☐ Health behaviours (e.g. smoking, alcohol or substance use) ☐ Disability (e.g. physical, intellectual, acquired brain injury) ☐ Other e.g. pain, oxygen use, other:		
Medication	Will you need to take any medication whilst at PAG...	☐ No ☐ Yes – note time frame ☐ Webster pack ☐ Other packaging ☐ Self administered ☐ Requires verbal prompt/reminder ☐ Staff assisted (Staff must have relevant qualification)		
Other	Any other medical, healthcare or safety matters...	☐ Describe allergies (e.g. food, medication, other): describe ☐ Medical or other alerts ☐ Personal safety (e.g. feeling afraid, elder abuse, legal issues) ☐ Personal Alert Victoria		

Part 3: Summary and action							
Summary / interpretation of assessment information							
Next steps / action arising from assessment	Proceed to care planning ☐ Yes ☐ No ☐ Other, describe:						
Referrals to be actioned	☐ No ☐ Yes ☐ Completed ☐ Date completed						
Travel/transport arrangements discussed	☐ PAG pick up ☐ Taxi ☐ Self/family ☐ Other, describe:						
PAG fees information discussed and provided	☐ No ☐ Yes Comment:						
Date of assessment		Name of assessor		Signature		Position/Agency	

8 Care planning

Why is it needed?

Good practice and the national Community Care Common Standards (and future Home Care Standards) require that each person attending a PAG has an individual care plan.

In the past, in some organisations, there may have been greater emphasis on fitting the person into a PAG program, rather than on working out how the PAG can respond to the person's goals, interests and choices.

First and foremost a PAG care plan (or support plan) is a tool for the client. It should provide a summary of the situation or context (i.e. the person's main reason for attending PAG), their goals and how you will work together to achieve those goals. It includes information that is meaningful and relevant to the client and is written in a way that the client understands.

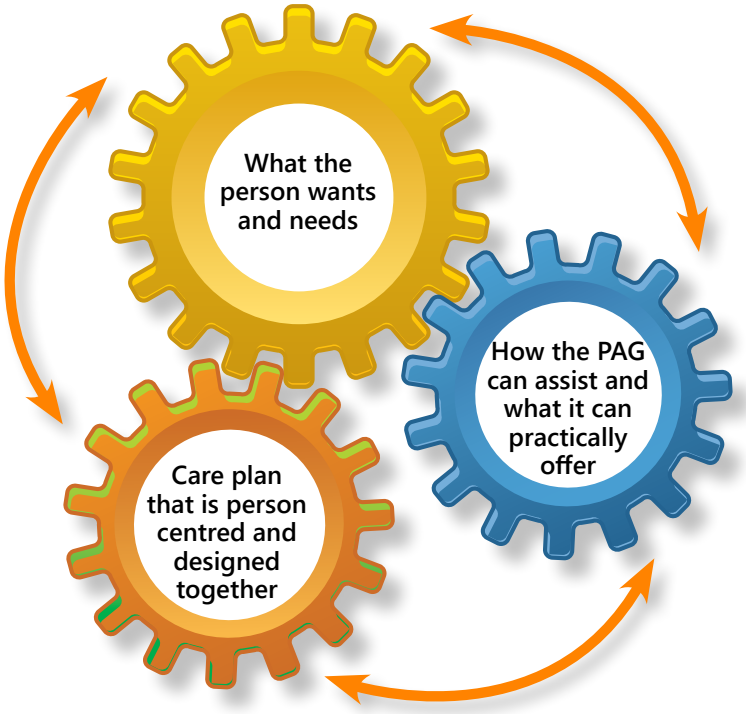
It is co-designed – that is, designed together by the person, their carer, the PAG coordinator and staff as a result of the assessment conversation, discussion and engagement. It is therefore a mutual or shared responsibility.

A PAG care plan is about connecting the person's goals to the services provided by the PAG, and offering choices and actions for how they can be achieved in the PAG context. It is organised around the priorities and needs of the person, and balanced with what, practically, the PAG can provide.

A PAG care plan is a plan about what the person, and where relevant their carer, aims to achieve by attending the PAG, any specific goals, and how the PAG will support the person to do so.

HINT

Remember that a PAG care plan is not a treatment plan as it does not prescribe treatment for the person's condition; nor is it a management plan as it does not manage the person or their health.



From assessment to care plan

Summarising the assessment conversation can assist to link into the care planning process. For example:

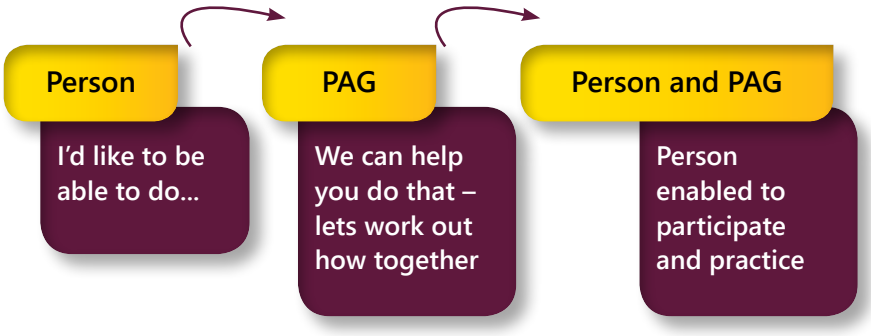
'We've talked about lots of things today. Let's see if I've understood all the things that are important to you, then we can work out a plan.'

Just collecting the assessment information is not enough – it has to be discussed and developed into care plan goals and actions. This requires thinking and a collaborative effort to explore options and make decisions. The assessor guides the conversation with the person, makes suggestions and offers options so the person can choose and self-direct their support. For example:

'You mentioned you would like to improve your muscle strength. Do you have any preference for how this could occur. Would you consider joining our gentle exercise group...'

- 'You mentioned that your daughter gave you a book in which to record your life story. Is this something you would like assistance with?'
- 'You mentioned that you used to travel a lot – would you like to visit some of those places (e.g. books, movies or talks)?'
- 'How would you feel about trying [a] or [b]?' 'What might appeal to you most?'

A PAG care plan is a working document. Goals may be developed over time as staff members learn more about the person, and the person learns more about the PAG.



Dear PAG,
Did you know that I came to Australia from Sicily when I was 26 years old? My wife kept our traditions alive in our new country with our own children. When she died last year a piece of me died with her, and when my family sold our orchard it was a huge upheaval. Coming to the group still feels strange after a year - people I don't really know, food that is different to that at home and conversations that are new to me. But I am tough and resilient, and perhaps in another year I will feel more a part of it. I appreciate all your efforts and your care.

A PAG care plan should include the items shown in the table below.

Table 6:
Items to include in a PAG care plan template

A PAG care plan should document the following information	Included ✓
Administrative information	
The client's name, DOB, sex, unique identifier.	
Who the care plan was prepared by - other people involved in the development of the care plan.	
Who else had input.	
The date of the development of the care plan.	
The planned date for review of the care plan.	
Expected exit date from the PAG (if known).	
Who the care plan will be shared with / who copies of the care plan will be provided to.	
The person responsible to distribute the copies.	
The date the copies were distributed.	
Client or carer acknowledgement that they understand and agree to the care plan.	
Date of the client or carer acknowledgement.	
Goals, actions, responsibility and timelines	
Current situation: the person's main reasons or purpose in attending the PAG, as expressed in their own words wherever possible.	
Goals: what the person wants to achieve (e.g. linked to their overall health, wellbeing, independence and/or enjoyment).	
Timeframe: In relation to achieving the goals and actions (i.e. by when).	
Actions: the agreed strategies or actions (e.g. the specific things that the PAG will do to assist the person achieve their goals).	
Progress: How the person will determine whether they have achieved their goals.	
Responsibility: The staff member, volunteer or other person responsible for the actions.	
Other information such as referral, information provision or other actions.	
Medical, health, safety and care whilst at PAG	
Reflective of the items in the assessment template, as relevant to the goals and actions above and the person's participation at PAG.	

HINT

It is recommended that each organisation compare the care plan items above to their existing care plan. (Although the format and wording differs slightly the items are equivalent to the goal directed care plan template and audit tool included in the Goal Directed Care Planning Toolkit 2013). This will inform the decision about whether to use the care plan or to improve or amend your existing care plan format.

9 The care plan - our shared responsibility

Just exactly whose 'plan' is it?

The care plan is an agreed plan of action between the person and the PAG, and where relevant, their carer. It should record the person's main reason for attending the PAG and their goals.

The care plan is focussed on the individual person, and describes what the PAG will provide and how the person's goals can be supported in the PAG.

In this sense, it is both the person's and the PAG's plan – it is designed and enacted together. This means that both the service and the person and where relevant their carer, have a responsibility in setting and achieving the goals.

It is important to note that people from some cultural communities (such as some CALD or refugee communities) have had limited opportunities for goal setting. It may be a new approach for the person and will take time to develop.

The likely duration of the PAG should be discussed with the person at commencement and throughout the review process.

HINT

Both the person and the service provider have a role to play, and contribution to make, to achieving the person's goals as discussed and written in the care plan.

Dear PAG,

Like you, I was a teenager not so long ago. The difference was that I lived through the war - you only had to deal with adolescent moods, boyfriends, bad hair cuts and parents who didn't understand you. Sometimes I think that getting older would be better if it could be like being a teenager again - we would not be expected to conform to societal ideas about getting older and ageing gracefully, and could find our own 'identity' without stereotypes. The privilege of getting older is meant to be that you can be yourself, but sometimes services expect you to conform to their expectations. So dear PAG, perhaps just think of me as an indulgent teenager and respect my identity, my life choices and who I am. In attending PAG, I want to stay healthy and active for as long as possible and age (dis)gracefully!

Setting individual goals in a group setting

PAG programs and activities are best designed to reflect the interests and goals of the people attending. Interesting assessment conversations are likely to lead to innovative PAG responses. As PAG assessment becomes more person centred and goal directed, this will influence and lead to new and different PAG programs and responses.

What is likely to be offered in PAGs in future may therefore be different to what is being offered now – because as clients change the PAG changes to respond to a different set of interests and needs. This may include less of a focus on activities within a PAG 'building' and a broader scope of possibilities with more of a focus on supports within the community, or with volunteer support.

Because a PAG is limited to its scope of operation and not able to provide everything that a person wants or wishes to achieve, lateral thinking and a problem solving approach to develop creative ways of achieving the person's wishes is required. (See the case studies in section 14)

Some one-to-one time may be available for the person, however most of the support will occur whilst the person is part of a group. Support can be provided in the form of encouragement, motivation, discussion, visual prompts, resources, materials and activities to enable the person to practice and maintain skills whilst enjoying social interaction with other people.

Goal directed care planning is the key to providing effective support at PAG.

HINT

Goals are best written in the client's words. Goals must be meaningful to the client and able to be measured. Goals can be built up and added to over time.

Dear PAG,

Gee! You never know what to expect at PAG.

Friday 10th August saw a bus load of us taking a short drive to the home of the St. Kilda Football Club at their new Seaford ground. The day was rather chilly, but the welcome we received from was very warm indeed. They told us some of the history of the club, showed us some of the facilities including the basket-ball court, many of their trophies and the honour boards, listing past and present players and officials while answering our many questions.

Then it was outside for morning coffee and muffins while we watched their practice session. We thought it wise not to join them at that time!

To cap off this most enjoyable morning, each of us received a very acceptable souvenir bag of Saint's memorabilia.

To all who arranged this excellent outing, those at the PAG - the staff and of course, the St. Kilda Football Club - we say a great big "Thank you"

For many people the concept of setting goals is not familiar and they will require prompts to help identify and clarify goals. For example:

- 'What are you hoping to achieve by working together?'
- 'What would you like to do, try or experience with us?'
- 'You mentioned...do you think we could work on that together?'
- 'Have you thought about...'
- 'What is something small that we could help you achieve?'

A person's care plan should include information about supporting, fostering and encouraging independence. The person's goals should be realistic and able to be supported and contributed to, through the group setting provided by PAGs.

The care plan may also be part of a broader SCTT Shared support plan if the person is receiving other services. Where the PAG care plan forms part of a shared approach to care across multiple service types or agencies, it will be necessary for partnership arrangements to be in place. PAGs can support clients with shared goals whilst at PAGs, but generally do not take the lead in coordination across services.

The PAG care plan template shown below has been designed to flow on from the assessment template and as such it separates the person's goals from their medical, healthcare and safety needs whilst at PAG and administrative information.

It is more detailed than the SCTT Shared support plan (2012 version) and is more specific to PAG than the general goal directed care plan template that may be used for other HACC service types.

Agencies can adjust and modify the PAG care plan template depending on individual organisational needs and requirements. For example, PAGs for younger people with a disability or dementia, or for specific activities such as monthly group outings.

10 PAG care plan template and instructions

These instructions apply to the PAG service specific template shown on the next pages. The first page is focused on the person's reason for attending PAG and their goals, and the second page is focused on the person's their medical, healthcare and safety needs whilst at PAG. Add rows to the table as required.

Page 1

Current situation – main reason: Use this space to record the person's main reason (why) for attending PAG. For example, in response to the question/s: '[Name], what would you say your main reason would be for thinking about joining this group? What would you like to achieve by working together?' The reason should be evident from the assessment conversation, and should be written in the persons own words.

My goals (aims): Record the person's goals in their own words. Use lead in questions to assist the person to identify their goals. For example: 'In coming to the group, is there anything specific you would like to achieve or attain...perhaps something to do with your health, your wellbeing or that would give you satisfaction? What could we work on together?'

By when: Use this column to record an indicative time or month for when the person hopes to achieve their goal.

How we will work on this together (Actions): Use this column to describe how the PAG and the person will work on their goal together.

Who will assist me: Record who will assist the person with each action (who will do what) e.g. staff, volunteer, family.

When and how often: List the frequency of the action e.g. weekly on Tuesdays, each day at 1.00pm.

Review of my progress: This column should be completed as part of the formal review. Record the person's progress towards achieving their goal. For example, include a brief description or summary of their progress. For example, fully achieved, partially achieved, still in progress, still working together on this, no longer a goal, new goal identified etc.

Other comments: Record any additional comments, such as other ideas or goals that may be considered in the future.

Referrals or other actions: List any referrals or follow up required. For example, referral to an allied health program.

Page 2

Health, safety and care: Based on this information from the assessment, use this column to record the specific health, safety or care requirements of the person whilst at PAG (e.g. in relation to toileting, mobility, nutrition etc).

How I will be assisted: Use this column to describe the actions PAG staff will take in response to the person's needs (e.g. how toileting assistance will be provided – verbal prompts, direction to the bathroom, help with trousers etc).

When: Use this column to list the time and frequency at which the assistance will to be provided e.g. 10.00 am each day.

Review of my care needs: This column should be completed as part of the formal review. Record any updated information about the persons care needs whilst at the group. Note whether the help is still relevant and appropriate (i.e. to continue as is) or whether a change is required. New items should be added to reflect any changes in the person's needs whilst at PAG.

Date of this care plan: Record the date of the care plan.

Date set for review: Record the future date set for the review.

Expected finish date: This provides a broad timeframe and sets the scene for the client's eventual exit. This should be handled sensitively in conversation.

Copy of this plan to be given to: List who the person wants to give a copy of their plan to e.g. family member, GP.

Person responsible to provide copy: List who will give that person the copy e.g. PAG coordinator, client.

Date copy provided: Record the date the copy of the plan was provided to the person listed.

Acknowledgement: Ask the client or carer or representative to sign the document to indicate that they agree to the plan as listed and to copies of the plan being provided to the people listed.

Office use only: Record when the person was provided with a copy of the plan and the date; or if they declined a copy.

HINT

The care plan example on the next page is person centred and records information from the person's perspective. It is preferable to use a size 14 or larger font so it is easy to read. This means a care plan will usually be at least two pages long.

Affix consumer label / unique identifier (repeat on each page)

Template 2:
PAG care plan template

Care plan for my Activity Group

My name:		My date of birth:	
I like to be called:		The language I speak at home:	
My carer's name:		Other people involved in this plan:	
Staff member name and position:			
Current situation: My main reason for attending PAG is:			

My goals (aims)	By when	How we will work on this together (Actions)	Who will assist me	When and how often	Review of my progress

Other comments:	
Referrals or other actions:	

My health, safety and care whilst at the group	How I will be assisted	When	Who will assist me	Review of my care needs

Date of this care plan:		Date set for review:		Expected finish date of group (if relevant):	

I would like a copy of this care plan to be given to:	Person responsible to provide copy:	Date the copy was provided:

Acknowledgement: "I understand and agree to this care plan and to copies being provided to the people listed above."

Signature of client or carer or legal representative:		Date:	

Office use only:

☐ Client and/or carer provided with a copy of this care plan and date:

☐ Client and/or carer declined a copy

11 Monitoring and review

While a formal review process may occur on a yearly basis, monitoring and review are ongoing as staff members learn more about the person, what is important to them and observe changes over time.

Monitoring

Monitoring is the ongoing observation about a person's participation in PAG activities, and is undertaken as part of normal interaction in daily activities by all PAG staff.

It is based on conversation and interactions with the person, and where relevant their carer, to monitor their participation, progress towards their goals and general wellbeing.

For example:

- 'How did you enjoy the [activity] this week?' 'Are you happy to keep doing this?'
- 'What did you think about [x] – are you pleased with what you achieved?'
- 'Would you like us to change anything about [the activity]?'

Because PAG staff have daily interaction with clients, it is essential that they have access to the person's care plan so they can understand and support the person in working towards their goals.

Organisations use a range of systems and documentation to record each client's daily or weekly participation and progress. This information is then used to contribute to the more formal review process.

Review

Review builds on the informal monitoring process described above by providing the opportunity for a more formal review or reassessment. It is a process that provides both updated information about and the specific opportunity to re-visit the reasons that the person is attending the PAG, the extent to which their goals and aims are being attained and any changes to the person's situation.

As noted previously, PAG staff who monitor, interact and talk with clients on a daily basis, collect important information to contribute to the review process.

Discussion about the person's goals should consider:

- whether the PAG activities are meeting the persons wishes and they want to continue e.g. 'You told us that your main reason for attending was xyz – what has changed about that?'
- what participation in PAG has meant to the person
- whether their goals are being attained and the PAG is making a difference to them
- what could or should change, because the person has attained their goals, or their preferences or situation has changed
- opportunities or planning for transition or exit.

Considerations about the person's medical, healthcare and safety needs include:

- any changes to their living situation, care relationship or emergency contacts
- any changes to their needs (e.g. mobility, nutrition, vision, hearing, personal care, health conditions, medication, other) whilst at PAG
- where relevant, discussion about a likely timeframe for transition or exit.

The review process should reflect the passage of time and the changes that have occurred. The review process will result in either a revised and updated care plan, or agreement to transition out or exit from the PAG.

HINT

A *review* is about the person's progress towards their goals and can result in adjustments to their existing care plan. It can also lead to reassessment if the person's circumstances have changed significantly. A *reassessment* builds on the previous assessment information to reconsider the person's needs and goals to develop a new care plan.

Time to go - Preparing for transition

When should a person stop attending a PAG?

The answer to when a client should transition or exit is different for each person as it depends on their individual situation, goals and other supports and services available to them.

Many people become 'attached' to their social group at PAG and find the concept of exit somewhat challenging. However it is important from both the person's and the provider's perspective to have a broad time frame in mind for each person's transition or exit from PAG.

The time frame may be influenced by the structure of the PAG and the model used for program planning. For example, some PAGs use a term-based model where clients select their interest area and the group they wish to attend each term; whilst others are structured so as to provide ongoing choices throughout the year. Some people may decide to leave the PAG and then return at a later date.

PAG coordinators and staff members should periodically discuss and present information about transition and exit so that PAG clients and their carers are aware of their options, become used to the idea, and discuss it during the review process.

Dear PAG,

I am grateful for the physical and mental exercises afforded to me along with others during the past few years. The transport arrangements made it feasible. Thank you immensely for that kind service of yours.

Due to the exercises and training you gave me (along with others) I have been able to move my limbs freely and easily as a result of those exercises - all due to your efforts to train us. I am very thankful to your exercise trainer, and also to the lady whose advice on diet I am following closely. I am noticing appreciable changes in my body as a result.

I regret that I have decided to discontinue attending your group because I have joined a local club where I can do hydrotherapy and Easy Movers exercises.

I will miss you all - but it has to be! Once again a big thanks to all.

Indicators that it is timely to review the person's participation include that:

- the reason for them attending PAG has changed substantially
- they have achieved their goals and/or satisfied their interests
- they have joined other community groups or social opportunities instead
- changes to their support needs mean that the PAG is no longer their preferred, or a suitable option.

In all cases, the PAG coordinator and staff should encourage a review interview to discuss the situation with the person and where relevant, their carer, and explore:

- opportunities to join alternative community groups or clubs
- whether a further assessment may be beneficial.

Triggers for transition or exit typically include the following:

- the person has completed the activity group and attained their goals and does not require reassessment
- the person is no longer interested in attending, or is no longer enjoying their participation
- the person has developed social connections with other participants and/or with community groups and these are sustainable without PAG support, or is having their social support needs met through other avenues
- the person requires a higher or more intensive level of support or care than the PAG is able to offer
- the person has moved into residential aged care.

HINT

The Victorian HACC program manual (2013) states that HACC services cease when a person moves into residential care. However, there can be a transition period out of PAG, and there may be other ways in which the person can retain contact with their PAG friends. For example, through a coffee group, telephone contact or other activity as organised by the residential care provider.

12 Complex situations and managing workplace stress

Assessment and care planning

Undertaking assessments and care planning is a complex and at times demanding and stressful role. People may have unrealistic expectations about what a PAG can and cannot provide, leading to workplace stress.

'Stress' is a generic term widely used to describe the feelings and physiological responses that some people have in response to pressures they face in their lives. In the workplace, stress can be experienced as a 'challenge' and can produce positive effects, however, prolonged or intense stress (distress) can result in psychological and physical harm. Distress may arise when demands and pressures are considered unrealistic or unreasonable, or when a person's skills and abilities are not well matched to their role, and is likely to result in a decline in functioning, performance and overall levels of wellbeing.

The following tips to minimise work related stress are noted in *Strengthening assessment and care planning: A guide for HACC assessment services in Victoria.*

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

Working relationships

PAG staff can develop close working relationships with clients over time. As a person ages and their needs become more complex staff can experience a heightened sense of obligation and be exposed to complex and stressful situations.

It is important that PAGs manage these working relationships and stressful situations effectively.

- Understand the boundaries of the PAG role. It is unwise and unprofessional to allow a person to become dependent on PAG staff.
- Develop and use links with other service providers, in particular HACC assessment services.
- Access information about other options that may assist the client (for example, from the HACC assessment service).
- Access secondary consultation to discuss complex client situations (for example, from the HACC assessment service).
- HACC Access and Support workers (available in some regions) work with clients experiencing barriers to access to services and complexity as a result of their diversity, and may be able to provide assistance.
- If there are stressors in the workplace they should be acknowledged and discussed with peers and supervisors.

13 Example of completed assessment and care plan

Included on the following pages are the PAG assessment and care plan templates, which have been completed for a hypothetical client, named John Smith. The example is based on the templates and instructions as shown in the previous sections of this guide.

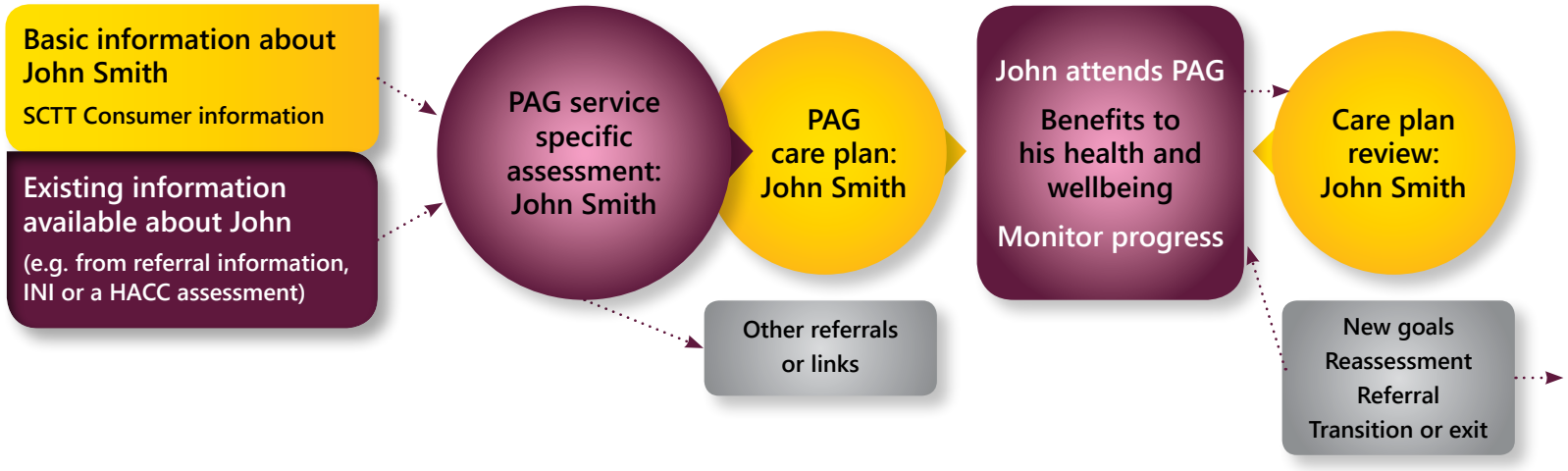
It is assumed that basic information as per the SCTT Consumer information form (including need for an interpreter or assisted communication) has already been collected.

Note that these templates are not mandatory. However, they have been designed to include the headings and items that reflect what is currently understood to be good practice for PAG assessment and care planning.

The care plan should be in a large size font so it can be easily read by the client.

Your organisation may choose to format the documents differently – however, this is the minimum level of information that should be collected and recorded by the PAG coordinator (or similar) for each client's individual assessment and care plan (and review).

Diagram 6:
Assessment and care planning process



Affix consumer label / unique identifier (repeat on each page)

Template 3: PAG Service specific assessment - completed example

Name:	*John Smith*	Date of birth:	*3 October 1933*	With input by carer:	*Ethel (Partner/Carer)*
Likes to be called:	*Johnny*			With input by other:	*Sally (daughter)*
Has the person had a recent assessment:	☑ No ☐ Unsure ☐ Yes: If yes, agency and date:	Other current support services (if known):		*Nil*	

Part 1: Individuality, social and emotional wellbeing

Conversation starter: I would like to understand more about you as a person so we can work out together what might suit and interest you. Can you tell me a bit about yourself....

Category	Areas	Response	Interpretation for PAG	Action or referral
About you	Carer, family members, history Significant others, friends, diversity	*John is married with 3 children. Daughter Sally, granddaughter and great grandson (age 8) all live nearby. Two sons live overseas. Ethel has been his partner since his wife died 20 years ago. He has various friends from the golf club but has lost touch. At present he plans to enjoy each day as it comes. Attends local Catholic church occasionally. Would like to get back to the golf course or at least the 19th hole occasionally.*	*Close and supportive family however wife (carer) and John would like him to 'get out of the house' more.*	
What you enjoy (Consider past, present, future)	Enjoyment, work, volunteering, hobbies, interests, good/bad days, opportunities	*Spending time with family and friends. Jazz, golf, swimming, horse racing, movies, (all on TV), road trips, holidays, woodwork, my shed. Was a builder after the war. A good day is sunny, good food, good company, not too much pain, and feeling like I have achieved something. Would like to write his life story - daughter has been encouraging him. Would like to make something for his great grandson as a keepsake.*	*Could assist with life story - volunteer to assist.* *Could make something for school fete in September.*	
Your social preference	Communication, socialising preferences	*Ex golf club. In younger days also belonged to a jazz club and a book group.* *Comfortable in group settings provided has hearing aids on.* *First language is English but can speak a little Greek (His first wife was Greek). Generally finds it easy to mix/join in.*	*Buddy with other sports minded people to talk to.*	
Keeping healthy	Physical health, fitness, likes, opportunities	*Used to swim a bit; stopped golf 5 years ago. Not currently doing any exercise but likes idea of keeping healthy and strong. Says he has felt a bit lazy lately and would like to do something to get the energy flowing.*	*Open to ideas re exercise. Start with chair based group and get physio to monitor progress?*	*Discuss with physio*
Brain health	Learning, thinking, memory, mental health, opportunities	*Uses computer. Not interested in board games, bingo or quizzes (unless they are sports related questions) No memory problems reported.*	*Involve in conversation, get him to think/look up information.*	

Part 2: Medical, healthcare and safety – Only ask for information that is not already available from other sources				
Conversation starter: I would like to understand about your healthcare needs so that if you decide to come to PAG we can assist you in the way you prefer.....				
Category	**Prompts**	**Response**	**Care requirement at PAG** (Description)	**Referral / information required**
Mobility	How do you go moving around at home - inside and outside Or about in the community... Any falls in the last 6 months...	☐ Walks independently ☐ Supervised ☑ Uses aids/equipment: stick, frame, wheelchair, scooter ☐ Can sit to stand independently ☐ Requires assistance ☐ Assistance required to get in/out of vehicle ☐ Drives ☐ Uses public transport ☐ Fall within last 6 months – is a falls assessment needed? ☐ Has existing link to physio/other	*Uses walking frame - remind to be careful especially at pool or on rainy days. Avoid steps - use lift or ramp.*	
Eating well	Do you have any particular dietary requirements...	What are your favourite foods___*strawberries and cream* ☐ Normal diet ☐ Diabetic ☐ Vegetarian ☑ Gluten free ☐ Traditional/bush tucker ☐ Religious ☐ Other dietary requirement (cut up, soft food) ☐ Aids/equipment ☑ Uses dentures ☐ Other:	*Gluten free food at all times. Consider outing to strawberry farm in spring?*	
Vision	How is your vision...	☑ Glasses for reading ☐ Glasses for distance ☐ Assistance to clean glasses ☐ Other visual aids (e.g. contact lenses, prosthesis, glass eye)	*Check glasses are clean.*	
Hearing	How is your hearing...	☑ Hearing aid right ear ☑ Hearing aid left ear ☑ Requires batteries check ☐ Other	*Trouble checking batteries - PAG can do this.*	
Personal care	How do you manage in the bathroom and toilet...	☐ Independent ☑ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Incontinent ☐ Indwelling catheter ☐ Uses aids/equipment (e.g. pads): describe	*Reminder to go to toilet.*	
	And with dressing/grooming...	☐ Independent ☑ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Uses dressing/grooming aids/equipment: describe	*May require assistance at pool with shoes/socks.*	
Health conditions	Do you have any health conditions we should be aware of that might affect your participation at the PAG...	☐ Dementia - Note behaviours, triggers, management strategies ☑ Diagnosed conditions / pre-existing conditions ☑ Chronic diseases: describe ☐ Recent illnesses or hospital admissions: describe ☐ Health behaviours (e.g. smoking, alcohol or substance use) ☐ Disability (e.g. physical, intellectual, acquired brain injury) ☐ Other e.g. pain, oxygen use, other:	*Arthritus, Gout. Be alert to changes / always ask how he is feeling today.*	
Medication	Will you need to take any medication whilst at PAG...	☐ No ☑ Yes – note time frame ☐ Webster pack ☐ Other packaging ☑ Self administered ☐ Requires verbal prompt/reminder ☐ Staff assisted (Staff must have relevant qualification)	*Self administered by John as needed (no specific time).*	
Other	Any other medical, healthcare or safety matters...	☐ Describe allergies (e.g. food, medication, other): describe ☐ Medical or other alerts ☐ Personal safety (e.g. feeling afraid, elder abuse, legal issues) ☐ Personal Alert Victoria		

Part 3: Summary and action							
Summary / interpretation of assessment information	*John is interested in PAG and has expressed numerous interests and aspirations. It is likely that he will benefit from the PAG and be an active participant for 1 – 2 years. Also gave John information about the concert in the park Jazz sessions.*						
Next steps / action arising from assessment	Proceed to care planning ☑ Yes ☐ No ☐ Other: describe:						
Referrals to be actioned	☑ No ☐ Yes ☐ Completed ☐ Date completed						
Travel/transport arrangements discussed	☑ PAG pick up ☐ Taxi ☐ Self/family ☐ Other, describe:						
PAG fees information discussed and provided	☐ No ☑ Yes Comment:						
Date of assessment	*25 January 2015*	Name of assessor	*Lucy Lui*	Signature	*Lucy Lui*	Position/Agency	*PAG Coordinator, Ace Agency*

Affix consumer label / unique identifier (repeat on each page)

Template 4:
PAG care plan - completed example

Care plan for my Activity Group

My name:	*John Smith*	My date of birth:	*3 October 1933*
I like to be called:	*Johnny*	The language I speak at home:	*English*
My carer's name:	*Ethel*	Other people involved in this plan:	*Sally (daughter)*
Staff member name and position:		*Lucy Lui, PAG Coordinator*	
Current situation: My main reason for attending PAG is:		*To get out of the house, have fun and get some help with documenting my life story.*	

My goals (aims)	By when	How we will work on this together (Actions)	Who will assist me	When and how often	Review of my progress
To get help to finish my life story.	*I finish it by September*	*1. Join the life story group. (See group program for details)*	*Staff, volunteer*	*Monday afternoon until June*	
To keep up my general fitness and muscle strength by doing 2 physical programs.	*For the next 12 weeks or longer*	*2. Do the chair based exercise program. (Supervised by physiotherapist)* *3. Join the hydrotherapy and swimming group.*	*Staff, allied health assistant*	*Chair based - Monday mornings each week* *Swimming - Wednesday mornings each week*	
To make something for my grandson's school fete.	*By the fete in June*	*4. Participate in the woodwork group (by sanding and painting items).*	*Staff, volunteer*	*Each Wednesday*	
Chit chat - I don't see many folk these days.	*Ongoing*	*5. Join in conversation in all of the activities.*	*All*	*When I am the PAG*	

Other comments:	*In future I would like to join a movie club*
Referrals or other actions:	*PAG Coordinator to make a referral to tele-link.*

My health, safety and care whilst at the group	How I will be assisted	When	Who will assist me	Review of my care needs
Bathroom	*Remind me to go to toilet (Three verbal prompts then guide to bathroom)*	*After morning tea, after lunch, and before drop off.*	*Staff*	
Safe use of walking frame	*Avoid steps - use lift or ramp. Encourage me to walk slowly, especially at the swimming pool.*	*Ongoing*	*Staff*	
Nutrition/diet	*I have gluten free food. (NB: My favorite food is strawberries and cream)*	*Lunch*	*Staff*	
Hearing	*Check the batteries in my hearing aids*	*First thing each Monday*	*Volunteer*	

Date of this care plan:	*1 February 2015*	Date set for review:	*30 June 2015*	Expected finish date of group (if relevant):	*2016*

I would like a copy of this care plan to be given to:	Person responsible to provide copy:	Date the copy was provided:
Sally - my daughter	*Johnny*	*10 February 2015*
Dr. Alston (by post)	*PAG Coordinator - Lucy*	*10 February 2015*

Acknowledgement: "I understand and agree to this care plan and to copies being provided to the people listed above."

Signature of client or carer or legal representative:	*John Smith*	Date:	*1 February 2015*

Office use only:

☑ Client and/or carer provided with a copy of this care plan and date: ☐ Client and/or carer declined a copy

Template 5:
PAG care plan review - completed example

Care plan for my Activity Group - My Review

My name:	*John Smith*	My date of birth:	*3 October 1933*
I like to be called:	*Johnny*	The language I speak at home:	*English*
My carer's name:	*Ethel*	Other people involved in this plan:	*Sally (daughter)*
Staff member name and position:		*Lucy Lui, PAG Coordinator*	
Current situation: My main reason for attending PAG is:		*My reasons is still the same - it hasn't changed much. It is to get out of the house and have fun.*	

My goals (aims)	By when	How we will work on this together (Actions)	Who will assist me	When and how often	Progress - Has this been achieved?
To get help to finish my life story.	*I finish it by September*	*1. Join the life story group. (See group program for details)*	*Staff, volunteer*	*Monday afternoon until June*	✓ *Yes, finished*
To keep up my general fitness and muscle strength by doing 2 physical programs.	*For the next 12 weeks or longer*	*2. Do the chair based exercise program. (Supervised by physiotherapist) 3. Join the hydrotherapy and swimming group.*	*Staff, allied health assistant*	*Chair based - Monday mornings each week Swimming - Wednesday mornings each week*	*Progressing well and have not missed any classes. I enjoy both of these but need a new pair of togs.*
To make something for my grandson's school fete.	*By the fete in June*	*4. Participate in the woodwork group (by sanding and painting items).*	*Staff, volunteer*	*Each Wednesday*	✓ *Yes, finished*
Chit chat - I don't see many folk these days.	*Ongoing*	*5. Join in conversation in all of the activities.*	*All*	*When I am the PAG*	*I have a new buddy*
New goal: To be a move critic for 10 movies	*December*	*6. A PAG volunteer can help me attend a movie club*	*Volunteer*	*TBC*	

Other comments:	
Referrals or other actions:	*The referral to tele-link did not proceed as John changed his mind.*

My health, safety and care whilst at the group	How I will be assisted	When	Who will assist me	Review of my care needs
Bathroom	*Remind me to go to toilet (Three verbal prompts then guide to bathroom)*	*After morning tea, after lunch, and before drop off.*	*Staff*	*Working well, continue*
Safe use of walking frame	*Avoid steps - use lift or ramp. Encourage me to walk slowly, especially at the swimming pool.*	*Ongoing*	*Staff*	*Working well, continue*
Nutrition/diet	*I have gluten free food. (NB: My favorite food is strawberries and cream)*	*Lunch*	*Staff*	*Would like more variety in GF meals*
Hearing	*Check the batteries in my hearing aids*	*First thing each Monday*	*Volunteer*	*Good thanks, continue*
New: Medication	*Remind me to take my pill*	*Lunchtime*	*Staff*	

Date of this care plan:	*30 June 2015*	Date set for review:	*30 November 2015*	Expected finish date of group (if relevant):	*2016 (mid)*

I would like a copy of this care plan to be given to:	Person responsible to provide copy:	Date the copy was provided:
Sally - my daughter	*Johnny*	*30 June 2015*
Dr. Alston (by post)	*PAG Coordinator - Lucy*	*30 June 2015*

Acknowledgement: "I understand and agree to this care plan and to copies being provided to the people listed above."

Signature of client or carer or legal representative:	*John Smith*	Date:	*30 June 2015*

Office use only:

☑ Client and/or carer provided with a copy of this care plan and date: ☐ Client and/or carer declined a copy

14 Case studies

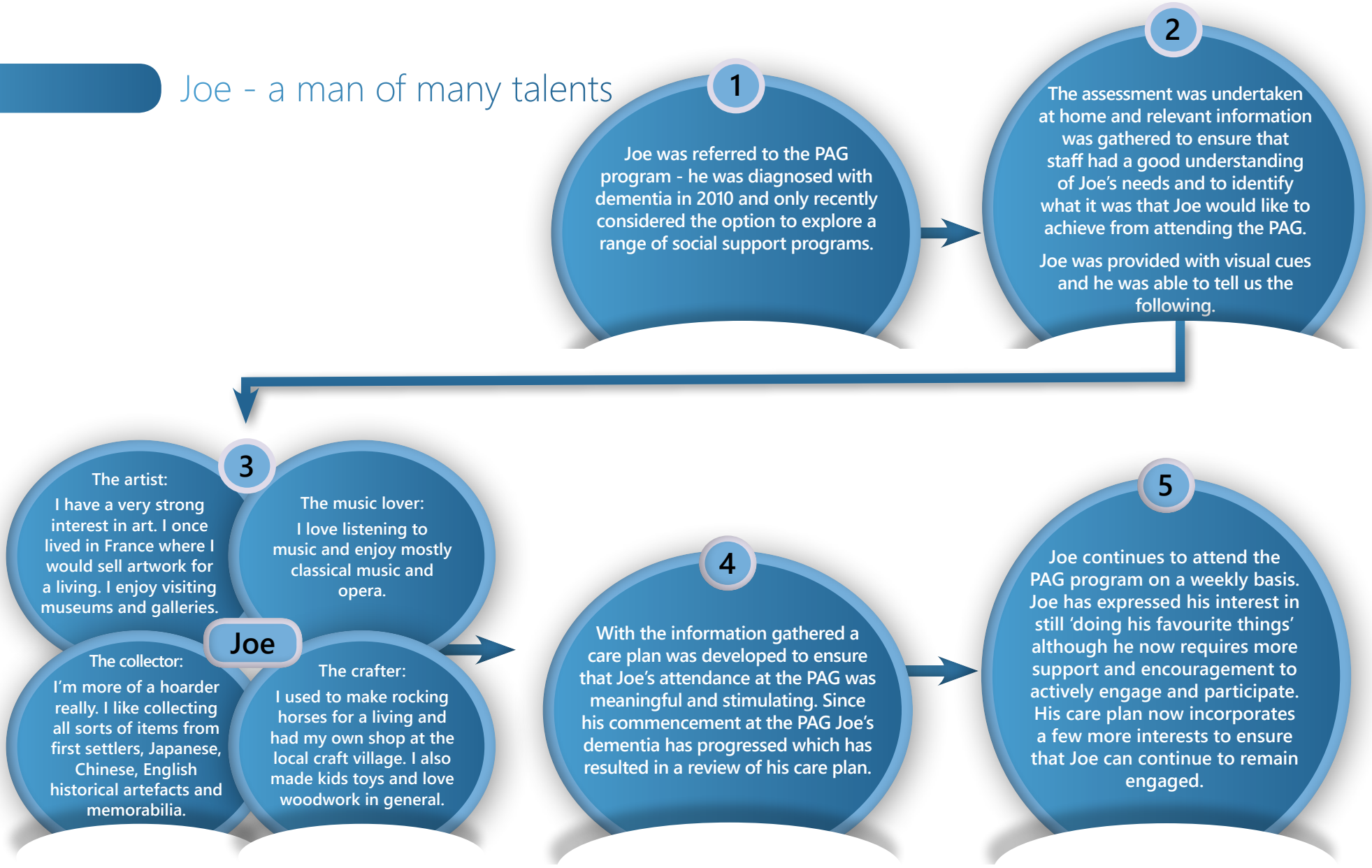
Kevin's dream comes true

1. Kevin is a 72 year old man, with an intellectual disability. During a conversation with staff Kevin raised a lifelong dream to ride a bike.
2. Kevin has never ridden a bike due to health issues and lack of support.

   PAG staff were determined to help Kevin's dream come true... to get him in the saddle.
3. With staff members encouragement and support Kevin participates in weekly exercise session to enhance his fitness, strength, balance and endurance. Staff facilitate a weekly session for Kevin to learn the road rules.
4. PAG staff organised fundraising – donations paid for the safety gear. Staff approached the local bike shop who stepped in and donated a $700 tricycle. Kevin was ecstatic – he said that the bike will give him freedom and save money.
5. Kevin has a new dream now to "ride his bike to Castlemaine."
6. This is a wonderful example of never giving up on your dreams.

   Also, when a community unites, amazing things can happen!

Joe - a man of many talents



Betty's love of horses

1

Betty, aged 87, is well known in her local community. Her family has lived in the country town for many generations. Following a recent fall at home, and at her GP's insistence, she was assessed by the HACC assessment service. One result was a referral to the PAG.

2

Sally, the PAG coordinator, knows Betty and sees her occasionally in the main street. Sally has hinted to Betty over recent years that she may wish to attend the PAG, however Betty always responds that she is not 'old enough yet!' Following the referral, Sally makes contact and visits Betty at home.

3

In preparing for the home visit, Sally reads the assessment provided by the HAS and thinks about what might appeal to Betty and how a PAG can assist her. Much of the factual information she requires about Betty's health is already included with the referral and assessment information, so she decides to focus on gaining a better understanding of Betty's life story. They engage easily in conversation and Sally asks Betty about 'what makes her tick' and what she currently most enjoys in her life.

4

Sally finds out that Betty has always had a love of horses. As a child she travelled in a jinker and belonged to a pony club. When her husband was still alive (15 years ago) they would attend harness and other racing events. She also asked Betty about 'the highlights' of her life, and whether she had ever won any awards. Betty revealed that many years earlier she had won a short story competition. Sally then asked Betty for her ideas about what a PAG would need to offer to be of interest to her, so that as the doctor said, 'they could help her stay healthy'.

5

Betty said she would be willing to try the PAG if the activities and the other people attending were interesting. Building on their discussion, Sally talked about how the PAG had a story writing club, where some people chose to prepare their life story, others chose to write or record fiction or poetry, and others simply read and discussed stories. She also talked about the monthly outings and that she would canvas interest in a horse-related group and outings if Betty would assist with some of the organising (even in a small way) whilst at the PAG. Betty agreed to.

6

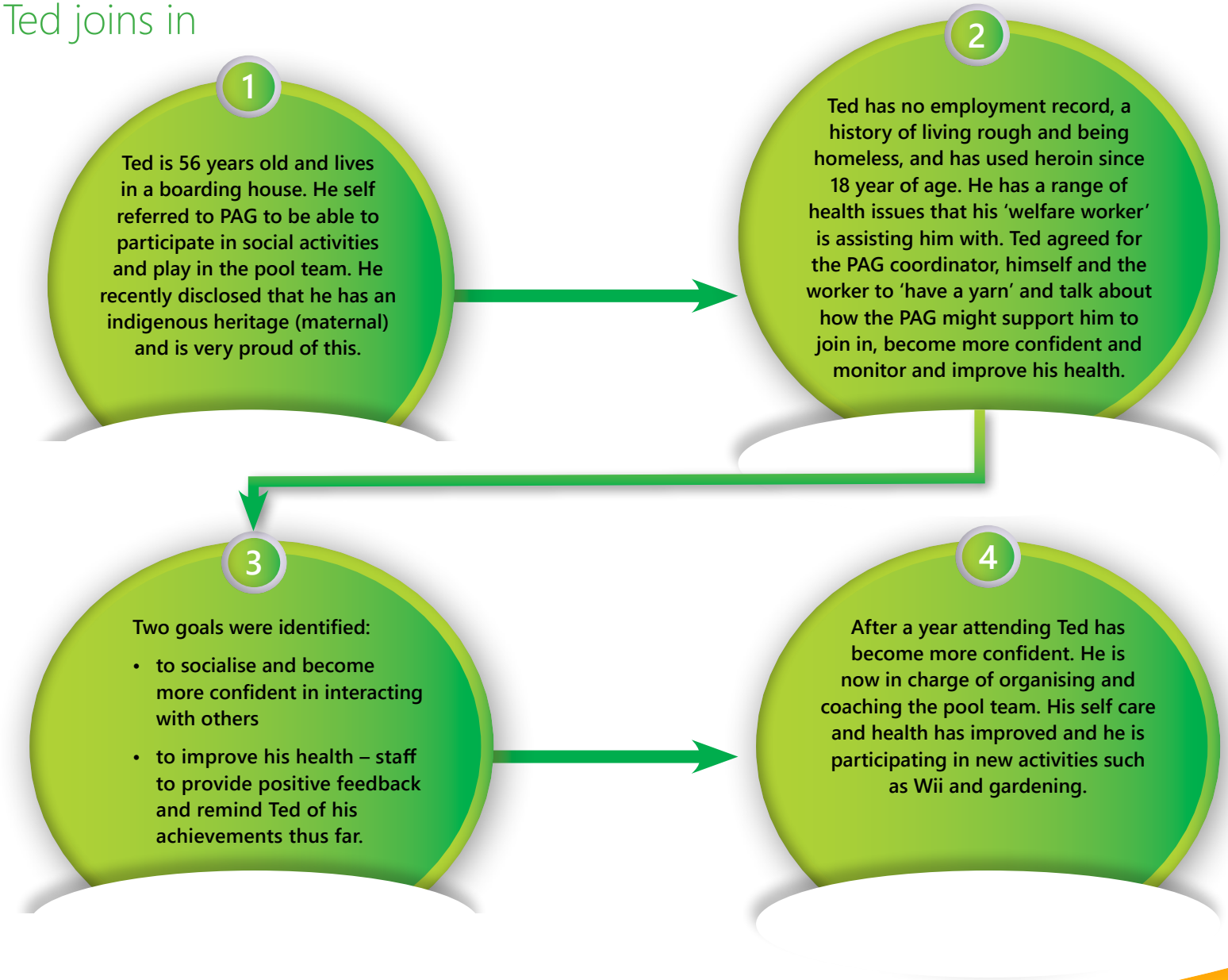
Betty's care plan recorded two goals.

1. To write a children's story about horses. The PAG would provide a Dictaphone (Betty's arthritis meant she could not write) and a volunteer would type the story in a large size print for her to correct the following week.

2. To participate in the gentle exercise group to assist with keeping her body healthy and to improve / maintain her balance so she was less reliant on her walking frame. A physio would oversee this program for her.

A review date was set for six weeks, by which time Betty was part way through her story. She reported that she was enjoying the activities and the company of others and wished to keep attending.

Ted joins in


1
Ted is 56 years old and lives in a boarding house. He self referred to PAG to be able to participate in social activities and play in the pool team. He recently disclosed that he has an indigenous heritage (maternal) and is very proud of this.
2
Ted has no employment record, a history of living rough and being homeless, and has used heroin since 18 year of age. He has a range of health issues that his 'welfare worker' is assisting him with. Ted agreed for the PAG coordinator, himself and the worker to 'have a yarn' and talk about how the PAG might support him to join in, become more confident and monitor and improve his health.
3
Two goals were identified:
• to socialise and become more confident in interacting with others
• to improve his health – staff to provide positive feedback and remind Ted of his achievements thus far.
4
After a year attending Ted has become more confident. He is now in charge of organising and coaching the pool team. His self care and health has improved and he is participating in new activities such as Wii and gardening.

Amanda works towards her goals

1

Aged 26, Amanda was referred to PAG when her mother found out about the service on the internet. Amanda had been diagnosed with a condition that meant her sight was deteriorating and she had already lost the vision in one eye. Her low vision meant she could no longer drive her car and had to give up her chef apprenticeship. She had lost her confidence and was becoming socially isolated.

2

A PAG assessment was undertaken and relevant information was gathered to ensure that PAG staff had a good understanding of Amanda's needs and to identify what Amanda wanted to achieve by attending PAG.

After further conversations and a short time spent as part of the PAG group Amanda became more settled and comfortable. PAG staff were able to develop a goal plan with Amanda that was written in her own words and was meaningful to her. Amanda identified that she would like to:

1. Keep fit and healthy
2. Help in the community
3. Put together a Relay for Life team to raise money for Cancer research
4. Help out at a nursing home.

3

Amanda was supported by PAG staff, volunteers and participants to achieve these goals by:

- supporting her to join the local gym
- starting a swimming group
- taking part in a PAG walking group
- volunteering for Meals on Wheels
- organising fund raising events and a team and entering the Relay for Life
- helping at a local nursing home two hours per week.

4

By being involved in these activities at PAG Amanda gained the confidence to independently volunteer at a local op shop and deliver pamphlets to keep fit.

Amanda continues to attend PAG. For the first two years she attended five days per week but as she regains her confidence and re-establishes connections into the community her attendance has reduced to three days per week. Amanda has been able to achieve all of her goals in some way and is excited about working together to create the next goal plan.

15 Other useful links and resources

Knowledge base

This guide has focussed on the aspects of individual assessment, care planning and review. However, there are many other considerations to PAG service design and delivery. A comprehensive approach to PAG service delivery benefits from the following. Links to these documents are available on the department's website at http://www.health.vic.gov.au/hacc/index.htm.

Knowledge base	Look for the...
Knowledge of the Victorian HACC program's policies, guidelines and quality standards – in particular the HACC assessment framework, Active Service Model, Diversity planning and practice	Victorian Home and Community Care program manual 2013 Framework for assessment in the HACC program Active Service Model Diversity planning and practice
Knowledge of the Service Coordination framework	Victorian Service Coordination Practice Manual
Knowledge of the policies, procedures and standards of your organisation	Your organisation. For example the procedure for engaging interpreters, access to professional development, consumer input.
PAG assessment, care planning and review	This document Goal directed care planning toolkit
Program planning and activity planning (including available funds, resources, staff development), working with volunteers	Well for Life publications Relate, Motivate, Appreciate Enabling the use of easy living equipment for everyday activities Volunteer resource kit PAG pathways manual
Compliance with the HACC quality framework	Victorian Home and Community Care program manual 2013
Compliance with Community Care Common Standards (and future Home Care Standards)	Community care common standards

Appendix 1: Templates

- PAG service specific assessment template
- Prompt questions for use with part 1 of the assessment template
- Care plan for my Activity Group

Affix consumer label / unique identifier (repeat on each page)

PAG service specific assessment template

Name:		Date of birth:		With input by carer:	
Likes to be called:				With input by other:	
Has the person had a recent assessment:	☐ No ☐ Unsure ☐ Yes: If yes, agency and date:	Other current support services (if known):			

Part 1: Individuality, social and emotional wellbeing

Conversation starter: I would like to understand more about you as a person so we can work out together what might suit and interest you. Can you tell me a bit about yourself....

Category	Areas	Prompts (Use your professional judgement and the presenting situation as to which prompts and questions to use).	Response	Interpretation for PAG	Action or referral
About you	Carer, family members, history Significant others, friends, diversity				
What you enjoy (Consider past, present, future)	Enjoyment, work, volunteering, hobbies, interests, good/bad days, opportunities				
Your social preference	Communication, socialising preferences				
Keeping healthy	Physical health, fitness, likes, opportunities				
Brain health	Learning, thinking, memory, mental health, opportunities				

Part 2: Medical, healthcare and safety – Only ask for information that is not already available from other sources				
Conversation starter: I would like to understand about your healthcare needs so that if you decide to come to PAG we can assist you in the way you prefer.....				
Category	**Prompts**	**Response**	**Care requirement at PAG** (Description)	**Referral / information required**
Mobility	How do you go moving around at home - inside and outside Or about in the community... Any falls in the last 6 months...	☐ Walks independently ☐ Supervised ☐ Uses aids/equipment: stick, frame, wheelchair, scooter ☐ Can sit to stand independently ☐ Requires assistance ☐ Assistance required to get in/out of vehicle ☐ Drives ☐ Uses public transport ☐ Fall within last 6 months – is a falls assessment needed? ☐ Has existing link to physio/other		
Eating well	Do you have any particular dietary requirements...	What are your favourite foods___ ☐ Normal diet ☐ Diabetic ☐ Vegetarian ☐ Gluten free ☐ Traditional/bush tucker ☐ Religious ☐ Other dietary requirement (cut up, soft food) ☐ Aids/equipment ☐ Uses dentures ☐ Other:		
Vision	How is your vision...	☐ Glasses for reading ☐ Glasses for distance ☐ Assistance to clean glasses ☐ Other visual aids (e.g. contact lenses, prosthesis, glass eye)		
Hearing	How is your hearing...	☐ Hearing aid right ear ☐ Hearing aid left ear ☐ Requires batteries check ☐ Other		
Personal care	How do you manage in the bathroom and toilet...	☐ Independent ☐ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Incontinent ☐ Indwelling catheter ☐ Uses aids/equipment (e.g. pads): describe		
	And with dressing/grooming...	☐ Independent ☐ Some assistance (e.g. prompt) ☐ Full assistance ☐ Resistant behaviour ☐ Uses dressing/grooming aids/equipment: describe		
Health conditions	Do you have any health conditions we should be aware of that might affect your participation at the PAG...	☐ Dementia - Note behaviours, triggers, management strategies ☐ Diagnosed conditions / pre-existing conditions ☐ Chronic diseases: describe ☐ Recent illnesses or hospital admissions: describe ☐ Health behaviours (e.g. smoking, alcohol or substance use) ☐ Disability (e.g. physical, intellectual, acquired brain injury) ☐ Other e.g. pain, oxygen use, other:		
Medication	Will you need to take any medication whilst at PAG...	☐ No ☐ Yes – note time frame ☐ Webster pack ☐ Other packaging ☐ Self administered ☐ Requires verbal prompt/reminder ☐ Staff assisted (Staff must have relevant qualification)		
Other	Any other medical, healthcare or safety matters...	☐ Describe allergies (e.g. food, medication, other): describe ☐ Medical or other alerts ☐ Personal safety (e.g. feeling afraid, elder abuse, legal issues) ☐ Personal Alert Victoria		

Part 3: Summary and action							
Summary / interpretation of assessment information							
Next steps / action arising from assessment	Proceed to care planning ☐ Yes ☐ No ☐ Other: describe:						
Referrals to be actioned	☐ No ☐ Yes ☐ Completed ☐ Date completed						
Travel/transport arrangements discussed	☐ PAG pick up ☐ Taxi ☐ Self/family ☐ Other, describe:						
PAG fees information discussed and provided	☐ No ☐ Yes Comment:						
Date of assessment		Name of assessor		Signature		Position/Agency	

Prompt questions for use with part 1 of the assessment template

Note: Refer to instructions in the guidelines for use of these questions and the assessment template.

Use your professional judgement as to which questions are relevant to the client and presenting situation.

Category	Areas	Prompts (Use your professional judgement and the presenting situation as to which prompts and questions to use).
About you	Carer, family members, history Significant others, friends, diversity	Tell me about you and your family…and who is most involved in your life… Do you have a carer or a person who helps you…Are these arrangements working well for you… What about friends and significant others…who do you like to keep in touch with… Have you had any recent bereavements or losses… Do you have any lifestyle considerations, cultural, religious values or beliefs that we should be aware of… Are there any events, outings or festivals that you would like to attend…or connections to make… What is most important to you in your life at present…
What you enjoy (Consider past, present, future)	Enjoyment, work, volunteering, hobbies, interests, good/bad days, opportunities	What would you describe as the highlights of your life and your personal accomplishments… What sort of work did you do…and what aspects of this did you enjoy most… What sort of things do you enjoy doing, what are you good at…what makes you happy… What do you like to do in your spare time…has this changed over time and if so how… Do you have any hobbies at present…or that you hope to try but haven't yet… Is there anything in particular you want to achieve… What are your personal favourites e.g. favourite food, fruit, music, sport, book, movie, craft… How would you describe a 'good day' for you…
Your social preference	Communication, socialising preferences	How do you like to communicate…(e.g. preferred language, assistance, aids, understanding)… Can you tell me about how you like to interact or socialise with others… What makes you feel comfortable or 'belong' in a group setting…(e.g. big or small groups, a particular community, type of group, boisterous or quiet/relaxed)… Do you belong to any groups or clubs…or would you like to… How would you describe the ideal social outing for you…
Keeping healthy	Physical health, fitness, likes, opportunities	I would also like to hear about what you do at present to keep healthy. Can you tell me about what types of exercise or sport do you most enjoy doing (or watching)…are you currently doing this… Do you have an exercise program at present…what is the most energetic thing you do at present… Are you interested in something to help you stay physically fit and healthy…do you have any ideas about what…do you have a physio or coach…
Brain health	Learning, thinking, memory, mental health, opportunities	How is your memory these days…do you need help remembering things…if so what… **For a person with memory loss, dementia, brain injury, or intellectual disability:** Discuss with the person and/or their carer whether a specific response is required. (e.g. does the person get anxious or agitated, triggers, positive behaviour support and reinforcement strategies, whether a behaviour support plan is required etc)

Affix consumer label / unique identifier (repeat on each page)

Care plan for my Activitiy Group

My name:		My date of birth:	
I like to be called:		The language I speak at home:	
My carer's name:		Other people involved in this plan:	
Staff member name and position:			
Current situation: My main reason for attending PAG is:			

My goals (aims)	By when	How we will work on this together (Actions)	Who will assist me	When and how often	Review of my progress

Other comments:	
Referrals or other actions:	

My health, safety and care whilst at the group	How I will be assisted	When	Who will assist me	Review of my care needs

Date of this care plan:		Date set for review:		Expected finish date of group (if relevant):	

I would like a copy of this care plan to be given to:	Person responsible to provide copy:	Date the copy was provided:

Acknowledgement: "I understand and agree to this care plan and to copies being provided to the people listed above."

Signature of client or carer or legal representative:		Date:	

Office use only:

☐ Client and/or carer provided with a copy of this care plan and date:

☐ Client and/or carer declined a copy