Living at home assessment

Introduction

This section describes the requirements for HACC funded Living at home assessments. It is based on the *Framework for assessment in the HACC program in Victoria*, which identifies assessment as a building block for active service model implementation.

The *Framework for assessment in the HACC program* is essential reading for HACC assessment service providers.

Readers should also refer to the sections:

- Part 3: 'The Victorian approach to care: the active service model'
- Part 2: 'Service coordination, assessment and care planning'.

A Living at home assessment is a funded HACC activity delivered by designated HACC assessment services.

The purpose of a Living at home assessment is to gain a broad understanding of a person and their carer's needs, in order to assist the person to live at home as independently as possible.

This involves careful care planning, matching the person's needs and goals to the most appropriate service response either from carers, family members and friends, local community groups and/or subsidised services funded through the HACC program or other health and community services.

There are 99 designated HACC assessment services in Victoria. HACC assessment services comprise 73 local governments, 18 community health and health services, with the remainder being district nursing, bush nursing and other non-government community service organisations.

A number of resources have been developed to assist HACC assessors to develop consistency in their understanding of the concepts, skills and thinking behind Living at home assessments.

HACC assessors should use the following resources in their day-to-day practice:

- *Strengthening assessment and care planning: a guide for HACC assessment services in Victoria* (Department of Health 2010)
- *Strengthening assessment and care planning: workbook* (Department of Health 2010)
- *Induction resource for HACC assessment services* (Municipal Association of Victoria 2010)
- *Strengthening assessment and care planning: dementia practice guidelines for HACC assessment services* (Department of Health 2012)
- *A guide to services for people with dementia and their carers* (Department of Health 2012).

Scope

HACC Living at home assessments are provided by HACC assessment services. A Living at home assessment includes:

- initial contact and initial needs identification
- a face-to-face, holistic assessment with the person, carer and family members, usually in their own home, which:
  - builds on the person's strengths, goals and aspirations
  - identifies opportunities for improving functional capacity and participation in social and community activities
  - includes risk management
- service-specific assessments for services provided by the assessing organisation including the identification of occupational health and safety issues for these services and a fees assessment
- goal directed care planning including a care plan summarising the goals and actions from the holistic assessment and a service plan for services provided by the assessing organisation
- care coordination for people receiving services from multiple agencies.

Assessment for personal care

An assessment for personal care can only be undertaken by staff with adequate skills and training.

If the person's health is unstable and/or if they have complex care needs, the personal care assessment is undertaken by a registered nurse (formerly a division 1 nurse), or other relevant health professional. For more information, see Part 3: 'Personal Care Policy'.

Who is eligible for a Living at home assessment?

Any organisation can refer to a HACC assessment service if they believe the person has broader and more complex needs than can be addressed through their organisation. People and their family or carers can also self-refer.

Organisations referring to a HACC assessment service for a Living at home assessment should provide as much information as possible in the referral to reduce duplication of information gathering.

Fees assessment

All people receiving HACC services must be informed about the HACC Fees Policy. A fees assessment is part of the service-specific component of a Living at home assessment.

HACC assessment services do not charge a fee for the Living at home assessment, as this is a free service. For more information refer to Part 1: 'Fees Policy'.

Exclusions

The Living at home assessment activity includes the provision of care coordination but does not include case management. The Linkages activity is the only HACC activity that provides case management. See Part 3: 'Linkages'.

Assessment

In the context of the active service model, a Living at home assessment is critical to assisting people maintain or improve their health, wellbeing and independence.

A Living at home assessment is based on the following principles:

- person-centred practice
- carer and family focus
- promoting independence
- work in partnerships
- goal directed care planning and service delivery
- system-focused approach.

A Living at home assessment is a process not a one-off event. It includes assessment, care planning, review, reassessment and exit.

The assessment begins with a focus on the person's presenting and underlying needs.

Assessments typically cover:

- general health including nutritional risk
- diversity and cultural requirements
- domestic and personal activities of daily living
- mobility and falls prevention
- cognitive function
- carer and family needs
- environmental risk and personal emergency planning including meeting obligations under the Vulnerable People in Emergencies Policy 2012
- social, emotional and psychological wellbeing
- capacity for functional improvement and self-management.

For further information on assessment domains, and practice skills for Living at home assessments see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Relevant sections in the *Service agreement information kit* include:

- section 4.13: 'Language Services Policy'
- section 4.14: 'Cultural diversity guide', including the *Victorian Government Aboriginal inclusion framework* and *Enabling choice for Aboriginal people with a disability*
- section 4.18: 'Vulnerable People in Emergencies Policy'
- section 4.19: 'Emergency Preparedness Client and Services Policy'.

Care planning

Care planning is a collaborative process with the assessor, the person and their carer. Effective care planning leads to the development of flexible, tailored care options that support the best possible outcomes for the person. Goal directed care planning is empowering, motivating and provides a shared sense of purpose between the person, their carer and service providers.

Care planning resulting from a Living at home assessment includes:

- a holistic care plan documenting the person's priorities, goals and agreed actions resulting from the assessment
- service-specific care plans or service plans for HACC services provided by the assessing organisation
- a referral action plan for referrals to a range of other required services
- information about services or activities such as health promotion and social activities that the person or carer can choose to pursue
- timeframes for review including exit from the HACC program
- assistance with timely transition to more appropriate types or levels of care, such as packaged care or residential aged care.

Care planning needs to be system-focused as well as person-centred. This involves:

- taking account of demands on the organisation's resources and the community care system as a whole
- appropriate targeting of resources and consistency in determining eligibility, priority of access and resource allocation
- suggesting options and alternative sources of support if there is high demand for HACC resources.

For further information on goal directed care planning in Living at home assessments see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Care coordination

In addition to care planning, care coordination is provided for a subgroup of people with complex needs and circumstances. This includes people receiving services from multiple organisations without case management. Care coordination is an extension of the assessment and care planning process, and may include tasks such as:

- facilitating access, care planning and coordination between multiple organisations or services involved with the person, including those outside the HACC program
- facilitating the development and review of the shared care plan
- monitoring and reviewing the progress of the service-specific care plans
- identifying the person responsible for care coordination who may become the key worker.

For further information on care coordination see *Strengthening assessment and care planning: a guide for HACC assessment services* (Department of Health 2010).

Working in partnerships

HACC assessment services are required to work in partnership with key HACC services such as allied health, nursing and access and support workers to achieve a timely and coordinated approach to assessment, reduce duplication and implement the active service model.

Links to other services such as Aged Care Assessment Services (ACAS), disability services and mental health services are also important for coordinated and streamlined care.

Working in partnerships enables and encourages interdisciplinary practices such as:

- secondary consultation
- joint assessments
- case conferences
- shared orientation
- professional development.

Practitioner co-location is also an effective way to promote interdisciplinary practice.

The *Guidelines for streamlining pathways between ACAS and HACC assessment* (Department of Health 2011) describes referral pathways and opportunities for collaboration designed to ensure that frail older people get the right assessment at the right time.

See also:

- Part 3: 'Access and support'
- Part 2: 'Interface programs'
- Part 2: 'Diversity'.

Assessment alliances

In order to work effectively with other organisations and take a lead role in using the active service model, HACC assessment services should develop and work within regional or subregional assessment alliances.

For more information refer to the *Framework for assessment in the HACC program* (Department of Human Services 2007).

Staffing statement

Staff employed to undertake Living at home assessments are expected to have relevant skills and qualifications. The HACC assessment framework requires HACC assessment services transition to assessment staff with relevant higher education qualifications.

Since the composition and names of qualifications change over time and a wide variety of courses are available, the following list is generic. In some cases the registered occupation is listed.

Examples include:

- registered nurse (formerly division 1 nurse)
- physiotherapist
- occupational therapist
- dietitian
- qualifications recognised by the Australian Association of Social Workers
- psychology
- counselling
- disability studies
- health sciences (practice oriented, not population-health oriented)
- Vocational Graduate Certificate in Community Service Practice (Client assessment and case management).

Examples of relevant postgraduate diplomas, certificates and masters degrees include:

- disability studies
- aged care
- counselling
- case management
- complex care
- health promotion
- social work in health settings
- social work in mental health
- community health nursing.

For more information see Part 1: ‘Employee and related requirements’.

Reporting requirements

Organisations funded for HACC assessment are required to participate in the quarterly collection of the HACC minimum data set (MDS).

The reporting requirements are found in Part 1: 'Reporting and data collection'.

The HACC MDS is used to record details of individual clients who receive a Living at home assessment, including hours of assessment and care coordination.

- Assessment and care planning should be reported in hours/minutes against the assessment data item in the HACC MDS.
- Care coordination should be reported in hours/minutes in the HACC MDS under the care coordination data item.

For details see *MDS counting rules for HACC assessment services*: *update* (Department of Health 2013).

Links

Framework for assessment in the Home and Community Care Program in Victoria (Department of Human Services 2007)
http://www.health.vic.gov.au/hacc/downloads/pdf/framework.pdf

Strengthening assessment and care planning: a guide for HACC assessment services in Victoria (Department of Health 2010) http://www.health.vic.gov.au/hacc/downloads/pdf/assess_guide.pdf

Strengthening assessment and care planning: dementia practice guidelines for HACC assessment services (Department of Health 2012)
http://www.health.vic.gov.au/hacc/assessment.htm#download

Goal Directed Care Planning Toolkit: Practical strategies to support effective goal setting and care planning with HACC clients
http://www.iepcp.org.au/active-service-model-emr-hacc-alliance

MDS counting rules for HACC assessment services: *update* (Department of Health 2013)
http://www.health.vic.gov.au/hacc/assessment.htm

Guidelines for streamlining pathways between ACAS and HACC assessment services: improving the client journey (Department of Health 2011)
http://www.health.vic.gov.au/agedcare/downloads/pdf/acas_has_guidelines.pdf

Carers Recognition Act 2012 (Victoria) and the *Victorian Charter Supporting Care Relationships.*
http://www.dhs.vic.gov.au/carersact

Vulnerable People in Emergencies Policy (2012)
http://www.dhs.vic.gov.au/facs/bdb/fmu/service-agreement/4.departmental-policies-procedures-and-initiatives/4.18-vulnerable-people-in-emergencies