



Ongoing Needs Identification in NSW Primary Health and Community Care: How and Why

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How to use this manual

Welcome to this primer on the hows and whys of ongoing needs identification and screening in NSW.

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1 Introduction and background

This document provides guidelines on how to use the screening and assessment tools that are being tested by some NSW regions as part of the NSW Comprehensive Assessment Pilots. These tools draw heavily on those initially developed for use in Primary Care Partnerships on Victoria¹ and then subsequently modified for use in South Australia². They were then modified and further developed for use in the Mid North Coast Coordinated Care Trial³. The tools in the NSW model incorporate elements from each. They are the recommended standardised suite of items that cover the primary care domains in the comprehensive assessment pilots. But their use is not restricted to the pilots. They represent a workable compromise between the evidence from the literature and tools that are familiar from common practice.

These guidelines discuss how to complete a screening procedure using the Ongoing Needs Identification (ONI) tools, how to undertake an Ongoing Needs Identification that may prompt referral and/or further assessment and how to complete a Summary and Action Plan. If required, the information can be used to develop an agency's own service-specific consumer care plan and a multi-agency service coordination plan. Issues relating to care planning, service coordination planning and assessment (specialist and comprehensive) are not included in these guidelines⁴.

The guidelines are divided into 14 sections:

1. Introduction and background
2. Overview of the ongoing needs identification tools and how to use them
3. How to complete the contact details
4. How to complete the service entry data set
5. How to complete the ONI summary and action plan
6. How to complete the supplementary living arrangements profile
7. How to complete the supplementary carer profile
8. How to complete the supplementary health conditions profile
9. How to complete the supplementary psychosocial profile
10. How to complete the supplementary functional profile
11. How to complete the supplementary health behaviours profile
12. How to use the tools to investigate need and develop a consumer care plan
13. Frequently asked questions
14. Selected bibliography for screening in primary care

¹ Details of the Victorian model can be found at: <http://hnb.dhs.vic.gov.au/acmh/phkb.nsf>

² Details of the South Australian model can be found at www.eraproject.sa.gov.au

³ Eagar K and Owen A (2002) *Ongoing Needs Identification in the Mid North Coast Coordinated Care Trial: How and Why*. Centre for Health Service Development, University of Wollongong.

⁴ Additional material including electronic copies of the associated forms, tools for functional assessment, a template care plan, an alert sheet and an environmental profile are available as files that can be down-loaded from the CHSD website at www.uow.edu.au/commerce/chsd.

1.1 The NSW Comprehensive Assessment System Implementation

The evaluation of community care demonstration projects in NSW from 1994 onwards showed the limitations inherent in not having standardised data items and joined up reporting and information systems. Without them, comparisons are limited and service planning and coordination are handicapped⁵. In a similar way, the coordinated care trials showed the essential significance of assessment and reliably measuring client functional needs⁶. Fine and Thomson (1995) also found periodic reassessment to be a major factor affecting the effectiveness of community service interventions⁷.

Much progress has been made within local systems since the first round of effort at stimulating integration through local innovations in health and community services. This has included reform work in HACC and support for integrating community care services in NSW consistent with the national policy direction set by the national assessment framework⁸.

It also includes more sharing of common data items through the widespread use of the client information and referral record (CIARR)⁹, and a reporting requirement that includes the HACC MDS¹⁰. The HACC MDS will include the screen data items on functional dependency from July 2004¹¹.

In March 1998 the Home and Community Care (HACC) Program released a National Framework for Comprehensive Assessment for the HACC Program, produced by the Lincoln Gerontology Centre. NSW, as part of the national reform of assessment in the HACC program, released Community Care Assessment in NSW (1998), this was jointly approved by Department of Ageing Disability and Home Care (DAD&HC) and NSW Health¹².

This reform was based on the following principles:

- assessment and service provision systems need to be separated for people with complex care needs,
- not all people who require a HACC service require a comprehensive assessment nor is it desirable to do so,

⁵ NSW Government, Office on Ageing (subsequently the NSW Ageing and Disability Department), *Community Solutions*. Evaluation: Measuring Change. Social Policy Directorate, 1994, p.8. See also evaluation comments in *Community Solutions*, Issue No.2, September 1995, p.6.

⁶ Eagar K and Woods K, (1999) Client assessment the starting point for coordinating care. Chapter 3 in Department of Health and Aged Care *The Australian Coordinated Care Trials: Methodological issues in trial design and evaluation*. ISBN 0642393834 <http://www.health.gov.au/hsdd/cocare/pdf/cctbook2.pdf>

⁷ Fine M and Thomson C, (1995) Factors Affecting the Outcome of Community Care Service Intervention: A literature review. Aged and Community Care Service Development and Evaluation Reports, No.20 Dept of Human Services and Health. October 1995. See p.53.

⁸ Lincoln Gerontology Centre. National Framework for Comprehensive Assessment - Aged and Community Care Service Development and Evaluation Report No. 34, March, 1998.

⁹ National Review of CIARR, 1999. The review included recommended new ATSI and NESB items.

¹⁰ Brian Elton and Associates 1996. National Review of HACC Data Requirements. Final report: Future Directions. Canberra, Commonwealth Dept of Health and Family Services.

Commonwealth and State/Territory HACC Officials 1998. HACC Data Dictionary, version 1.0. Canberra, Commonwealth Dept of Health and Family Services. AIHW Work Program 1999-2000 ISBN 1-74024-020-0, AIHW Cat. No. AUS-17

¹¹ Centre for Health Service Development (2002). A national measure of functional dependency for Home and Community Care services in Australia. Department of Health and Ageing, Aged and Community Care Service Development and Evaluation Reports, No.41, July 2002.

¹² Community Care Assessment in NSW: A Framework for the Future - A Discussion Paper, November 1998.

- a screening tool should be developed to direct people towards the appropriate level of assessment or service provision; and
- that the relative need of service users can be objectively measured.

Many of these principles were based upon the local learning and broader findings of the NSW Community Care Demonstration projects. The proposed implementation will directly build upon this work. This includes the identification of agencies that can undertake detailed/specialist assessment, the use of the electronic Client Information and Referral Record (CIARR) and linkages across funding programs including NSW Government Health and Disability services.

To implement this reform in NSW the Department (DAD&HC) made funding available to Age Communications to develop a draft Regional Comprehensive Assessment Framework to assist regions develop both local Assessment Networks and the process and protocols to enable the Assessment Networks to operate. Concurrently DAD&HC funded HACC reform workers to assist regions implement this reform as well as the CIARR and the HACC Minimum Data Set (MDS).

Those developing local Assessment Networks have identified and documented which agencies and workers have the skills and capacities to undertake either screening or assessment or both. They have also established processes to enable the efficient flow of referrals, ensure that case conferences are well informed and adequately documented, that assessments of people with special needs occur and complaints processes are in place. Potential assessment agencies include Community Health Agencies, Aged Care Assessment Teams (ACATs), Community Options and Disability Resource Teams.

However, concurrent with that work, a national functional screening tool and assessment tools were developed¹³ and, in February 2002, these were adopted as the national standard. At the same time, new models were being developed in Victoria¹⁴, South Australia¹⁵, and the Mid North Coast Coordinated Care Trial¹⁶ that went well beyond screening and assessment for HACC services to focus on the development of an integrated system across primary care. In Queensland, Executive Directors of Community Health have recently agreed that Queensland should build on this same approach to develop an integrated health and community care system. These developments are important and reflect some national momentum for implementing the change of focus. Significantly, practitioners on the ground have driven most of this change and maintained its momentum.

The advent of the functional tools and systems for primary care screening and assessment is leading to a fundamental re-think of comprehensive assessment and its reformulation as a “system of comprehensive assessment”. This a more practical notion that the system is bigger than any one program, and has as its front end a set of screens and prompts that encourage early detection of problems and referral for more detailed assessments only when required.

To assist in the roll out of these reforms, implementation networks are being established across NSW. At a minimum, these networks will develop and test a client centred assessment system which is appropriate for potential and current clients of funded (HACC) services who are frail aged and those with disabilities, in particular those identified as belonging to HACC special needs groups. This minimum scope is consistent with the scope of work undertaken to date in the development of Regional Comprehensive Assessment Frameworks. But this scope is simply a

¹³ Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, Quinsey K, Adamson L and Fildes D (2001) A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 report of the HACC dependency data items project. Centre for Health Service Development, University of Wollongong www.uow.edu.au/commerce/chsd

¹⁴ Details of the Victorian model can be found at: <http://hnb.dhs.vic.gov.au/acmh/phkb.nsf>

¹⁵ Details of the South Australian model can be found at www.eraproject.sa.gov.au

¹⁶ Eagar K and Owen A (2002) *Ongoing Needs Identification in the Mid North Coast Coordinated Care Trial: How and Why*. Centre for Health Service Development, University of Wollongong.

minimum requirement and regions could elect to go beyond this minimum scope (see next section). In these cases, existing Regional Comprehensive Assessment Frameworks need to be modified to reflect the needs of a bigger system.

The NSW comprehensive assessment system projects are not piloting the screening and assessment tools, but rather their implementation. Evaluation of the implementation will involve both qualitative and quantitative analysis.

Now with rigorous testing of the tools for functional screening and assessment and a number of trials and implementation of the format for broader primary care screening in Victoria and SA, it will be possible to evaluate how these tools work in practice. But progress will be possible only if everyone uses similar tools, with the resultant ability to compare what happens in the system as a whole and make comparisons across different services and settings.

1.2 Scope of NSW Comprehensive Assessment Systems

Figure 1 below shows the possible scope of the assessment system implementation in different settings. Regions were invited to submit proposals to participate in the testing of the various tools. The minimum scope required of regions is to test the CIARR and the functional screening and assessment tools in HACC funded services¹⁷.

But regions wishing to do so could expand the scope beyond this minimum requirement. In the event, most regions submitted proposals in which the scope extended well beyond the minimum requirement.

This included an expansion of the agencies involved, with most including aged care and community health and some also including GPs. Depending on local arrangements, some specialist services are also in-scope.

Regional pilots have also expanded their scope to include Ongoing Needs Identification. Some may also include Service Coordination Planning.

Figure 1 Possible scope of NSW projects

Scope of processes included		Level 1	Level 2	Level 3	Level 4
Scope of participating agencies		Functional screen	Functional assessment	Ongoing Needs Identification	Service Coordination Plan
Level 1	HACC	Minimum scope of pilots			
Level 2	Level 1 + Aged care	Optional scope of pilots			
Level 3	Level 2 + Community health				
Level 4	Level 3 + GP				
Level 5	Level 4 + Specialist health & community care				

¹⁷ These guidelines are not applicable to regions testing this minimum scope. The relevant guidelines for minimum scope regions are those produced by Queensland Health - Eagar K and Owen A (2002) *Functional Screening and Assessment: How and Why*. Centre for Health Service Development, University of Wollongong. www.uow.edu.au/commerce/chsd

1.3 Central logic of the approach – levels of screening and assessment

The ONI allows service professionals to decide whether a more detailed or comprehensive assessment is required, thereby conserving and better targeting resources. It facilitates appropriate referral to other service providers and helps in the identification of consumers with urgent needs. The ONI may result in the consumer being referred for a more in depth assessment (if required). But it can also result in the development of an action plan without the need for assessment.

This model makes a distinction between the depth and scope of different activities, and it is the depth that defines the difference between screening and assessment. The division of roles and responsibilities around screening, assessment and service provision (in terms of who does what within a region) should be worked out at the local level through cooperative arrangements, usually recorded as a set of protocols.

To a large extent this attention to local processes is the vital ingredient in making the system work, but it is not sufficient in itself. Without standardised tools and a common language for referral and planning, the local protocols may just give “joined up worrying”, which can help but does not create the environment of “joined up working” that the pilots are attempting.

The ideas are summarised in Figure 2.

Figure 2 The tiered screening and assessment model

Activity	Depth	Scope	Used for referral purposes?	Covered in these guidelines?
Ongoing Needs Identification (ONI)				
Consumer Information	Shallow	Narrow	Yes	Yes
Summary and Referral Information	Shallow	Narrow	Yes	Yes
Supplementary (optional) Profiles	Shallow	Broad	Yes, where relevant	Yes
Assessment:				
Specialist (eg, disability mental health)	Deep	Narrow	No	No
Comprehensive (eg, ACAT)	Deep	Broad	Yes, where relevant	No
Care Plan	Deep	Narrow	No	No
Service Coordination Plan	Deep	Broad	Yes	No

2 Overview of the Ongoing Needs Identification tools

2.1 How to use them

These guidelines are written on the assumption that the ONI is being completed (at least initially) on paper forms rather than electronically. This is because at the time of writing these guidelines, most agencies are still not able to use the information in an electronic format. However, when the necessary support services and software are in place (and this is likely to vary by local area) the information tools will be simpler to use. They are described in each section in terms of a table showing the data specifications, and they are expected to be compatible with an electronic information-sharing environment¹⁸.

The Ongoing Needs Identification tools contain items that are designed to collect demographic and social details about individual consumers, plus there are items in the supplementary profiles to allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all items will be relevant for every consumer and, in some cases, the information will not be required. In these cases, simply follow the instructions at the top of the form.

It is likely that many of the items on the **Contact Details** sheet will be collected during the initial contact with the consumer or the person referring the consumer. Some items, however, may not be collected until the first time a consumer is seen by a clinician. In some cases, the information may not be collected until much later in the process. Remember that the tools are designed for ongoing use and not for a one-off event.

The tools are designed so that the first 4 pages cover the core information that should be collected on all consumers and a summary of the action to be taken. The remaining six profiles are to cover domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem.

The first two sections (called ICI pages 1 to 2 and ONI pages 1 to 2 on the paper version) cover:

- contact details (of the consumer, other agents or agencies and their GP);
- a standard data set with codes for categories to cover demographic details, benefits and entitlements, and related matters;
- A summary and initial action plan – to be completed at the end and with prompts for investigating other domains using the relevant supplementary profiles.

The set of additional domains covered by the supplementary profiles have been chosen by combining evidence from the literature review¹⁹, and a review of the range of tools currently in use. The evidence for the use of particular items refers mostly to their validity and reliability, and items judged to be in common use, but with no evidence of how valid and reliable they are, will eventually need more evidence as to how useful they are.

The data items in the forms covered by these guidelines have been tested through consultations with the field in NSW and in other States. This has involved developing different draft versions in different settings and has included the evaluation of how different items perform, and the analysis

¹⁸ The specifications for the items in each section are described in a format that shows how they can be coded into fields for electronic storage and transmission.

¹⁹ Owen A, Poulos R and Eagar K (2001) *Using the evidence to develop best practice models for identifying initial primary and community care needs*. Centre for Health Service Development, University of Wollongong

of data collected from field tests^{20, 21, 22}. The feedback from testing to date indicates that the items can be used to further investigate the scope of the consumer's needs at the initial contact point. The domains covered and their associated profiles are living arrangements, a carer profile, health conditions, psychosocial profile, functional profile, and a health behaviours profile.

The ONI Summary and Action Plan brings together the different information that is useful for planning care for those consumers that require either simple or more complex interventions. The summary covers a description of the consumer's problems/issues, and a list of current services used in the last three months. The second page contains a series of prompts for the collation or collection of evidence of consumer need(s), an initial action plan and a box for comments on risk or urgency.

Each page has the same space for an identifier at the top to allow the information to be shared and the bottom of each page has a space for identifying the person and agency completing the form. Signing and dating every form is an accreditation requirement by most standards agencies. There is also a box for identifying if the information has been updated. This allows the superseded information to be kept as a historical record in the file.

The design of the tools assumes that they can be used for any consumer. However, for children and adolescents most of the supplementary information will not be relevant. A separate tool for this group is not included because it is assumed they will be referred directly for an assessment to an experienced agency or professional.

The content of the different tools is summarised below:

TOOL	CONTENT	Pages
Each form has an agency identifier and an "Office Use Only" section to record how the information was obtained and whether this page has been updated. When a new form is created the old information becomes part of the consumer's record.		
CONTACT DETAILS	Demographic and social details of the consumer, contact person/s, GP details and comment box.	ICI p.1 of 2
SERVICE ENTRY DATA SET	Codes to record source of referral, other demographic information and benefits, entitlements and insurance status.	ICI p.2 of 2
ONI SUMMARY AND ACTION PLAN, p 1	Summary of presenting problems and consumer permission to proceed, current services used in last three months.	ONI p.1 of 2
ONI SUMMARY AND ACTION PLAN, p 2	Describes consumer issues and prompts for supplementary profiles. Initial action plan with codes for referral(s) and further investigation(s). Prompts for risks or urgency factors and alerts. Completed at the end using info from other tools	ONI p.1 of 2
LIVING ARRANGEMENTS	Codes and comments for living arrangements, employment, financial and legal profile and comment boxes.	LAP p.1 of 1
CARER PROFILE	Codes and comments on carer issues, prompts for supplementary profiles on carers and comment boxes.	CP p.1 of 1
HEALTH CONDITIONS, p 1	Overall health, pain, vision hearing and falls, basic health status measures, comment box	HCP p.1 of 2

²⁰ Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, Quinsey K, Adamson L and Fildes D (2001) A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 report of the HACC dependency data items project. Centre for Health Service Development, University of Wollongong www.uow.edu.au/commerce/chsd

²¹ Swerissen H, Macmillan J and Weeks A (2002) PCP Initial Needs Identification & Care Planning Tools Template Development Evaluation Report. Australian Institute for Primary Care, La Trobe University Melbourne. <http://www.latrobe.edu.au/aipc>

²² Appleyard M (2002) ERA Project: Report on the trial of the Initial Needs Identification Tool Template. www.eraproject.sa.gov.au

TOOL	CONTENT	Pages
Each form has an agency identifier and an "Office Use Only" section to record how the information was obtained and whether this page has been updated. When a new form is created the old information becomes part of the consumer's record.		
HEALTH CONDITIONS, p 2	List of self-reported conditions, medical diagnoses and medications. Prompt for home medication review and comment box.	HCP p.2 of 2
PSYCHOSOCIAL PROFILE	Covers mental health, and well being (K10 scale), personal and social support, family and personal relationships and disability criteria. Comment box.	PP p.1 of 1
FUNCTIONAL PROFILE, p 1	Functional screening questions for activities of daily living and self-care.	FP p.1 of 2
FUNCTIONAL PROFILE, p 2	Questions on cognitive and behavioural problems, with prompts for further functional assessments and aids and equipment currently used. Comment box.	FP p.2 of 2
HEALTH BEHAVIOURS	Asks about regular checks, screen for risk factors, nutrition and physical activity, with prompts for further investigation	HB p.1 of 1

The **ONI Summary and Action Plan** (the third and fourth pages of the core information tool) are informed by any relevant detail from the supplementary profiles. As a result this page will usually be completed at the end and is used as a basis for putting together the action plan. It is also a starting point for using an agency's own care plan template, which would follow from assembling this information after relevant investigations have been completed. The key point is that any care plan template should allow the plan to be described in the format that is suitable for the enhanced primary care items in the Medical Benefits Schedule.

The use of the supplementary profiles depends on the particular consumer's presenting problems or the areas usually investigated by a particular agency or clinician, or as a result of any issues arising during the initial contact. The supplementary tools are completed after the core information has been collected. The core information is recorded on the **Contact Details, Service Entry Data Set, ONI Summary and Action Plan**. The assumption is that the next steps of referral and/or care planning are a continuation of that process, and that the core consumer information will be available to share if the consumer consents to this.

There are **six Supplementary Profiles**. Complete only those profiles that are relevant for the consumer. The tools are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. Rather, use the tools to guide a conversation with the consumer. The tools are designed to be completed based on all sources of information available to the person completing them (observation, answers to questions, information contained in a referral letter, client notes or information provided to you by a carer or referring agency). They are also designed so that different providers can add to the profiles over time.

There are instructions on each page about how to note any issues that you have not canvassed or that are inappropriate for the consumer. Most accreditation agencies have standards that do not allow for items on a form to be left blank. Accordingly, the general instruction is to record 99 or NA, depending on the case.

The design of the set of tools assumes that children and adolescents will be directly referred for a relevant assessment to be completed and so it is expected that supplementary profiles will only rarely be completed with children and adolescents. Similarly there may be service specific assessments that are required, for disability, dementia or mental health for instance, and these would result from appropriate referral.

The profiles are not designed as a diagnostic tool, nor are they considered to be an assessment (while they are wide in scope, they are shallow in depth). They are tools to help determine the

consumer's risks, eligibility, priority for service and health promotion opportunities. The profiles standardise the way this information is collected as early in the consumer's contact with the service system as possible.

As you complete the profiles, consider whether the consumer requires particular types of assessments and/or urgent services that cannot wait for a formal assessment process to be complete. Consumers should be informed about the range of service options that are available to meet their needs. This is not limited to the services provided by your own agency. Consider the wider range of services supports and resources such as for-profit services, information services, financial entitlements or other alternative services.

Pages 1 and 2 of the **ONI Summary and Action Plan** may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used this way if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of ONI page 1 of 2 for each issue.

For example there may be 2 issues – seeing the dentist and getting referred to a sexual assault service – and it would be inappropriate to share all information for both referrals. If appropriate this action plan can be used as the basis for developing a care plan and/or a service coordination plan.

For those areas where the forms are used as part of the primary care system, including community health and primary medical care, the care plan format is useful in satisfying the requirements for care planning in general practice (ie for claims under Medicare). The same information may be used at the next level (coordination between services, many of which may have their own care plans) where a service coordination plan may be appropriate.

The **Alert Box** on ONI page 2 of 2 has space for comments that can be used for recording information on risk and urgency, and for prompting the use of your current procedures for the notification of Alerts if appropriate. Remember that local networks will have their own protocols for calling up occupational health and safety checks in people's homes and there will be data forms designed for this specific purpose. Think about the risk and urgency of consumer issues under four main headings:

1. Situations in which the consumer is at risk for any reason.
2. Situations in which the consumer presents a physical or emotional risk to other people, including family, friends and neighbours. This excludes risks to health professionals, which should be separately identified.
3. Situations in which the consumer represents a risk to a health professional, either intentional or unintentional and whether or not this is the consequence of the consumer's presenting problems.
4. Situations in which there is an occupational health risk to a health professional for any other reason.

2.2 For the Record - Information Updated

Each page on the paper version of the ONI has a box on the bottom to record if new information has been added. If new issues or problems are identified after a page has been completed, the new issues should be recorded on a new page. The new page is used to record any changes or additions, not to repeat issues recorded on the previous ONI. Indicate on the existing ONI that the information on the page has now been updated. This will indicate to other health professionals that a new page has been created. Do not change the original record as the original record forms part of the client history and should be stored on the client record.

2.3 A point of clarification – INI and ONI

The NSW Ongoing Needs Identification (ONI) suite of tools draws heavily on a format initially developed for use in Victoria and subsequently modified for use in South Australia. The Victorian tools are called Primary Care Partnerships Initial Needs Identification (INI) tools. The term 'INI' caused some confusion in NSW because it was interpreted as implying that all of the information would need to be collected at the point of referral or first contact. This was never meant to be the case. The ONI begins at referral or first contact, but does not end there. It is the front end to a system that is ongoing.

The contact information collected at referral or first contact is still called the Initial Contact Information (ICI). Likewise, 'Initial Action Plan' has been retained. In both cases, this is because it is expected that both will be completed early in the process. After Initial Contact Information has been collected and an Initial Action Plan has been developed, consumers with ongoing care needs will move into an assessment phase. Subsequently consumers may have a service specific plan or in some cases a 'Care Plan' and in more complex cases a service coordination plan.

Identifying a person's needs, and their opportunities for health promotion, is an ongoing process that begins at referral. But needs and opportunities change over time (hence the 'information updated' section discussed above) and will be identified at different times. The ONI is designed as a tool to support a live process that involves all of the contacts a person has with the service system and that continues beyond initial contact. The tool is called the ONI to reinforce the idea that, while needs identification initially begins at referral, it is an ongoing process to better identify, and hopefully meet, consumer needs.

It makes sense to capture as much information as possible as early as possible. And, with the consumer's consent, it makes sense to share that information between all of the providers involved in the person's care. Consumers do not want to tell their story multiple times and providers do not have the time or the resources to capture information that is already on record elsewhere. We have arguably entered an era of too much information, collected too many times and for too many reporting requirements for too many programs. The ONI tools are designed to simplify and improve information, and to do so based on some evidence of what is most useful.

3 How to complete the Contact Details

The contact details are designed for collection at the point of first contact with the consumer or when a referral to a service is made. This first page of information can be completed by a staff member or by the consumer. When the ONI is in widespread use, this first page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral. The referral agency would also fax or transfer all other sections of the ONI.

The logical order for completion is to work down each column. The details are all entered direct and in a standardised format. In an electronic environment this will be the last time these details are recorded, unless they are updated.

The data items in the Contact Details sheet (ICI p.1 of 2) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
CONSUMER DETAILS		
Title	Alphanumeric	Circle one
Surname or Family Name	Alphanumeric	No
Given Names	Alphanumeric	No
Preferred Names	Alphanumeric	No
Date of birth	Date	No
Sex	Alphanumeric	Circle one
Usual Address (for correspondence, home visits)	Alphanumeric	No
Contact Address (if different from usual address)	Alphanumeric	No
Contact Phone (tick preferred)	Numeric	No
Work Phone, Mobile	Numeric	No
Comments	Box	No
WHO THE AGENCY CAN CONTACT IF NECESSARY		
Case manager, next of kin, carer, guardian emergency contact	Alphanumeric	No
Person(s), contacts, relationship to consumer	Alphanumeric	No
GP CONTACT DETAILS		
GP name and contact details	Alphanumeric	No
OFFICE USE ONLY		
Name of person completing the form, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

The remainder of this section provides a description of each item in the Contact Details sheet (ICI p.1 of 2).

Unique Client Record Number

An identification number issued by the initial contact agency for use in identifying a consumer. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Title

The title the person commonly uses.

Family Name

The consumer's family name or surname.

Given Names

The consumer's given name(s) or name by which they are commonly known.

Preferred Name/s

The name commonly used by the person. This can also be used to record any other names or aliases that the consumer commonly uses or by which they are commonly known.

Date of Birth

Record the consumer's date of birth as accurately as possible in dd/mm/yyyy format. Where the exact date of birth is not known, a close approximation should be recorded.

Sex

The sex of the consumer. Where this is not apparent, record the sex as identified by the consumer.

Usual Address

The address where the consumer usually lives, which is usually (but not always) the consumer's contact address for contact and case management purposes. Usual address is made up of the following elements:

- Street number and street name;
- Suburb/town/city;
- Postcode.

State is not required as it can be derived from the postcode.

If the person is homeless, the usual address should be used to record any way to contact the consumer. This may be nil or might be a particular venue where contact can be made. Some consumers may not wish to have a contact address disclosed. Remember that, if the person is homeless, you should do all you can to develop an initial action plan on the spot. Maintaining contact with a homeless person is difficult, as is organising services for them. Take the opportunity while you have it.

If the usual address is different from the contact address, record the contact address in the comments box,

Contact Address

Record if different from Usual Address. Collect same elements as Usual Address. Otherwise, leave blank.

Contact Phone Number/s (tick preferred)

The consumer's contact telephone number to be captured for contact and case management purposes. Record work numbers if different from usual telephone. Otherwise, leave blank. The consumer's mobile number (if one is available) for contact and case management purposes.

Who the agency can contact if necessary

Record the contact person/s and their relationship to the consumer. This might be the case manager, next of kin, carer, guardian, friend, or an emergency contact.

General Practitioner

The name and contact details of the consumer's usual General Practitioner. If none, leave blank. Note, however, that a consumer must have a GP to be eligible for the use of the enhanced primary care Medical Benefit Schedule items. If the consumer sees more than one GP, record the one identified by the consumer as their usual or preferred. If they see a GP in more than one place, record the most common place.

Comment box

Note any relevant directions or contact issues. Use this box also to record any particular requirements eg, 'Mrs Brown does not answer phone, 'Contact daughter only' or 'Person is homeless, leave message at the neighbourhood centre'.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

4 How to complete the Service Entry Data Set

The contact details are designed for collection early in the process. This page of information should be completed by a staff member, rather than by the consumer. When the ONI is in widespread use, this page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral, along with all other relevant sections of the ONI.

The data items include a number of items that have attached code sets that can be part of an electronic information system. The use of standard codes helps data entry and means that the information can be used later to build a client classification system. The logical order for completion is to work down each column. The data items in the Service Entry Data Set (ICI p.2 of 2) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Source of Referral	Numeric	Yes
Consumer consent for referral (circle)	Y/N	Yes
Source of referral contact details (if relevant)	Box	No
Country of birth	Numeric	Yes
Indigenous status	Numeric	Yes
Main language spoken at home	Numeric	Yes
Interpreter required	Numeric	Yes
Preferred language (if not spoken English)	Alphanumeric	No
Government Pensioner/Benefit Status	Numeric	Yes
Government Pensioner/Benefit Card Number	Numeric	No
Medicare Number	Numeric	No
Health Care Card Number	Numeric	No
DVA Card Status	Numeric	Yes
DVA Number	Numeric	No
Insurance Status	Numeric	Yes
Health Insurer Name and Card Number	Alphanumeric	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

The items here are a minimal requirement for most Minimum Data Sets and the items derive from those in current use. The ONI forms do not attempt to be inclusive and to reconcile all these requirements as many redundancies and overlaps have been avoided in the design of the forms and their associated items. The remainder of this section provides a description of each item in the Service Entry Data Set.

Initial Contact Agency Client Identifier

An identification number issued by the initial contact agency for use in identifying a consumer. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Source of Referral

Record the person or organisation that referred the consumer to the agency using one number only in the codeset of 22 pre-coded choices.

Consent for referral

Confirm that, if not self-referred, the consumer has given consent for the referral. Any interchange of consumer identifier numbers must be performed in accordance with NSW and Commonwealth Privacy Legislation and associated guidelines. A separate consent form meeting all the necessary requirements is expected to be produced by the relevant Departments for the purposes of the implementation trials.

Source of Referral Contact Details

If you will need to provide feedback to the referral agency, or might need to follow up to seek further information, record relevant contact details here.

Country of Birth

The country that the consumer identifies as being the one in which they were born. The codes are for (1) Australia and (2) Other. There is an 'Other, specify' write-in category for responses other than Australia. For data entry into electronic information systems (but not on this form) all responses can be coded to the Standard Australian Classification of Countries (SACC) (ABS 1269.0).

Indigenous Status

A consumer may be recorded as being not Aboriginal but not Torres Strait Islander, Torres Strait Islander but not Aboriginal, both Aboriginal and Torres Strait Islander, or neither Aboriginal nor Torres Strait Islander origin. An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives. Code '9' for where the answer is 'not stated'.

The consumer should be informed during data capture that the answer given or refusal to answer will not affect the consumer's access to services.

Main Language Spoken at Home

This is the main language spoken by the consumer to communicate with family and friends. The item has codes for (1) English and (2) Other and an 'Other - specify' write-in category for responses other than English. For data entry into electronic information systems (but not on this form) all responses can be coded to the Australian Standard Classification of Languages (ASCL) (ABS 1997).

Interpreter Required

This is the consumer's self-assessed need for an interpreter. This may include a sign language interpreter. Record (1) Interpreter not needed or (2) Interpreter needed.

Preferred Language

Record the consumer's preferred language if the 'interpreter needed' option was chosen in response to the 'Interpreter Required' item. For example, if the person uses sign language, and requires a deaf interpreter, record this as their preferred language.

Do not assume that the main language spoken at home is the consumer's preferred language. For example, a young person in a non-English-speaking household may have English as their own preference.

Use this box to also record any special communication devices or requirements. For example, the consumer might prefer an interpreter of a particular sex or religion, or may have assistance to communicate with speech or hearing devices.

Government Pensioner/Benefit Status

Record whether the consumer receives a pension or other benefit from the Commonwealth government by selecting the code for the pension or benefit type. Record any relevant card number in the box. Likewise, record Medicare and (if relevant) Health Care Card numbers in the boxes.

DVA Card Status

Record the consumer's Department of Veterans' Affairs (DVA) Card Status by using the codeset. Record any relevant card number in the box.

Insurance Status

Record the current insurance status of the consumer including the level of private health insurance (if any) and/or whether the consumer is eligible for services paid by a third party payer such as motor vehicle accident insurance, Workers Compensation or Ambulance Fund.

The primary purpose of this item is to allow a health professional to know whether the consumer can access privately funded services such as private dental and allied health services. Where relevant, record the appropriate card number in the box provided.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

5 How to complete the ONI Summary and Action Plan

The items on **ONI p.1 of 2** cover a summary of the identified needs and current services. Most information on this page will be able to be completed at the end of the process. When the ONI is in widespread use, this page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral, along with all other relevant sections of the ONI.

Use this page to record presenting problem/s and issues of relevance for the consumer. The top heading asks for one or more short statements of why the consumer is seeking services then the box is used to note the action required. A code set is provided to record the action required.

Any other issues (which may be unrelated to the reason for seeking services) that arise in your conversation with the consumer should also be recorded here. This other information might be based on discussion with the consumer, observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency. This will include any issues arising from the supplementary profiles. Codes are used for the action required and all other information is alphanumeric.

In both cases, list the issues in priority order. The first issue listed is the one that is of most importance to the consumer. Complete remaining issues in the priority order determined by the needs of the consumer. If more than 10 issues, start another page.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
WHY THE CONSUMER IS SEEKING SERVICES		
Description of problem or issue	Alphanumeric	No
Action required	Numeric	Yes
Other issues	Alphanumeric	No
Action required	Numeric	Yes
Current services	Alphanumeric	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Note that, while this is the first section of the ONI summary and action plan, it may not be completed until you have completed the next steps in the ONI process, which are determined by the consumer's needs and presenting problems.

The ONI is designed in this way because it makes the most sense to agencies or professionals receiving any subsequent referrals. The logic here is that some simple issues can be dealt with by supplying information or referring directly to a service-level provider. Examples might be a GP visit or a home maintenance or food services referral. Local protocols will control how such referrals are made.

Local agencies will also have their own versions of care plans and service-specific formats for taking this summarised screening information to the logical next stage of providing some planned assistance to the consumer.

Unique Client Record Number

An identification number issued by the initial contact agency for use in identifying a consumer. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Why the consumer is seeking services

The first set of boxes are for a description of the problem or issue as identified by the consumer or the referring agency, and the second set is other issues identified by the consumer or through the needs identification process. It is completed based on all sources of information available to the person completing them (observation, answers to questions, information contained in a referral letter, client notes or information provided to you by a carer or referring agency).

To elicit this information directly from a consumer or carer, the sorts of questions you can ask might be: 'Can I ask you about some other issues that often impact on peoples health?' or 'Are there any other issues you'd like to discuss or concerns you have?' The list of problems and issues can be updated over time. Use the 'information updated' section to indicate that the situation has changed.

Action required

Codes are used for ten types of possible action associated with the problems or issues. They fall into 3 categories covering how much further information, action or planning is required:

Services are required that do not need, or cannot wait, an assessment

Code (1) Service provision – see Initial Action Plan

An assessment is required

Code (2) Specialist assessment (eg, mental health assessment)

(3) Comprehensive assessment (eg, aged care assessment)

No further action is planned

The purpose of this item is, in part, to capture unmet demand. This item also captures situations where the issue is addressed at first contact. There may be two or more reasons for no further action. If so, enter both codes. For example, a consumer may refer elsewhere because the requested service was not available. In this case, enter 5 and 9.

Code:

(4) Nil: Consumer ineligible for service.

(5) Nil: Referred elsewhere.

(6) Nil: Advise/information provided. No further action required.

(7) Nil: Consumer declines further referral or service.

(8) Nil: Consumer issue resolved. No further action required.

(9) Nil: Requested service not available.

(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location).

Current services

The prompts for services are listed alphabetically, including self-help. Use this box to record details of services used by the consumer in the last three months. The purpose of listing services used is twofold. First, the information will often suggest consumer problems and issues that have not been identified to this point. If so, consider whether any supplementary profiles need to be completed. This additional probing will need to be age-appropriate. Second, current service utilisation will need to be taken into account in formulating an initial action plan and, if necessary, in developing a care plan.

Ask the consumer whether they have used any **other services** in the last 3 months. If the consumer reports that they have used other services, ascertain what they are and whether the consumer is still in contact with the service.

Page 2 (ONI p.2 of 2) prompts for additional screening profiles to be used and summarises the initial action required.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
OTHER CONSUMER ISSUES		
Consideration of further exploration of issues	Tick boxes	Yes
INITIAL ACTION PLAN		
Agency/health professional	Alphanumeric	No
Purpose of referral	Alphanumeric	No
Consumer consent to proceed	Numeric	Yes
Referral method	Numeric Y/N	Yes
Transport method	Numeric	Yes
Feedback required	Numeric	Yes
Date	Alphanumeric	No
Review date	Alphanumeric	No
Comment box for risk, urgency etc	Alphanumeric	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Only after completing the relevant supplementary profiles should you finalise page 2 of the ONI.

Other consumer issues

The relevance of other consumer issues can begin to be noted at this point and the tick boxes may prompt one or more supplementary profiles to be completed. Take into account the consumer's presenting problems and issues as well as all other information available to you. This other information might be your judgement based on interviewing or observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency. If there is any suggestion that the issue is relevant for the consumer, complete any relevant domains in the supplementary profiles, consider:

- Living Arrangements, including issues about informed consent if the consumer's decision-making capacity is in doubt.
- If carer issues are significant, complete the Carer Profile and consider whether completing a separate ONI on the carer might be useful.
- Health conditions if there are issues health status, pain, participation, vision, hearing or falls.
- Psychosocial issues, including mental health and well being and disability.
- Functional dependency, including the domestic, self care, cognition and behaviour domains of function.
- Health behaviours, risk factors and opportunities for health promotion.
- The implications for consent if consumers have problems with understanding the process due to cognitive or language difficulties or if there are problems with literacy or numeracy.

Initial Action Plan

The Initial Action Plan can describe a referral pathway for consumers who need further assessment or those with complex problems. It can be used to help keep track of how progress is going and whether any variation needs to be made to the initial plan of care. The columns capture more detail on what information the consumer has consented to share, and has codes for how the referral is being made, what transport is to be used, and what feedback is required.

This section of the ONI draws together all of the other key information collected in the ONI process and uses it to outline an initial action plan. It should be completed only after completing any relevant supplementary profiles. This plan has 8 components:

Agency/health professional: Complete in legible text. If you will be continuing to see the consumer, include yourself in the list of agencies/professionals for referral

For: Record purpose of referral in legible text.

If there is some reason for urgency, write 'urgent' in this column (eg, urgent assessment) and, if appropriate, use the Alert box to draw attention to the reason for the urgent response (eg, carer admitted to hospital today).

Consumer Consent: Record:

- (1) Yes, consumer consents to referral and to sharing of information as specified on the separate consumer consent form
- (2) Yes, consumer consents to referral but not to sharing of information
- (3) No, consumer has not consented to this referral.

Referral method: Record:

- (1) This form faxed to agency
- (2) Letter (copy on file)
- (3) Electronic
- (4) Verbal request – face to face or phone call
- (5) Other (includes referral to self).

Transport Method: Use this column to record how the consumer and the service will actually get together. Record:

- (1) Staff travel – service is delivered in home (eg, domestic assistance)
- (2) Staff travel - client too unwell to travel
- (3) Staff travel – client has no transport
- (4) Client travel – own car
- (5) Client travel – family/friends
- (6) Client travel – public transport or taxi
- (7) Client travel – walk
- (8) Community transport
- (9) Ambulance
- (10) Hitchhike
- (11) None (eg, telephone service to be provided).

Feedback required: Record:

- (1) to initial referral agency
- (2) to GP
- (3) to agency completing ONI
- (4) to carer/guardian
- (5) other (if other, record details in comment box)

Note that, if feedback is required, contact details will be required on page 2 of the ICI.

Date: Record date referral actually made. If no referral actually made, leave blank

Review Date: Record date when proposed action should be reviewed. If no review is required, leave blank.

Both pages 1 and 2 of the ONI (**Summary and Action Plan**) may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used this way if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of ONI page 1 of 2 for each issue. For example there may be 2 issues – seeing the

podiatrist and getting referred to a sexual assault service – and it would be inappropriate to share all information for both referrals.

This summary information can be used to develop a care plan. Agency or network specific care planning forms will generally already be in use in a regions or areas that have been planning for comprehensive assessment systems. Information at this point can be transferred to those formats, or agencies might chose to use their own associated care plan template.

Alert Box - Using the ONI to record risks and urgency

Page 2 of the Summary and Action Plan has an Alert box that can be used to make a note of risks and questions of urgency. Summarise any issues here according to how you judge the possibility of danger, loss of social participation or reduction in health status. Consider whether to trigger your own agencies' alert procedures and whether this should be indicated in the box.

A separate Alert Sheet and guidelines are available on the CHSD website for those agencies that do not have their own forms and procedures. This is optional material available in addition to these core guidelines and covers some useful standard definitions and categories.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

6 How to complete the supplementary Living Arrangements profile

Use this profile if you have any reason to believe that there are issues in relation to the person's housing and living arrangements, their employment status and any relevant financial or legal issues, including decision-making capacity.

The data items in the Living Arrangements profile are amenable to electronic recording and reporting for associated minimum data sets. The data items in the Living Arrangements profile (LAP p.1 of 1) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
Living Arrangements	Numeric & box	Yes
Accommodation	Numeric & box	Yes
Employment Status	Numeric & box	Yes
Financial and Legal Profile		
Legal orders and decision-making responsibility	Numeric & circle	Yes
Past experience with legal system	Numeric & circle	Yes
Financial decisions and cost of living decisions	Numeric & circle	Yes
Comments	Box	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Living arrangements

Find out what living arrangements the person has – whether they live alone, with family or with others – by asking questions like “Who lives in the house with you?” The person's living arrangements need to be taken into account in formulating an initial action plan and, if necessary, developing a care plan. They will often flag risks and urgency. Make any comments or summary notes on living arrangements and family situation in the box provided. Note that there is a separate carer profile that might also be relevant.

Evidence / source – HACC MDS

Accommodation

Codes are provided to record the consumer's accommodation type. There are 16 different possibilities listed and these are compatible with the codes in the HACC MDS. You need to use the information in this item if the person requires home modifications. Record any relevant comments on accommodation difficulties or issues in the comment box.

Evidence / source – HACC MDS

Employment status

Ask about the person's current employment status and occupation, record status using the codes and record any relevant comments or notes. Note that the financial and legal profile on this form includes a question about cost of living decisions that is relevant to financial hardship arising from unemployment.

Evidence / source – modified from the NMDS for Medical Rehabilitation

Financial and legal profile

Legal issues might include any relevant court orders or mental health, guardianship or financial management orders, depending on the person's circumstances and presenting problems. Under **decision-making responsibility** consider whether the person is capable of making their own decisions. If there are no formal orders

in place, they may have given someone else a Power of Attorney, or may have informal arrangements in place to safeguard their interests

If, in your opinion, the answer to the question about decision-making capacity is 'not sure' or 'no', consider the need for assistance, the need for a cognitive assessment and the implications for consent.. In some cases they may already have a decision-maker appointed under Guardianship arrangements.

Financial issues might include whether a person is capable of making their own decisions about financial matters or whether there is some financial risk in their immediate circumstances. If the person is not capable of looking after their own finances, they may have granted a Power of Attorney or may have appointed a financial manager themselves, or had one appointed under the Guardianship Tribunal. The person's financial situation may need to be taken into account in assessing risks and urgency and in formulating an initial action plan and, if necessary, developing a care plan.

Evidence / source – based on review of current practice in Victoria and South Australia and considerations of relevant NSW legislation

Cost of living decisions.

It is useful to inquire as to whether there are any trade-offs the person makes because of financial difficulties. Do this by asking: 'Because of limited income, (has the consumer) /have you, during the last month had to make any difficult decisions among purchasing any of the following: prescribed medications, necessary medical care, adequate food, home care, necessary transport?'

If yes, discuss the issues with the consumer and consider the need for counselling (eg health-related, financial, gambling) and the need for material support. This question can generate important information to allow you to assess both risk and urgency.

Evidence / source – This question has been modified from the MDS-HC, an instrument developed in the USA for a minimum data set for home care. The validity and reliability of this item for Australian populations is unknown, however it would appear to have content validity.

Comments

Consider all the issues such as the need for material assistance and decision-making and use the box at the bottom of this section for any relevant comments and to summarise the required action.

Issues to do with the home environment may be recorded here and this might prompt an agency's use of its own assessment tools for home safety, or for occupational health and safety issues.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

7 How to complete the supplementary Carer profile

Use this profile if the person has a carer. There are a number of items related to carer support and codes for recording different types of threats to caring arrangements. Bear in mind the wide range of possible caring arrangements including people with serious illness or disabilities caring for others and children caring for adults.

The data items in the Carer profile are amenable to electronic recording and reporting for associated minimum data sets. The data items in the Carer profile (CP p.1 of 1) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Carer Profile		
Availability	Numeric	Yes
Residency status	Numeric	Yes
Relationship	Numeric	Yes
Carer Support		
Someone to help	Numeric & circle	Yes
Carer Payment	Numeric & circle	Yes
Carer support information	Numeric & circle	Yes
Carer training	Numeric & circle	Yes
Current threats to carer arrangements		
Current threats	Numeric	Yes
Sustainability of arrangements	Numeric	Yes
Other carer issues		
Consideration of further exploration of issues	Tick boxes	Yes
Comments	Box	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Carer Profile

The Carer Profile has codes for recording availability, residency and the relationship of the carer to the care recipient.

Evidence / source – HACC MDS

There are also items in this section on supports available for the carer, on current threats to carer arrangements and whether the carer arrangements are sustainable.

Carer Support

This set of items covers carer support and is recorded as 'Yes', 'No', 'Not sure' or No Carer. There are four dimensions of care support covering whether the carer has someone to help them, whether they receive a payment or allowance, whether they have been given information about support services such as respite, and whether they need any practical training in tasks such as lifting or administering medicines.

Evidence / source – These are additional items modified from the Illawarra Carer Survey, DADHC 2002.

Current threats to carer arrangements

Current threats to carer arrangements are described by a series of six self-explanatory codes and the item asks the screener to tick all that apply:

- (1) Carer – emotional stress and strain (if so, consider completing a Psychosocial Profile on the carer)
- (2) Carer – acute physical exhaustion/illness (if so, consider completing the Health Conditions and Psychosocial Profiles on the carer)
- (3) Carer – slow physical health deterioration (if so, consider completing the Health Conditions and Psychosocial Profiles on the carer)
- (4) Carer – factors unrelated to care situation (eg, carer moving away or taking on a new job)
- (5) Consumer – increasing needs (including physical health deterioration)
- (6) Consumer – other factors

These codes can be used as prompts to guide your conversation with the carer or referral agency. Based on your conversation, determine whether current carer arrangements are sustainable **without additional services or support** and record one of the following 5 codes:

- (1) No, have already broken down (the situation is an immediate crisis)
- (2) Yes, but only weeks (without additional services or support the arrangements will break down within a matter of weeks)
- (3) Yes, months (without additional services or support the arrangements will break down within a year)
- (4) Yes, years (without additional services or support the arrangements could eventually break down, but not likely within the next year or two)
- (5) Don't know (in which case, consider the need for referral and assessment).

As with other items on the form, simply record a code of 99 if carer issues are not relevant.

Evidence / source – HACC MDS with additional items modified from the Illawarra Carer Survey DADHC 2002.

If there are significant carer issues, complete a separate ONI on the carer, and/or make the appropriate referral to a carer support agency or information service.

The Carer Availability option has a code (4) Not Applicable – the consumer is the Carer. This option is selected when a separate ONI is completed on the carer.

Comments

Consider all the issues such as the need for material assistance and decision-making and use the box at the bottom of this section for any relevant comments and to summarise the required action.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

8 How to complete the supplementary Health Conditions profile

This profile is for common health issues including those most commonly screened for the purposes of early detection by community health nurses. The items include self-rated health, bodily pain, interference with normal activities, vision, hearing and falls, height, weight, blood pressure/pulse, teeth and feet, vaccinations, fitness to drive and continence.

Issues listed in the Health Conditions profile are based on those required for compatibility with the items in the Enhanced Primary Care program for GPs. They are recorded here as self-report by the consumer, and as such should not be considered to be diagnoses. A separate section on Medical Diagnoses allows for the screener to identify medical diagnoses made by a medical practitioner.

If there are problems reported, consideration should be given to medical referral and further inquiries about activities of daily living and screening for further assessment by completing the Functional Profile. The data items in the Health Conditions profile (HC p.1 of 2) are shown in the following table.

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
Overall health	Scale tick box	Yes
Bodily pain	Scale tick box	Yes
Interference with normal activities (past 4 weeks)	Scale tick box	Yes
Vision		
Reading	Scale tick box	Yes
Distance	Scale tick box	Yes
Hearing	Scale tick box	Yes
Falls (inside/outside past 6 months)	Alphanumeric	No (list)
Height and weight	Numeric	No
Blood pressure/pulse	Numeric	No
Oral health	Box	No
Feet	Tick box	Yes
Feet – comment	Box	No
Vaccinations	Tick box	Yes
Vaccinations – date	Alphanumeric	No
Fit to drive	Tick box	Yes
Fit to drive – comment	Box	No
Continence		
Leaking urine	Tick box	Yes
Reason	Tick box	Yes
Faecal incontinence	Tick box	Yes
Continence – comment	Box	No
Comments	Alphanumeric	No (list)
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Overall health

This question is selected from the SF-36. This question has been widely used and is in current use in the DVA D677 and the D673. Self reported health agrees well with objective measures of health. It has been found to be a good predictor of subsequent illness and premature death.

In asking the consumer about their overall health inquire about how they are going and whether they have experienced any recent changes in their health. If the consumer reports that they have had significant changes, ascertain whether the consumer is already under the care of a medical practitioner and whether they have told their medical practitioner about the changes.

If the consumer reports poor health, consider completing the Functional Profile and the Psychosocial Profile.

Evidence / source – SF-36

Bodily pain

Consider whether the consumer may be experiencing bodily pain. If so, ask questions such as 'How much bodily pain have you had during the past 4 weeks?' If the consumer reports that they have had significant bodily pain, ascertain whether the consumer is already under the care of a medical practitioner and whether they have told their medical practitioner about their pain. If not, refer the consumer back to their GP. Consider whether pain is impacting on their ability to manage activities of daily living (see Functional Profile) or on their personal or social relationships (see Psychosocial Profile). If so, complete the relevant profile.

Evidence / source – SF-36

Interference with normal activities

Use the question 'How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?' to score the consumer (or have them score themselves) on the scale. Score from 'not at all to quite a bit' and identify and record any issues that may require action. If problems are identified, complete the Functional Profile to screen for assessment on activities of daily living.

Evidence / source – DVA-673

Vision, hearing and falls

Tick the box to indicate the description that best matches the consumers situation. If the question is irrelevant or the information is not known, record NA. If problems are identified, complete the Functional Profile.

Evidence / source – these questions have been selected from the 1999 Older Peoples Health Survey and the falls item has been selected from the DVA D677 form on the basis of its common usage

Height and weight

Record actual height and weight and use these to calculate the Body Mass Index (BMI).

$$\text{BMI} = (\text{weight in kg}/(\text{height})^2 \text{ in m})$$

Evidence / source –EPC assessment item.

Blood pressure/pulse

Record actual readings.

Evidence / source –EPC assessment item.

Oral health

Use the diagram to indicate missing teeth, untreated caries or other oral health problems such as gum disease. Use the comment box to note significant oral health issues and to identify whether the person is eligible for any free or subsidised oral health services.

Oral health is a significant health issue for many people but, with rare exceptions, cannot be easily accessed in the public system. Services for people under 18 years are free (but difficult to obtain) through the public health system. If a person has health insurance or is covered by DVA or is able to pay for their own dental care, refer to a private dentist. If not, refer young people to a public sector dental therapist.

Feet

Use the tick boxes to record whether the person has any foot problems and the comment box to record the details.

Evidence / source –EPC assessment item.

Vaccinations

Tick any vaccinations that the person has had and record the date for each. If the actual year or date is not known, record an approximation.

Evidence / source –EPC assessment item.

Fit to drive

Use the tick boxes to indicate whether or not the person is fit to drive and the comment box to note any issues. Refer to the AustRoads Guidelines for further information.

Evidence / source –EPC assessment item.

Continence

There are 3 questions relating to continence, 2 relating to urinary continence and 1 to faecal soiling or change of bowel habit. Tick the appropriate boxes and record details in the comment box. If there are any problems, refer the consumer back to their GP. If continence is an issue, and continence aids are required, refer the consumer to the National Continence Scheme and/or PADP.

Evidence / source –EPC assessment item.

The data items in the Health Conditions profile (HC p.2 of 2) are shown in the following table. This section covers health and medical issues related to treatment, including medications and a prompt for referral for a Home Medicines Review which has to be agreed between the GP and the pharmacist.

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
Health conditions	Alphanumeric	No
Medical diagnoses	Alphanumeric	No
Current medications	Alphanumeric	No (list)
Cooperation with treatment – takes own medicine	Numeric	Yes
Cooperation with treatment – willingness to take own medicine	Numeric	Yes
Cooperation with treatment – cooperate with health professionals	Numeric	Yes
Use of webster pack or similar	Numeric Y/N	Yes
Prompt for home medicines review	Numeric Y/N	Yes
Comments	Alphanumeric	No (list)
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Health conditions

In considering health conditions, check whether the consumer may have had any relevant problems in the past that might be related to their present problem. This may include overall health, hospital stays, medical interventions or other conditions or disabilities. If the consumer has any allergies or other medical conditions that should be known by a health professional treating the consumer, record them in this box.

Also inquire about any current conditions the consumer may have that have been long-standing, persistent or recurrent. Use questions such as 'Do you have any health conditions that interfere with your normal activities that are long-standing or recurring?' to identify and record any conditions that may require action. Age appropriate

questions may also be useful. For example, for older people consider questions such as 'People in your age group sometimes have problems leaking urine. Does this sometimes happen to you?' If the consumer reports that they have a chronic condition, ascertain whether the consumer is already under the care of a medical practitioner and whether any plan of long term management, coordinated care or self-help is already in place.

If the consumer is pregnant, record the details and make sure that they are receiving antenatal care. If not, make the necessary arrangements.

Medical diagnoses

If the Health Conditions profile is being completed by a medical practitioner, use this section to record the diagnoses. If it is completed by other disciplines, a medical diagnosis should only be recorded if there is written evidence that a medical practitioner has confirmed the diagnosis. If not, record the condition under 'Health Conditions' (see above) and complete it based on what the consumer tells them. There are different medico-legal implications depending on who completes the profile, so non-medical staff should be clear about not recording their own versions of diagnoses.

Current medicines

The medication section relates to all medicines, including over the counter, bush medicine and alternative treatments. Identify the number of medicines the consumer is currently using. Use questions like: "Please tell me the names of your prescription medicines and how often you take them?" "Do you take them the way your doctor wants you to take them? (if no: why not?)" "Is there someone who helps you take the medicines the way your doctor wants you to, or do you handle this your self?" "Please tell me the names of your medicines for which you do not need a prescription (ie over-the-counter)?"

Note that in some cases consumers may be taking another person's medicines or they may be sharing medications with a partner or spouse. If appropriate to the conversation you are having, or if there is some suggestion that circumstances such as this might apply, explore whether any problems exist from issues such as sharing of medicines.

Poly-pharmacy may suggest that a medication review is required. If so, seek the appropriate referral pathway. A recommendation for a Home Medicines Review is prompted by the question above the comment box on this page and this can be carried out by the GP and pharmacist with the client's consent.

The inability to manage your own medicine (the right medicine, in the right dose, at the right times) is an indicator of problems in managing activities of daily living. If problems are identified, complete the Functional Profile. In some cases, it may also indicate cognitive impairment²³. If there are no physical reasons why the consumer cannot manage their own medicine, consider the need for a cognitive assessment.

Cooperation with treatment

There are 3 questions about cooperation with treatment, 2 of which relate to medicine. The first asks whether the person currently takes their own medicine while the second asks about whether they are willing to do so. Note that a person may not manage their own medicine even though they are willing to do so (eg, if the person has memory problems, they might just forget). The 3rd asks about general cooperation with health professionals.

Take these factors into account when formulating your initial action plan.

Evidence / source – Modified from the Life Skills Profile (Rosen et al. 1989).

Webster Pack or similar

This question asks whether the person uses pre-packaged medicines. If the person's compliance with medicine would be improved by having access to it pre-packaged, make the necessary arrangements.

Home Medicine Review (HMR)

The use of multiple medicines (poly-pharmacy) or the use of single medicines over a long time may suggest that a Home Medicine Review (HMR) is required. If so, record 'Yes' and refer the consumer back to their GP.

²³ Cromwell D, Eagar K and Poulos R (2002) *The performance of an instrumental activities of daily living scale in screening for cognitive impairment in elderly community residents*. In press

Comment box

Use this box to summarise information on health conditions on this form or to capture any new information arising from questions such as 'Can you think of any other issues that interfere with your normal activities (outside and/or inside the home)?'

The profile does not contain a list of all the possible health risks and problem conditions that might need further investigation. For example chronic or degenerative diseases, diabetes, cardiovascular disease, lung function, falls and so on might be present, and can be noted in the comment box.

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9 How to complete the supplementary Psychosocial Profile

The Psychosocial Profile is used to screen for psychosocial issues including emotional and well being, personal and social support, family and personal relationships and eligibility for support through disability services. Common difficulties with personal, social and service provider relationships are covered.

The psychosocial profile is not a diagnostic tool, nor is it a mental illness profile. The focus of this profile is on emotional well being, not mental illness, and on prevention and early identification rather than diagnosis and treatment. It captures some common risk factors associated with mental health problems (such as lack of social supports) and so identifies opportunities for prevention. It also includes a screen (K-10) that can be used for the early identification of individuals who may have, or be at risk of developing, high prevalence psychological problems such as anxiety and depression. It does not screen for low prevalence mental illnesses or disorders such as psychosis.

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
Emotional wellbeing (the K-10 scale)	Scale scores	Yes
Total scale score as indicator for referrals	Total score	Yes
Sleeping trouble	Tick box	Yes
Sleeping trouble	Comment box	No
Personal and social support	Scale tick box	Yes
Family and personal relationships	Comment box	No
Relationships with service providers	Numeric Y/N/DK	Yes
Relationships with service providers	Comment box	No
Disability		
Eligibility	Y/N/DK	Yes
Criteria	Tick box	Yes
Comment box	Alphanumeric	No
OFFICE USE ONLY		
Name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Emotional wellbeing

Use the K10 scale to probe for signs of emotional wellbeing such as depression, anxiety and coping ability. Record the total score. This is a scale of psychological distress developed for use in population surveys. This 10 item scale has five response categories and the score is the sum of those responses. The score range is from 10 to 50.

Rather than being used as a guide to conversation, the K10 is often best undertaken as a series of structured questions, as detailed in the profile. It can help to make this scale less difficult to administer if you use a style that is less conversational and more like a structured set of questions in a formal interview.

Preface the questions with a comment such as "I'd like to ask you some questions about how you've been coping over the last month. We routinely ask these questions of everyone...('caring for another person', 'who has had a recent illness', 'who is seeking counselling services' or whatever is appropriate in the circumstances). This approach is more likely to be perceived by the consumer to be non-judgemental. It probes these issues without any implication that this specific consumer is not coping. Ask "in the past four weeks about how often did you feel..."

K10 scale		Score
1	tired out for no good reason?	
2	nervous?	
3	so nervous that nothing could calm you down?	
4	hopeless?	
5	restless or fidgety?	
6	so restless you could not sit still?	
7	depressed?	
8	that everything was an effort?	
9	so sad that nothing could cheer you up?	
10	worthless?	

Score:

1 None of the time 2 A little of the time 3 Some of the time
 4 Most of the time 5 All of the time

Recommended action: refer for primary care mental health assessment if total score is 16-29 and for a specialist mental health assessment if score is 30 or more.

This 10 item scale has five response categories and the score is the sum of those responses. The score range is from 10 to 50. People who score 0-15 have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the Composite International Diagnostic Interview (CIDI), and a remote chance of reporting a suicidal attempt in their lifetime. People who score 16-30 have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder and 1% chance (three times the population risk) of ever having made a suicide attempt. People who score 30-50 have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and 6% chance (20 times the population risk) of ever having made a suicide attempt.

The recommended action is to refer for a primary care (GP) mental health assessment if the total score is 16-29 and for a specialist mental health assessment if the score is 30 or more.

Evidence / source – Kessler R, School of Public Health, Harvard University, Boston (unpublished manuscript).
 Andrews G and Slade T (2001) Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian Journal of Public Health* 25, 6: 494-497.

Sleeping difficulty

Use this question as another opportunity to identify emotional issues and worries. If sleep is a problem, explore whether this is a long or short-term issue. Consider a GP referral or a referral to a stress management program if sleeping is a problem.

Evidence / source –EPC assessment item.

Personal and social support

Use this question if you feel that it is appropriate to the consumer's presenting problems: "During the past 4 weeks...Was someone available to help you if you needed and wanted help? For example if you...

- felt very nervous, lonely or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself"

If the consumer has little support consider referral and the possibility of completing a Functional Profile. The person's social support situation may need to be taken into account in formulating an initial action plan and, if necessary, developing a care plan. It is also a known indicator of both risk and urgency.

Evidence / source – Dartmouth COOP Charts. It has a convergent correlation of 0.61 with the Medical Outcome Study for social support (Nelson et al. 1998).

Family and personal relationships

Ask about the person's current personal and family relationships – whether they are experiencing any particular difficulties and record the response in the comment box. The two questions with coded answers are about friendships and personal problems with other householders.

Ask the consumer whether they have any other relevant family or personal problems that might be related to their presenting issue or to their mental well being or social relationships. Identify and record any issues that may require action.

Relationships with service providers

This question seeks to identify whether the consumer mistrusts health and community service providers because of what they see as bad experiences with providers and government agencies in the past. This might include legal services (policy, custody disputes in court, divorce), health services (hospitals, doctors), schools, community services (health, welfare) or social security (pensions, benefits or other entitlements).

Evidence / source – Designed for MNC CCT

Disability

Check if the person is eligible for disability support services and whether an assessment is required. The tick box format for the criteria can be used to summarise the information. If so, consider referral to a specialist disability agency.

Evidence / source – DHS, Victoria

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10 How to complete the supplementary Functional Profile

The information collected on the Functional Profile is used to screen for any difficulties the consumer may have in activities of self care and daily living, things that we all need to do as part of our daily lives. The questions refer to how the consumer is managing at present and should be used to formulate an initial action plan and, if necessary, to develop a care plan.

Other information obtained in the process of completing this profile may also be used to recommend referrals for further assessment in the domains of self care, domestic, behavioural and cognitive functioning. Specific trigger points for these referrals have been developed on the basis of research to develop national measures of functional dependency for HACC and aged care programs²⁴. They are also explained on page 2 the form.

The items on pages FP p.1 of 2 and FP p.2 of 2 are shown in the following table:

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Unique Client Identifier	Alphanumeric	No
Functional screen	Scale scores	Yes
Housework	Scale score	Yes
Walking out and about	Scale score	Yes
Shopping	Scale score	Yes
Medicines	Scale score	Yes
Money	Scale score	Yes
Walking	Scale score	Yes
Bathing	Scale score	Yes
Cognition (asked of third party)	Scale score	Yes
Behaviour (asked of third party)	Scale score	Yes
Comment box	Alphanumeric	No
Aids and equipment currently used	Tick boxes	Yes
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Evidence / source – National HACC Functional Dependency Study (Eagar et al. 2001).

Activities of daily living (functional screen)

Using this profile, you can screen for the consumer's needs over the four functional domains measured through scores on 9 questions. The screen does not attempt to capture all aspects of function. Rather, the 9 items in the screen have been selected because they are **good predictors** of how well a person is functioning in other aspects of their life.

Housework, travelling and shopping are *domestic tasks* that are generally lost early. A consumer who is independent in these tasks does not usually require a more detailed assessment of domestic or self-care tasks.

²⁴ Centre for Health Service Development (2002). A national measure of functional dependency for Home and Community Care services in Australia. Department of Health and Ageing, Aged and Community Care Service Development and Evaluation Reports, No.41, July 2002.

Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, Quinsey K, Adamson L and Fildes D (2001) A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 report of the HACC dependency data items project. Centre for Health Service Development, University of Wollongong. See website www.uow.edu.au/commerce/chsd

Mobility and bathing are *self-care tasks* that are generally lost later than domestic abilities but earlier than self-care tasks such as feeding or toilet use. A consumer who is independent in mobility and bathing does not generally require more detailed assessment of self-care tasks.

The screen includes 2 items (managing your own medicine and managing your money) that not everyone is comfortable in asking or answering. However, their usefulness justifies their inclusion. Their power as screening questions is that they not only act as screens for domestic functioning. They are also reasonable predictors of cognitive and/or behavioural problems²⁵. These are very difficult domains to screen for (you can hardly ask the consumer at 1st contact if they have difficult or challenging behaviour or get confused!) but they are important indicators of a person's needs. For this reason, screening often has to be more indirect (and therefore isn't quite as accurate).

But, unless there are other indicators (for example, information supplied by a carer), a consumer who is independent in medication and money management usually does not require more detailed assessment of cognition/behaviour. Other indicators of challenging behaviour and cognitive functioning comprise the last two items in the screen.

The 7 items on page 1 are hierarchical so, if the consumer does not need help in doing housework and getting about, there is no need to ask about mobility and bathing. On page 2 items 8 and 9 are about cognition and behaviour and are asked of third party informants, not the consumers themselves.

Scoring instructions and an explanation of the way to use the scores to trigger the recommended functional assessments, are included on the form itself, as is a space for comments or other issues raised by the Functional Profile.

How to undertake a functional screen

The screen is designed for telephone administration or may be administered face-to-face.

It is suitable for administration to a consumer or to a carer, friend or other person (eg, service provider) who may be contacting the care coordinator or service provider on behalf of a consumer.

Part One of the screen is to be asked of the client, or the carer, friend, or other person. Where a carer, friend or other person is being questioned, the questions refer to the functional abilities of the client.

The interviewer should inform the respondent that a brief screen is to be undertaken.

After reading the introduction, the interviewer should carefully and clearly read each item (one item at a time), along with the options, to the respondent. The questions should be asked exactly as they are written. The questions ask 'Can you...?' rather than 'Do you...?' since some clients may not, for example, do the housework because their spouse or carer does it for them, yet be quite capable of undertaking it themselves.

We call this difference '*Can Do:Do Do*'. The task is to rate what a person 'can do' rather than what they 'do do'. The latter is influenced by opportunities in the environment, such as proximity to shops or the availability of a carer.

There are three main points to emphasise about how to complete the screen:

1. Rate what the person is capable of doing rather than what they do. Take into account the help that is required and the amount of prompting – if someone can do something but has chosen

²⁵ Cromwell D, Eagar K and Poulos R (2002) *Screening for cognitive impairment using instrumental activities of daily living in elderly community residents: a cross-sectional study*. Submitted for publication

- to have someone else do it (like dressing), rate as independent. If help or prompting is involved, rate as 1. If unable to do the task, rate as a 0.
2. Where an item is not relevant (eg, client does not use medicine), rate what the person would be capable of doing if the item were relevant to their situation.
 3. Make sure the ratings, especially of items regarding standards of cleanliness, are based on the person's own social or cultural context, not your own.

Answers are limited to specific categories but the structure for the 7 questions in part 1 is the same. If the respondent does not answer with an option, or qualifies the option, the options should be repeated and the respondent asked to select the option which best describes the situation.

The interviewer scores each item according to the answer given by the respondent. If a respondent will not, or cannot answer a question, the score box should be marked with a cross (x), to indicate it was not answered. If the answer box is left blank, it will be assumed that the question was not asked.

Part Two of the screen is not suitable for you to ask the client. You complete it based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, client notes or information provided by a proxy respondent, such as a friend, relative, carer or referring agency. The questions should not be asked directly of consumers for obvious reasons. Good evidence should justify a 'Yes' or 'No' and avoid going into areas of 'Why?' or 'How much?' as these are better covered at assessment should it be required.

Further information on the functional screen can be found by going to the CHSD website and downloading the HACC Functional Screening and Assessment Manual²⁶.

Part One: Questions to ask the client (or the person who represents the client)

Unique client ID

Use your own agency identifier.

Items 1 to 7:

These are self-explanatory. The questions should be read exactly as they appear. The respondent is to select only from the options provided.

Ratings:

2 = without help

1 = with some help

0 = completely unable to do

Notes on ratings

'X' to be used where the client will not or is unable to answer the question.

A code of 9 indicates that the interviewer did not ask the question.

A cognitively impaired person or a person with an intellectual disability who is able to do tasks with verbal prompting should be rated as scoring a 1.

Part Two: Questions for you to complete

Ratings (Items 8 and 9)

0 = yes (presence of reported cognitive or behavioural problem)

2 = no (no evidence of any cognitive or behavioural problem)

Notes

The purpose is simply to rate yes or no, rather than 'why' or 'how much'. 'Why' and 'How much' needs to be determined through a more thorough assessment.

²⁶ Eagar K and Owen A (2002) *Functional Screening and Assessment: How and Why*. Centre for Health Service Development, University of Wollongong. The CHSD website address is: www.uow.edu.au/commerce/chsd

What to do with the screening information once you've collected it

- Use the guidelines on the form to guide your decision about whether the consumer needs a more comprehensive assessment. They are guidelines only and you should use your own judgement. These guidelines will inevitably be refined over time as screening becomes routine and as expertise develops. Practical issues such as the availability of comprehensive assessment services and the urgency of the person's needs should also guide your decision.
- If the person has low or moderate functional needs and does not need further assessment, use the information to decide whether the consumer needs services and, if so, what it is they need. The functional screening results alone will not be sufficient for this as you will need a range of other information (eg, information about carers and social supports, financial resources). This information is collected in other profiles. Use all of the information you have to develop an initial action plan or care plan.

Aids and equipment currently used

The last section of the functional profile (FP p.2 of 2) has tick boxes for any aids and equipment that the consumer currently uses. The definitions of the codes used in this section are contained in the following table. These codes come from the HACC MDS but they are being used in the ONI in a different way. In the ONI, the item captures what aids and equipment the person currently has. In the HACC MDS, it captures what the HACC service provided.

Code Label	Code Label Definition
Self-Care Aids	These aids assist the client in their day-to-day routines of cooking/eating and personal hygiene. Examples of such aids are special crockery/cutlery, bath rails/shower rails, buttonhooks, bowel and urinary appliances etc.
Support and Mobility Aids	Aids mentioned here provide the client with ease of mobility as well as supportive mechanisms while at rest. Support aids include callipers, splints, special beds, cushions/pillows etc. while mobility aids include belts, braces, crutches, wheelchairs (manual and motorised) etc.
Communication Aids	These aids help the client with their inter-personal interaction and are inclusive of telephone attachments, writing aids, speaking aids (electrolarynx), intercom etc.
Aids for Reading	These are reading specific aids provided to clients and comprise of items like magnifying/reading glasses, Braille books, reading frames etc.
Medical Care Aids	Aids described in this category serve to provide assistance to clients with specific medical conditions. They include breathing pumps, pacemakers, Ostomy/Stoma appliances etc.
Car Modifications	These aids allow clients access to safe and comfortable transportation, either as the driver or passenger of the vehicle. They are inclusive of accelerator/brake/mirror and other driver related controls as well as other modifications like automatic transmission and room for wheelchair etc.
Other Goods/Equipment	This category of aids includes all items which lie outside the range of the above mentioned codes.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

11 How to complete the supplementary Health Behaviours profile

Use this form to record information about the person's lifestyle and to identify any opportunities that may be available to improve their health and well being. The questions are in the form of tick boxes, except for the nutrition screen, which gives a total score that can be used to indicate risk. The items are listed in the table below:

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Regular health checks (date)	Y/N	Yes
Smoking	Scale scores	Yes
Alcohol	Scale tick box	Yes
Frequency	Scale tick box	Yes
Quantity	Scale tick box	Yes
Nutrition (total score as risk indicator)	Scale scores	Yes
Weight (appearance)	Tick box	Yes
Physical activity	Y/N	Yes
Physical fitness	Tick box	Yes
Comment box	Alphanumeric	No
OFFICE USE ONLY		
Screeener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Regular health checks

Use your judgement to ask about likely issues: Have you had any health checks recently (eg a mammogram/pap smear or prostate check)? The question on health checks might cover breast screening for women 50 years and older within the recommended time frame (last 2 years) and, for the pap smear question, women of all ages. This should apply to teenagers and not just adults. If any checks have been undertaken, tick 'Yes' and establish if the check was done by the person's regular GP and note any relevant information in the box.

Risk factors

The opportunities for health promotion in the community are almost limitless. The results of the Australian Burden of Disease Study²⁷ offer some guidance as to which risk factors could most profitably be targeted by the ONI. These results and other relevant studies are discussed in the associated literature review undertaken to determine the most useful items²⁸.

Risk factors such as smoking, alcohol consumption, physical inactivity, hypertension, high blood cholesterol, obesity and inadequate fruit and vegetable consumption are responsible for large proportions of the overall burden of disease in Australia. The chief risk factor, responsible for 10% of total burden, is tobacco smoking, followed by physical inactivity (7%), high blood pressure (5%), and obesity (4%). Alcohol harm from hazardous drinking (4%) is offset by the benefits from alcohol in terms of cardiovascular disease, giving a net harm of around 2%. 'Fewer than five servings of fruit and vegetables' causes an estimated 3% of burden, as does high cholesterol. Illicit drugs, occupation and unsafe sex each account for less than 2% of the overall burden of disease²⁹.

These results indicate that targeting smoking, hazardous drinking, physical inactivity and obesity in consumers may be most worthwhile. The Health Behaviours form therefore prompts for inquiring about and recording these

²⁷ Mathers, C. D., Vos, E. T., Stevenson, C. E., and Begg, S. J. (2000). The Australian Burden of Disease Study: measuring the loss of health from disease, injuries and risk factors. *Medical Journal of Australia*, 172, 592-596.

²⁸ Owen A, Poulos R and Eagar K (2001) Using the evidence to develop best practice models for identifying initial primary and community care needs. Centre for Health Service Development, University of Wollongong www.wrhs.sa.gov.au

²⁹ Mathers et al. (2000) *ibid*

risks and opportunities for intervention, as well as nutrition, weight physical activity and fitness. Items have been selected from the DVA D677 form, and Enhanced Primary Care Assessment Form (Vic).

Smoking and drinking

The next questions are about smoking and alcohol use. Consider opportunities for health promotion and the need for a referral if either is an issue.

Evidence / source –DVA D677, and EPC forms.

Nutrition

These questions comprise the Australian Nutrition Screen and are selected from the Nutrition Checklist used in the D677 and the EPC Assessment Tools. Because their use as single items is unvalidated, the whole checklist should be used. This then allows total item scores to be used as a trigger for GP referral if the consumer scores in the 'high risk' range. Note that some items in the checklist have different scoring weights.

Depending on the consumer's presenting problems, ask questions such as: 'Do you have an illness or condition that made you change the kind and/or amount of food you eat?' or work through the checklist.

Evidence / source – the Nutrition Checklist in the D677 and the EPC Assessment Forms.

Weight

This item asks the interviewer to judge the appearance of the person and record in a tick box if they are underweight, average or overweight, and to consider referral for specialist or comprehensive follow-up if the person is significantly under or over weight.

It is important to use your own judgement about whether a person has significant weight problem before prompting further investigation. Whether the weight loss or gain has taken place over a short period of time will be relevant.. There may be other factors and information from other screening profiles such as Health Conditions or the Psychosocial Profile that might be worth considering.

Physical activity

A summary report called 'Getting Australia Active' contains a full description of the importance and relevance of physical activity and explains many of the concepts involved in reliably measuring both activity and fitness. For screening purposes, keep in mind the domains of physical activity include leisure, gardening and yard work, household chores, active transport and occupational physical activity.³⁰

"Physical activity is any bodily movement produced by skeletal muscles that results in energy expenditure"³¹. Important health benefits can be obtained through activity of moderate intensity - such as walking. It is considered appropriate to accumulate this type of energy expenditure through bouts as short as 10 minutes, towards the recommended total of 30 minutes on most days³².

Physical activity can be gauged by the question: 'Would you do at least 30 minutes of moderate physical activity (such as walking or yard work or any other type of exercise), on most days of the week?'

Evidence / source – Bauman A, Bellew B, Vita P, Brown W, Owen N. Getting Australia active: towards better practice for the promotion of physical activity. National Public Health Partnership, Melbourne Australia, March 2002.

Physical fitness

Fitness is a different but related concept to physical activity. The specific wording of this question has not been validated, but it appears to have content validity, given the current understandings of how best to capture this aspect of health behaviour. It should be noted that 'physical activity' has been used instead of 'exercise'. Exercise

³⁰ See Bauman (2002) page 179-182 and the associated website is at www.nphp.gov.au/sigpah

³¹ NSW Health (1996). *Physical activity and health. A special communication from the Chief Health Officer*, State Health Publication.

³² NSW Health, Public Health Division. (2000). *New South Wales Older Peoples Health Survey 1999*, NSW Health Department, Sydney.

Pate R, Pratt, M., Blair, S., Haskell, W., Macera, C., Bouchard, C., and al, e. (1995). Physical activity and public health: A recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medical Association*, 273(5), 402-407.

is a “planned, structured and repetitive bodily movement which is done to maintain one or more components of physical fitness” making it a subset of physical activity³³.

‘During the past 4 weeks...what was the hardest physical activity you could do for at least 2 minutes?’
If the hardest activity was less than moderate, consider the need for a referral. The following should be used as a guide:

Very heavy - run, fast pace; carry a heavy load upstairs or uphill (25 lbs, 10 kg)

Heavy - jog, slow pace; climb stairs or a hill at moderate pace

Moderate - walk, medium pace; carry a heavy load level ground (25 lbs, 10 kg)

Light - walk, medium pace; carry a light load on level ground (10 lbs, 5 kg)

Very light - walk, slow pace; wash dishes.

Consider both screening for Activities of Daily Living in the Functional Profile and the need for referral if the consumer’s response can be judged as ‘light’ or ‘very light’.

Evidence / source – Dartmouth COOP Charts. This question has a convergent correlation with the MOS Scale for Physical Function of 0.59 (Nelson et al. 1998).

Comment box including other issues

Use your own judgement to probe for sensitive issues such as substance abuse (legal or illegal) and safe sex habits. The comment box should be used as a place to summarise the information gained or to record any other relevant issues about health behaviours and risks. These should then inform the issues and initial action plan summarised on ONI page 2 of 2 and, if necessary, to develop a care plan.

Office Use Only

Record who has completed the form, and the designation or agency. Note that ‘agency’ includes identifiable agencies and centres, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client’s record.

³³ NSW Health (1996) op cit

12 How to use the tools to investigate need and to develop an initial action plan and/or a care plan

12.1 Using the Summary and Action Plan as prompts for referral and further assessments

The second part of the core information (ONI pages 1 and 2) provides prompts and ways to seek further information on specific domains that are relevant to the consumer's problems or issues that have arisen in the initial contact. The interviewer is expected to take into account the consumer's presenting problems and issues, the services that the consumer is currently using as well as all other information available to them. This other information might be based on their discussion with the consumer, observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency.

If there is any suggestion that the issue is relevant for the consumer, tick the relevant box and complete the suggested domains in the supplementary tools.

The supplementary tools also contain prompts for further assessment, referral or more action on behalf of the screener.

- The Living Arrangements profile covers accommodation and employment and decision-making and raises issues about informed consent if the consumer's decision-making capacity is in doubt. This profile also includes indicators of both risks and urgency (if living arrangements are unsatisfactory, housing is at risk and so on).
- The Carer profile covers issues about the availability of a carer and their needs. It suggests that, if carer issues are significant, they should be linked into carer support services and that completing a set of supplementary profiles on the carer might be useful. This profile also includes indicators of both risks and urgency (fragility of carer arrangements and so on), as well as whether there is any need for training or assistance.
- The Health Conditions form covers vision, hearing and falls and has prompts for investigating activities of daily living (the screen in the Functional Profile is the entry point to this domain), and for medical referral, or medication review.
- The Psychosocial profile has a scale for emotional health and well being that recommends generalist or specialist mental health referral depending on the score, prompts for investigating activities of daily living and assessment for disability services. The profile screens for risks such as suicide by asking about personal and social support and for high prevalence disorders such as anxiety and depression,
- The Functional Profile has prompts for the assessment of domestic, self care, cognition and behaviour domains of functional dependency. It also has a place to list the aids and equipment a consumer is currently using.
- The Health Behaviours form has prompts for referral for screening, and checks on risk factors such as smoking, drinking, nutrition advice, weight and physical inactivity. If fitness may be an issue, then consideration can be given to investigating activities of daily living (using the Functional Profile). Its importance is in identifying opportunities for early intervention and health promotion.

When all the relevant information has been collected, then the action plan and appropriate referrals should be considered. This might not all be done at the point of initial contact, but at a later time when sufficient information is available.

12.2 Using the ONI to record risks and urgency

Page 2 of the ONI Summary and Action Plan section has an Alert Box at the bottom that can be used to make a note of any issues of concern, including risks and record any questions of urgency, and the contact details in your agency for further information. This is used to record any concerns identified in relation to the possibility of danger, loss of social participation or reduction in health status. This is where a brief note can be made as to the circumstances involved, and attention can be drawn to more detail being available. If you trigger your own agency's alert procedures, consider indicating this in the box.

Briefly, the description of risks and the urgency of consumer issues can be considered under four main headings.

- Situations in which the consumer is at risk for any reason.
- Situations in which the consumer presents a physical or emotional risk to other people, including family, friends and neighbours. It excludes risks to community care workers.
- Situations in which the consumer represents a possible risk to a health professional or community care worker, whether intentional or unintentional.
- Situations in which there is an occupational health risk to a community care worker or health professional for any other reason.

Even if an alert system is not being used for this particular consumer, it is sometimes useful to consider if any low-level risks of the types described above are worth mentioning in this box.

Examples of this might be something like: 'note that consumer reports poor relationship with second daughter' or 'bathroom is on list for home modification - shower hose and bath board are temporary arrangement'.

12.3 Using the Initial Action Plan for referrals

The Initial Action Plan can describe a referral pathway for consumers who need further assessment or those with complex problems and help keep track of how progress is going and whether any variation needs to be made to the plan of care. The columns capture more detail on what information the consumer has consented to share, and has codes for how the referral is being made, what transport is to be used, and what feedback is required.

The 'Feedback required' column is intended to prompt the timely sharing of information between important participants in the consumer's care. The feedback column is of most relevance when this form is received by another agency and they can determine if the original referring agency, the agency completing the form, or the person's care-givers or GP require feedback.

By recording the actual date that the referral is made, the agency making the referral can keep track of waiting times and this may help determine whether additional follow-up action is required.

12.4 Developing a Care Plan

At this point there may be enough information for some agencies to develop a care plan, especially in cases where the consumer's needs are adequately described and a service specific plan of care is the next step. A care planning template is not provided as most services will have their own formats already in use.

A service coordination plan is only useful where multiple agencies are involved and after the consumer's needs have been fully assessed. Note that several goals of care might be involved, each with their own care plans at the level of different agencies.

13 Frequently Asked Questions

Q. *I already waste too much time filling out paper work. When all's said and done, isn't this just a bunch of new forms?*

If all you do is flick through the paper version of the tool, it's easy to come to your conclusion. But there's more to it than a bunch of extra forms to fill out:

- The ONI is designed to replace most of what you collect, not add to it. If all you do is add the ONI to your existing processes and systems, it will inevitably add to your workload. But that isn't the purpose of the ONI. If it adds to your workload, you probably need to go back and review what you do now.
- The design of the ONI assumes that you, and the agency you work for, are part of a bigger primary care service system that includes GPs, community health and HACC-funded services. It might also include secondary referral services such as hospitals, mental health and so on. The ONI is necessarily broad (but shallow) because it assumes that you are part of this bigger system. The idea is simple but of fundamental importance. You screen for all the consumers needs (including those you can't meet but someone else can) and other agencies screen for you.
- The goal is to get to a point where a consumer can enter the primary care sector at any point they choose and just have to tell their story only once. The advantages for consumers are obvious – not only having to tell their story only once but the ability to access the system at any point and the opportunity to receive care from providers who actually know what the system as a whole is doing.

Whether the ONI is just another bunch of forms or a better (more efficient and effective) system of screening for needs across agencies and professionals depends on how you use it.

Q. *Aren't we taking all this standardisation too far?*

Remember that the tools don't determine the structure of who does what in the local division of labour around screening and assessment. All they do is standardise what gets collected, not how it should be done from an organisational viewpoint and what it all means!

The big upside is that consumers don't have to repeat their details at every step, and we should get to a point of having a common entry point across the service system.

There is an obvious next step, once agreement on who does what has been achieved, and common tools are being used. With both standard ways to collect and share information, and by using the right information technology, we will soon have the opportunity to create virtual community care organisations in which various agencies work together as a virtual system.

However, a move towards virtual organisations represents a massive cultural leap and requires the support of both providers and consumers. Virtual organisations are within our grasp, and are not too far removed from local area arrangements where agreements and protocols already exist. However, we have a long way to go from a reality that is more like 'joined up worrying' to get to something more resembling 'joined up working'.

Q. *Can the consumer fill in part of the ONI? Will it serve as a consumer held record with a copy left in the consumers home, as tools like the CIARR has been?*

This is up to individual agencies and areas to decide in the context of their local service coordination models and agreed practices, processes and protocols within the area. The initial contact details can certainly be completed by the consumer. Consumer and community

consultations will need to consider the needs/requirements of consumers to hold their own records and access their records within the context of privacy guidelines and legislation.

Q. *What do the total numbers on the various screening tools actually mean? Should I add them all up?*

Except where it is stated in the profile (eg, the K10 in the Psychosocial Profile), the various screening scores don't mean much as 'scores', because the scales don't have equal weighting for all the items. So adding them up doesn't help and they weren't designed to really work that way. We don't expect the profiles to provide the answer to life, the universe and everything, nor for the answer to be '42'!

In practice, the scores are used as prompts for referral or further assessment where necessary. The key point is setting the thresholds for these prompts right such that you don't get either too many that get assessed or referred unnecessarily or too many that need something that miss out. We looked at the sensitivity and specificity of the screening tools to determine the best mix of these two attributes.

Q. *If I see another Minimum Data Set I'll go numb with boredom! How will the ONI tools link to all the other data collecting and reporting?*

The goal is that, eventually, a Common Data Set will streamline the common elements across all data collections. A sensible approach is that all of the Departments' data collections will comply with this common data set. Most States are considering options for the implementation of this process across all program areas in health and community care. This makes sense as there is little point attempting to standardise approaches on a program by program basis. There are too many programs and there is so much overlap and redundancy that the task would be pointless if done that way.

Q. *What liaison work is being done with the Commonwealth to streamline data collection and reporting?*

The Commonwealth is a major stakeholder in the development of national standards for data collections. In particular, the Australian Community Based Health Services Codeset (National Codeset) is auspiced by the National Health Information Management Group (NHIMG). The National Codeset was created to provide a 'comprehensive suite of codesets for use in the Australian Community Based Health environment' and was intended to reflect the activities and support the information management requirements of all types of health services delivered in a community based setting.

In its current form, the National Codeset provides a valuable first step in the development of a national framework for the collection of consistent and reliable data in community based health services. However, in order to be a relevant reference tool, significant work is required to align the National Codeset with other authoritative standards such as the National Health Data Dictionary (NHDD) and the National Community Services Data Dictionary (NCSDD). This work will be ongoing in order to enhance the synergies between the various standards.

Q. *What support will be provided for upgrading/altering of IM/IT systems to support implementation of the tool templates in an electronic format?*

A number of States have commenced work with some primary care software providers to inform them of these developments. It is expected that account will be made for development activities in the development cycle of the products. While discussions with vendors will continue during the development of the tools, more detailed work on applications support for the electronic tool templates will take place once the tools are being implemented in an agreed form.

Q. What work will be done over the longer term with GPs to encourage their adoption of these tools?

GPs are well placed to adopt the use of the tools. The Enhanced Primary Care (EPC) Medical Benefits Schedule (MBS) items especially concerning health assessments and case conferencing and care planning promote the involvement of GPs in shared assessment and multidisciplinary care planning. Funding and change management initiatives initiated by the Commonwealth through Divisions of General Practice promotes the involvement of GPs in these activities. The profiles have been designed so that they comply with the requirements for EPC claims.

Q. What level of training and competencies will staff implementing the ONI require and how will this be addressed?

Staff undertaking initial needs identification should have a broad understanding of the service system and advanced interviewing skills that provide a capacity to maintain and develop rapport throughout intensive inquiry and an ability to retrieve sufficient information through that inquiry.

The work with the range of primary care providers and other key stakeholders such as consumers and peak and professional bodies to facilitate agreement about the required assessment competencies and the best strategy for embedding these competencies among practitioners, is ongoing. This will ensure that in the longer term, consumers can be confident that workers with agreed competencies undertake screening elements.

Competencies development will build on previous work undertaken in the area of workforce development in the health and community care sectors. The training and skills development strategies that build the capacity of workers, organisations and the service system in this area are ongoing.

Q. What about the carers?

The carer needs and functions are taken into account through the Carer Profile (CP1) and the Living Arrangements form (LAP 1). If carers have identifiable needs of their own, they might be given their own ONI. Consider including in particular the functional screen (FP 1&2) if they are ageing carers of someone with a disability, or consider other profiles such as the psychosocial screen (PP 1) and the health conditions profile (HC 1), or any other screening forms that are relevant.

Remember the screening level is not about comprehensive assessment and carer needs might have to be addressed by an appropriate referral for assessment or their eligibility for respite. The function screen (FP 2) has two questions to ask of carers or other proxy respondents - about behaviour and memory problems - things you can't ask the consumer directly. While these questions are not about carer needs directly, they provide an opening to consider the items about the carer role in the carer profile.

Q. Will there be an adapted version of the screening tools that can be used with children?

The screen is not designed for children in particular and most of the items in the profiles haven't been validated for use with children. But the core information will be able to be collected on children and we assume that a referral for more detailed assessment will be an appropriate next step if needs are identified.

Our general impression from the testing and the training done to date is that kids can have their problems scored reliably on these tools as long as people take notice of the scoring instructions and use a bit of common sense.

Q. For some consumers the difficulties of getting through the screening seem too daunting. For example the consumer's disability or physical circumstances made it difficult to answer many of the questions.

Consumers with high levels of disability and no communication, consumers who were confined to bed, consumers who were very young and some consumers with brain injury and psychiatric illness, could clearly not perform any of the tasks and, in many cases, were unable to respond on their own behalf. For some consumers, the use of an interpreter for a consumer with a non-English speaking background might be found to be very time consuming and inappropriate. The screener should use their own judgement about the best way to get the relevant information, or refer the consumer to the appropriate assessment agency.

Q. Another problem is the question of the reliability of the answers from some consumers with cognitive disabilities.

Some consumers may have poor memory or be suffering from dementia but with a lack of insight into their condition and resistive behaviour towards care. It might be that a consumer has profound deafness that may prevent his or her understanding the questions. The screener should use their own judgement about the best way to get the relevant information, and/or refer the consumer to the appropriate assessment agency.

For consumers with cognitive problems (such as lack of insight, if they are delusional) all the questions might seem to be inappropriate. Similarly, most items might be inappropriate for a very disabled, bedridden consumer and for a young child with no speech or independent mobility.

For some younger consumers, the questions might highlight the progressive decline in their functional ability, so it could be quite distressing for the consumer to go into all that. Some young, able consumers might also find the questions invasive, offensive, inappropriate or just a joke.

The screener should use their own judgement about the best way to get the relevant information, either by inquiring of a carer or the referring agency, or refer the consumer to the appropriate assessment agency.

Q. What about special needs groups and ATSI populations?

The sample size in the different field tests of the screening tools to date has been insufficient to test the appropriateness for special needs groups such as ATSI consumers and consumers who do not speak English. This issue can only be assessed when the tools are introduced into routine practice, as the sample size achieved in any one-off field test will continue to be insufficient to test the appropriateness of the instruments for low-volume groups.

The main issue is expected to be around the use of the screening tools in remote areas, where the capacity of the local community to respond to need may be a more important dimension to be considering, but along with the level of need identified in individuals. Eventually it makes sense to have versions of the functional profile that take into account the living conditions in remote areas where transport and shops and house design make the mainstream version of the items less useful. Some active consideration of adapting the tools to these populations and settings has been going on for some time and there will be more progress possible after the 'mainstream' versions of the tools are better understood and refined.

Q. What about all the missing bits?

There are a number of general areas that are missing in the screening tools or covered by only a general question. Social isolation, the need for prompting and encouragement with personal hygiene and to use continence aids, problems with literacy and interpreting for consumers with communication difficulties or lack of English language skills are all important.

Other examples where screening won't give providers enough information are in the assessment of environmental hazards or areas where a service-specific assessment is more useful. The person's home is also a worker's workplace and so occupational health and safety concerns should be addressed with the appropriate protocols that should already be in place. Specialised assessment of consumers with disability or mental health issues should be prompted by efficient screening, not replaced by it.

While functional capacity in particular is thought to be of critical importance in driving the need for services, it is not the only measure of need, nor is it the only consumer-related cost driver. Other important consumer-related drivers (or variables) also need to be captured to gain a comprehensive picture of the consumer's needs. Consumer-related variables thought to be of particular importance (among others) are age, medical conditions and diagnoses, carer availability, risk of abuse and care setting. These should all be considered as part of developing a Summary and Action Plan (ONI p.1 & 2).

The box at the bottom of the ONI p.2 form is for comments on risks and urgency and can be used to note important issues that have to be taken into account.

Q: *If I read the questions out in exactly the form they are written, this is too awkward. Is there a satisfactory middle way?*

It is not necessary to read out the questions exactly as they are written, but standardisation is important. The screener is encouraged to keep the sense and direction of the questions while using their own judgement in having a conversation with consumers. As the items become more familiar a more colloquial style will be easier, while retaining the sense and meaning of the question.

An exception to this general rule is in the psychosocial profile where the K10 scale might best be administered in a more formal fashion, like a survey, to reduce the awkwardness of discussing emotional well-being.

Questions specifically about the Functional Profile (FP p.1&2)

Q: *Mobility items - inside and outside - ie the consumer can mobilise independently in a familiar environment, but has trouble outside. They can do a bit of housework, but not their lawns and gardens, and the back steps need a rail. How does this score?*

The form does not capture most of the important environmental information, however a box at the end asks about aids and equipment currently used. Also, a self-care or domestic assessment may be triggered by the various items on the screen. After the screen, then the assessment of the domains of self care (generally inside) and domestic (a mixture of inside/outside and getting around) should be triggered.

In the above example, a self-care assessment may not actually be suggested by the screen, but a follow-up on domestic function might be. We assume that assessment staff will use both tools in the next level of the assessment process after the screen.

On the FP form the need for a rail outside could be picked up under self-care (in Q9 on stairs). Having an internal stair rail in place means independent inside but its absence outside implies the person needs help (score 1). The consumer's score on the self-care items might then trigger (in routine practice, but not on our form because it is beyond the scope of functional dependency screening as defined in this project) an environmental assessment or OT visit to assess hazards.

Q: *Getting around and out and about - transport, shopping and mobility are pretty much all getting at the one thing, so why measure them all?*

These items were selected because people tend to lose their ability to do them at different times (and in a consistent order). The ability to shop is generally lost first, followed by transport and then indoor mobility. Knowing where a person sits on this continuum is important. Remember the domestic function items are more for 'out and about' and ask for a rating on shopping independently of transportation, which is covered under item 6. Meanwhile, the self-care items are more about getting around in a familiar environment.

The screen is designed to give reliable indicators for both mobility and basic self-care tasks and some pointers to cognition. Remember that Part Two of the screen isn't used directly with the consumer. It specifically asks an informant about the consumer's thinking and behaviour.

Q: *Finances and Medication - not necessarily a cognitive link. The screen is designed to use money and medications as pointers to cognitive function, but this may confuse the situation where someone is cognitively capable of handling their money and pills, but physically incapable (because of blindness or arthritis for example). What should be done here?*

In this case the screen score on items 4 & 5 would be: 1 = with some help; or 0 = completely unable. As noted on the form, this would not trigger a cognitive assessment unless you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items. It is likely the person might also score 1 or 0 on mobility or shopping items, which would trigger the self-care and/or domestic assessment.

Q: *Disability without incapacity - what about someone who is partially blind with practical aids in place, like informal financial arrangements or a Webster pack?*

They should score 2 on items 4 & 5 on the screen = without help, because they have the functional capability, and the screen tool would treat them in the same way as someone with a lesser level of disability who uses glasses and large digit phones and clocks.

Q: *What about someone who is legally blind but uses a magnifying glass and is not neglectful? They may be able to use a Webster pack, and that is an obvious preventive intervention to suggest as part of a care plan. How do they score?*

This person would score 2 = without help, on the screening item 4. This is because we want to score the consumer's present function, not a future likelihood or a "what if" scenario, nor even a direct service need. Although they are closely linked in routine practice, we are not scoring the person's need for an intervention, only their level of functional dependency (with their current aids and appliances).

It might be that on a re-screening in six months time the score would be 1 = with some help, or it might be that a domestic assessment now would indicate trouble in other areas like getting around or difficulties in the consumer conducting their business unaided when out and about.

Q: *My client varies a lot in his functional ability. Some days he can do a task, but the next day he can't. I have another client who can do domestic tasks but the next day she is in such pain that she can't get out of bed. How do I rate them?*

In both cases, rate the client at their worst in the last month. If a person cannot do a task without it resulting in significant pain and fatigue such as you describe, rate as a 0 (cannot do).

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Paper versions of the NSW ONI Tools

Electronic copies of these tools in Acrobat format are available for downloading from the CHSD website: www.uow.edu.au/commerce/chsd

NSW Initial Contact Information CONTACT DETAILS

If question is irrelevant or information not known, write Not Applicable or NA

Consumer details

Title (please circle) Mr Mrs Ms Other _____

Family Name: _____

Given Names: _____

Preferred Name/s: _____

Date of birth dd/mm/yyyy ____ / ____ / ____

Sex (please circle) 1. Male 2. Female

Contact details

Usual Address

____ (number) _____ (street)
____ (suburb/locality) _____ (postcode)

Contact Address (if different from usual address)

____ (number) _____ (street)
____ (suburb/locality) _____ (postcode)

Contact phone number/s (tick preferred number)	Can leave message? Y or N
Home	
Work	
Mobile	
Fax	
Email address	

Comments (including directions etc or any other contact issues)

Record Unique Record Number

or affix label here

Who the agency can contact if necessary

(eg, case manager, next of kin, carer, guardian, friend, emergency contact)

Person 1 Name

Contact details

____ (number) _____ (street)
____ (suburb/locality) _____ (postcode)

Phone: _____

Relationship to client

Person 2 Name

Contact details

____ (number) _____ (street)
____ (suburb/locality) _____ (postcode)

Phone: _____

Relationship to client

General Practitioner (if no GP, write NA)

Name

Address

____ (number) _____ (street)
____ (suburb/locality) _____ (postcode)

Phone: _____

Fax: _____

Email: _____

Office Use Only

NSW ONI FINAL DRAFT 16 OCTOBER

Name _____ Designation/Agency _____

Sign _____ Date _____ Contact number _____

If information needs updating, indicate below and record updated information on a new ICI

This information has been updated

Date: _____

Name: _____

Sign: _____

**NSW Initial Contact Information
SERVICE ENTRY DATA SET**

If information not applicable or not known, record 99

Service Entry Data Set

Source of Referral

- Record: (1) Self.
- (2) Family, significant other, friend.
- (3) GP/medical practitioner – community based.
- (4) Specialist aged or disability assess team/service (eg. ACAT).
- (5) Comprehensive HACC assessment authority
- (6) Community nursing service.
- (7) Hospital (public).
- (8) Psychiatric/mental health service or facility.
- (9) Extended care/rehabilitation facility.
- (10) Palliative care facility/hospice.
- (11) Government residential aged care facility.
- (12) Aboriginal health service.
- (13) Carelink centre.
- (14) Other community-based government medical/health service.
- (15) Other government medical/health service.
- (16) Other government community-based services agency.
- (17) Hospital (private).
- (18) Non government residential aged care facility.
- (19) Other non government medical/health service.
- (20) Other non government community-based service.
- (21) Law enforcement agency.
- (22) Other.

If not self-referred, has client given consent for referral? Y N

Source of Referral Contact Details (if relevant)

Country of Birth

Record: (1) Australia. (2) Other.

If other, specify _____

Indigenous Status

- Record: (1) Aboriginal but not Torres Strait Islander Origin.
- (2) Torres Strait Islander but not Aboriginal Origin.
- (3) Both Aboriginal and Torres Strait islander Origin.
- (4) Neither Aboriginal nor Torres Strait Islander Origin. (9) Not stated.

Main Language Spoken at Home

Record: (1) English. (2) Other.

If other, specify _____

Interpreter Required

Record: (1) Interpreter not needed. (2) Interpreter needed

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

Preferred language, (if not spoken English) including sign language, & any required communication devices or special interpreter needs

Government Pensioner/Benefit Status

- Record: (1) Aged Pension
- (2) Veterans' Affairs Pension (complete details below)
- (3) Disability Support Pension
- (4) Carer Payment (pension)
- (5) Unemployment related benefits
- (6) Other gov pension or benefit
- (7) No gov pension or benefit

Pension/Benefit Card Number

Medicare Number

Health Care Card Number

DVA Card Status

- Record: (1) No DVA Card
- (2) Yes – Gold Card
- (3) Yes – White Card
- (4) Yes - Other DVA Card

DVA Card Number

Insurance Status

Tick all that apply:

(1) None	
(2) Private health insurance – basic cover only	
(3) Private health insurance – including auxiliary cover for private dental and allied health services	
(4) Motor vehicle accident insurance	
(5) Workers compensation	
(6) Other 3rd party	
(7) Ambulance fund	

Health Insurer Name and Card Number

Office Use Only

Name _____ Designation/Agency _____

NSW ONI FINAL DRAFT 16 OCTOBER

Sign _____ Date _____ Contact number _____

If information needs updating, indicate below and record updated information on a new ICI

This information has been updated

Date: _____

Name: _____ Sign: _____

**NSW Ongoing Needs Identification
ONI SUMMARY & ACTION PLAN**

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

Why the consumer is seeking services

Description of problem or issue as identified by the consumer or referring agency	Action required
1	
2	
3	
4	

Description of other issues as identified by the consumer or in the ongoing needs identification process	
1	
2	
3	
4	

ACTION REQUIRED: Code

- | | | |
|---|---|---|
| (1) Service provision – see Initial Action Plan | (4) Nil: Consumer ineligible for service. | (8) Nil: Consumer issue resolved. No further action required. |
| (2) Specialist assessment | (5) Nil: Referred elsewhere. | (9) Nil: Requested service not available. |
| (3) Comprehensive assessment | (6) Nil: Advise/information provided. No further action required. | (10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location). |
| | (7) Nil: Consumer declines further referral or service. | |

Consumer permission to proceed

Yes No

If yes, proceed to next section. If no, finalise initial action plan on next page.

Current services

Record services used in the last three months. If more than 7 services used, append an additional page

Service	Record contact details or other information as appropriate

Consider all health and community services, including (but not limited to) Alternate Therapists, Aged Care, Alcohol and drug, Community health, Counselling, Dental care, Disability, Emergency accommodation, Family planning, Home care, Hospital inpatient, Hospital outpatient, Hospital emergency, Maternal and child health, Medical (GP), Medical (specialist), Men's health, Mental health, Palliative care, Rehabilitation, Residential Aged Care, Respite care, Self help groups, Sexual health, Women's health, Youth services.

Office Use Only

NSW ONI FINAL DRAFT 16 OCTOBER

Name..... Designation/Agency.....

Sign..... Date..... Contact number.....

If information becomes superseded, indicate below and record updated information on a new ONI

This information has been updated	<input type="checkbox"/>	Date: _____
Name: _____	Sign: _____	ONI Page 1 of 2

NSW Ongoing Needs Identification ONI SUMMARY & ACTION PLAN

If question is irrelevant or information not known, write Not Applicable or NA

Record Unique Record Number

or affix label here

Other consumer issues

Issue/s

If client requires HACC or HACC-like services

Living Arrangement, Carer and Functional Profiles (mandatory)

Health – consider overall health, age-related problems, disabilities, use of medicines

Profile of Health Conditions

Psychosocial – consider mental health and emotional well-being, personal and social supports, family and personal relationships

Psychosocial Profile

Functional status and activities of daily living– consider overall health, age-related problems, disabilities

Functional Profile

Health behaviours – consider lifestyle issues and opportunities for prevention and health promotion

Health Behaviours Profile

Determinants of health – consider living arrangements, housing, work, financial, legal

Living Arrangements Profile

Carer issues – if consumer has a carer

Carer Profile

After completing the relevant supplementary profiles, finalise the Initial Action Plan below.

Initial Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the initial action required. If more than 4 actions are required, append an additional sheet.

To be referred to:

Agency/health professional	For	Consumer Consent	Referral Method	Transport Method	Feedback required	Date	Review Date

Agency/health professional: Complete in legible text. If you will be continuing to see the client, include yourself in the list of agencies/professionals for referral

For: Record purpose of referral in legible text

Consumer Consent: Record (1) Yes, consumer consents to referral and to sharing of information as specified on consumer consent form (2) Yes, consumer consents to referral but not to sharing of information (3) No, consumer has not consented to this referral

Referral method: Record (1) this form faxed to agency (2) letter (copy on file) (3) electronic (4) verbal request – face to face or phone call (5) other (incl. refer to self)

Transport Method: Record (1) Staff travel – service is delivered in home (2) Staff travel - client too unwell to travel (3) Staff travel – client has no transport (4) Client travel – own car (5) Client travel – family/friends (6) Client travel – public transport or taxi (7) Client travel – walk (8) Community transport (9) Ambulance (10) Hitchhike (11) None

Feedback required: Record (1) to initial referral agency (2) to GP (3) to agency completing ONI (4) to carer/guardian (4) other

Date: Record date referral actually made. If no referral actually made, leave blank

Review Date: Record date when action should be reviewed. If no need for review, leave blank

Alerts (including any relevant comments on risk or urgency)

Office Use Only

NSW ONI FINAL DRAFT 16 OCTOBER

Name..... Designation/Agency.....

Sign..... Date..... Contact number.....

If information becomes superseded, indicate below and record updated information on a new ONI

This information has been updated Date: _____

Name: _____ Sign: _____

NSW Ongoing Needs Identification LIVING ARRANGEMENTS

If information not applicable or not known, record 99

Living arrangements

Record: (1) Lives alone (2) Lives with family (3) Lives with others

Comments on living arrangements, including family arrangements (consider issues such as stability of arrangements, number of people in household etc)

Accommodation

Record: (1) Private residence – owned/purchasing (2) Private residence – private rental (3) Private residence – public rental (4) Private residence – mobile home (5) Independent living unit within a retirement village (6) Boarding house/private hotel (7) Short term crisis, emergency or transitional accommodation facility (8) Domestic-scale supported living facility (9) Supported accommodation facility (10) Residential aged care facility (11) Psychiatric / mental health community care facility (12) Public place/temporary shelter (13) Private residence rented from Aboriginal Community (14) Temporary shelter within an Aboriginal Community (19) Other (99) Not stated / inadequately described

Comments on accommodation

Employment Status

Record: (1) Employed/self employed (2) Sheltered (3) Child/Student (4) Home duties (5) Unemployed (6) Retired for age (7) Retired for disability (8) CDEP (9) Other

Comments on employment

Record Unique Record Number

or affix label here

Financial and legal profile

Mental Health Act status

Record (1) Voluntary (2) Involuntary (3) CTO (4) N/A

Other current legal order (eg, AVO) (circle one)

Yes No Not sure

If yes, specify: _____

Decision-making responsibility

Record: (1) Self (2) Enduring Power of Attorney (3) Guardian

Is the person capable of making their own decisions? (circle one)

Yes No Not sure

If 'not sure' or 'no', consider the need for assistance, need for cognitive assessment and the implications for consent.

Financial decisions

Record: (1) Self (2) Power of Attorney (3) Financial Manager (4) Parent or Guardian

Cost of living decisions

Because of limited income, has the consumer during the last month made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, necessary home care, necessary transport?

Yes No Not sure

If yes, discuss issues with consumer and consider need for counselling (eg, financial, gambling, drug or alcohol) and need for material support.

Comments on legal and financial issues

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This information has been updated

Date: _____

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NSW Ongoing Needs Identification CARER PROFILE

If information not applicable or not known, record 99

Carer Profile

Carer Availability

Record (1) Has a Carer (2) Has no Carer (3) Not Applicable – no carer required (4) Not Applicable – the consumer is the Carer

Carer Residency Status

Record (1) Yes – Co-resident Carer (2) No – Non-resident Carer (3) Not Applicable – the Consumer has no Carer

Relationship of Carer to Care Recipient

Record (1) Wife/female partner (2) Husband/male partner (3) Mother (4) Father (5) Daughter (6) Son (7) Daughter-in-law (8) Son-in-law (9) Other relative – female (10) Other relative – male (11) Friend/neighbour – female (12) Friend/neighbour – male

Carer Support

Does Carer have someone to help them?

Yes No Not sure No Carer

Does Carer receive a Carer Payment or Allowance?

Yes No Not sure No Carer

Has Carer been given information about available support services?

Yes No Not sure No Carer

Does Carer need practical training in lifting, managing medicine or other tasks?

Yes No Not sure No Carer

If 'not sure' or 'no' to any of the above, consider the need to provide information and for assistance to arrange required support services

Current threats to carer arrangements

Tick all that apply

- (1) Carer – emotional stress & strain
- (2) Carer – acute physical exhaustion/illness
- (3) Carer – slow physical health deterioration

- (4) Carer – factors unrelated to care situation
- (5) Consumer – increasing needs
- (6) Consumer – other factors

Are carer arrangements sustainable without additional services or support?

Record (1) No, have already broken down (2) Yes, but only weeks (3) Yes, months (4) Yes, years (5) Don't know

Comments on carer issues, including whether emergency arrangements are in place

Record Unique Record Number

or affix label here

Carer Issue/s	Tick if relevant	Complete on Carer:
If carer requires HACC or HACC-like services	<input type="checkbox"/>	Living Arrangements and Functional Profiles
Health – consider the carer's overall health, age-related problems, disabilities, use of medicines	<input type="checkbox"/>	Profile of Health Conditions
Psychosocial – consider the carer's mental health and emotional well-being, personal and social supports, family and personal relationships	<input type="checkbox"/>	Psychosocial Profile
Functional status and activities of daily living– consider the carer's overall health, age-related problems, disabilities	<input type="checkbox"/>	Functional Profile
Health behaviours – consider the carer's lifestyle issues and opportunities for prevention and health promotion	<input type="checkbox"/>	Health Behaviours Profile
Determinants of health – consider the carer's living arrangements, housing, , work, financial, legal	<input type="checkbox"/>	Living Arrangements Profile

Other comments

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Date: _____

Name: _____

Sign: _____

NSW Ongoing Needs Identification HEALTH CONDITIONS

If question is irrelevant or information not known, write Not Applicable or NA

Record Unique Record Number

or affix label here

Overall health

In general, would you say your health is?

- Excellent
- Very good
- Good
- Fair
- Poor

Consider activities of daily living

How much bodily pain have you had during the past 4 weeks?

- None
- Very Mild
- Moderate
- Severe
- Very Severe

Consider activities of daily living

How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?

- Not at all
- Slightly
- Moderately
- Quite a bit

Consider Activities of Daily Living

Vision

Is your eyesight for reading (with your glasses)?

- Excellent
- Good
- Fair
- Poor

Is your long distance eyesight (with your glasses)?

- Excellent
- Good
- Fair
- Poor

Hearing

Is your hearing (with your hearing aid)?

- Excellent
- Good
- Fair
- Poor

Falls

Have you had a fall inside/outside the home in the past 6 months?

- Yes No

If yes, record number of falls _____

Consider both activities of daily living and need for referral if the consumer has any problems with vision, hearing or falls.

Height and weight

Weight _____ kg

Height _____ m

BMI _____

BP/Pulses

Systolic BP _____ mm/Hg

Diastolic BP _____ mm/Hg

Pulse regular

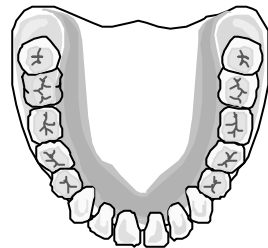
Pulse irregular

Pulse rate _____

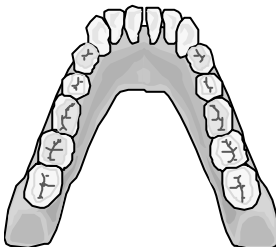
Consider check for postural hypotension?

- Yes No

Oral Health



Comments (eg condition of teeth, gums, dentures) including eligibility to access services



Feet

Problems with one or both feet?

- Yes No

Comments on feet

Vaccinations

- Influenza
- Pneumococcus
- Tetanus
- Other

date

Fit to drive

- Yes No

Comments

Refer AustRoads Guidelines

Continence

Leaking urine? Never
Sometimes
Often

Is this related to coughing or sneezing? Y
N

Faecal soiling/change of bowel habit Never
Sometimes
Often

Comment

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Date: _____

Name: _____ Sign: _____

NSW Ongoing Needs Identification HEALTH CONDITIONS

If question is irrelevant or information not known, write Not Applicable or NA

Record Unique Record Number

or affix label here

Health conditions as reported by consumer or carer (include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental)

Condition	Condition
1	5
2	6
3	7
4	8

Medical diagnoses confirmed by doctor (include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental)

Diagnosis	Diagnosis
1	5
2	6
3	7
4	8

Current Medicines – include prescriptions, over-the-counter, bush medicine and alternate products (including other people's medicine)

1	5
2	6
3	7
4	8

	0	1	2	3
Does this person generally look after and take her or his own prescribed medication without reminding?	Reliable with medication	Slightly unreliable	Moderately unreliable	Extremely unreliable
Is this person willing to take medication when prescribed by a doctor?	Always	Usually	Rarely	Never
Does this person cooperate with health services (e.g. doctors and/or other health workers)?	Always	Usually	Rarely	Never

Webster Pack or similar used for medicine? Yes No

Home Medicine Review recommended? Yes No

Comments

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If information needs updating, indicate below and record updated information on a new HCP

This information has been updated Date: _____

Name: _____ Sign: _____

Mental health and well being

In the past 4 weeks about how often did you feel...

K10 scale		Score
1	tired out for no good reason?	
2	nervous?	
3	so nervous that nothing could calm you down?	
4	hopeless?	
5	restless or fidgety?	
6	so restless you could not sit still?	
7	depressed?	
8	that everything was an effort?	
9	so sad that nothing could cheer you up?	
10	worthless?	

Score:
 1 None of the time 4 Most of the time
 2 A little of the time 5 All of the time
 3 Some of the time

Total K-10 Score: _____

Recommended action: refer for primary care mental health assessment if total score is 16-29 and for a specialist mental health assessment if score is 30 or more.

Have you had any difficulty sleeping?	Y <input type="checkbox"/>
	N <input type="checkbox"/>
Details:	

Personal and social support

During the past 4 weeks...Was someone available to help you if you needed and wanted help? For example if you...

- felt very nervous, lonely or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself

Yes, as much as I wanted

Yes, quite a bit

Yes, some

Yes, a little *Consider referral & activities of daily living*

No, not at all

Record Unique Record Number

or affix label here

Comment on personal and social support, including opportunities

Family and personal relationships

Does this person generally make and/or keep up friendships?

(1) Friendships made or kept up well (2) Friendships made or kept up with slight difficulty (3) Friendships made or kept up with considerable difficulty (4) No friendships made or none kept up

Does this person generally have problems (eg, friction, avoidance) living with others in the household?

(1) No obvious problem (2) Slight problems (3) Moderate problems (4) Extreme problems

Comments

Relationships with service providers

Does the consumer mistrust health and community service providers because of previous bad experiences?

Yes No Not sure

Comments

Disability

Is the person likely to be eligible for disability services (circle yes only if they clearly meet all of the criteria below)?

Yes No Not sure

Eligibility criteria (tick)

Has a disability attributed to an intellectual disability or a sensory, physical or neurological impairment or brain injury

The disability is permanent or likely to be permanent

Substantially reduced capacity in self-care/management or mobility or communication or learning

Need for continuing support

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This information has been updated

Date: _____

Name: _____ Sign: _____

Activities of Daily Living (functional screen)

Questions to ask the consumer (or the person who represents the consumer)¹.

I would like to ask you about some of the activities of daily living, things that we all need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all. The questions refer to how you are managing at the moment.

Record Unique Record Number _____ or affix label here

Item	Question	Score	Record score
1	Can you do housework...		
	Without help (can clean floors etc)?	2	
	With some help (can do light housework but need help with heavy housework)?	1	
	Or are you completely unable to do housework?	0	
2	Can you get to places out of walking distance...		
	Without help (can drive your own car, or travel alone on buses or taxis)?	2	
	With some help (need someone to help you or go with you when travelling)?	1	
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	
3	Can you go out for shopping for groceries or clothes (assuming you have transportation)...		
	Without help (taking care of all shopping needs yourself)?	2	
	With some help (need someone to go with you on all shopping trips)?	1	
	Or are you completely unable to do any shopping?	0	
4	Can you take your own medicine...		
	Without help (in the right doses at the right time)?	2	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	1	
	Or are you completely unable to take your own medicines?	0	
5	Can you handle your own money...		
	Without help (write cheques, pay bills etc)?	2	
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	1	
	Or are you completely unable to handle money?	0	
Do not ask the following 2 questions if the client scored 2 on all of the above 5 items (ie, can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.			
6	Can you walk...		
	Without help (except for a cane or similar)?	2	
	With some help from a person or with the use of a walker, or crutches etc	1	
	Or are you completely unable to walk?	0	
7	Can you take a bath or shower...		
	Without help?	2	
	With some help (eg, need help getting into or out of the bath)?	1	
	Or are you completely unable to bathe yourself?	0	

NOTES:

- If unanswered, score X.
- Rate what the person is **currently capable** of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 1). In rating an item that is irrelevant (for example, the person has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
- Item 6 (walking). Clients who are in a wheelchair should be rated as (1) if they are independent including corners etc or (0) if they are not wheelchair independent.

1 Reproduced from the OARS/MFAQ. Copyright: the Center for the Study of Aging and Human Development, Duke University Medical Center, Durham, North Carolina. Used with permission. Questions 1, 6 and 7 have been modified.

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This information has been updated Date: _____

Name: _____ Sign: _____

Questions for you to complete

Complete the following based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, consumer notes or information provided by a proxy respondent, such as a friend, relative, carer or referring agency.

Note that the consumer should not be directly asked to answer these questions.

Record Unique Record Number

or affix label here

Item	Question	Record score
8	Does the person have any memory problems or get confused?	
	No – score 2	
	Yes – score 0	
9	Does the person have behavioural problems for example, aggression, wandering or agitation?	
	No – score 2	
	Yes – score 0	

Recommended functional assessments based on this functional screen

Domestic

Look solely at items 1 to 5. Count the number of these items that scored 2 (ie, count the number of activities that the person can do without help). Refer for a domestic functional assessment if the person can do less than 3 activities without assistance – ie, the count is 2 or less (a count of 0, 1 or 2).

Self-care

Refer for a self-care functional assessment if the consumer SCORED LESS THAN 2 on either Item 6 (mobility) or Item 7 (bathing).

Cognition

Refer for a cognitive assessment if:

- the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 0 on Item 8.

Behaviour

Refer for a behavioural assessment if:

1. the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
2. the consumer scored 0 on Item 9.

Comments

Aids and equipment currently used

Self-Care Aids <input type="checkbox"/>	Medical Care Aids <input type="checkbox"/>
Support and Mobility Aids <input type="checkbox"/>	Car Modifications <input type="checkbox"/>
Communication Aids <input type="checkbox"/>	Other Goods/Equipment <input type="checkbox"/>
Aids for Reading <input type="checkbox"/>	List: <input type="checkbox"/>

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Name: _____ Sign: _____

NSW Ongoing Needs Identification HEALTH BEHAVIOURS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

Regular health checks

Yes No

If yes, record last date or year _____
 If yes, record health screens in last 2 years (eg, pap smear, breast, prostate)

Smoking

Never smoked

Has quit smoking

Currently smokes

If quit, record when _____
 Consider referral if currently a smoker

Alcohol

How often do you have a drink containing alcohol?

Never *If never, proceed to next section*

Monthly

Once a week

2-4 times per week

5+ per week

How many standard drinks do you have on a typical day when you are drinking?

How often do you have more than 6 standard drinks on one occasion?

Never

Monthly

Once a week

2-4 times per week

5+ per week

Consider referral if alcohol consumption is an issue

Nutrition

These questions may not apply to all (eg those with particular conditions or lifestyles). If a question has already been answered in a previous section, record a score based on the previous answer. Use the total score to decide whether action is required.

	yes	no	Score
Do you have an illness or condition that made you change the kind and/or amount of food you eat?	yes 2	no 0	
Do you eat at least 3 meals per day?	yes 0	no 3	
Do you eat fruit or vegetables most days?	yes 0	no 2	
Do you eat dairy products most days?	yes 0	no 2	
Do you have 3 or more glasses of beer, wine or spirits almost every day?	yes 3	no 0	
Do you have 6-8 cups of fluids most days?	yes 0	no 1	
Do you have teeth, mouth or swallowing problems that make it hard to eat?	yes 4	no 0	
Do you always have enough money to buy food?	yes 0	no 3	
Do you eat alone most of the time?	yes 2	no 0	
Do you take 3 or more prescribed or over the counter medicines every day?	yes 3	no 0	
Without wanting to, have you lost or gained 5kg in the last 6 months?	yes 2	no 0	
Are you always able to shop, cook and/or feed yourself?	yes 0	no 2	
Total score			

Total score: 0-3 'good', 4-5 'moderate', 6-29 'high risk'. Note that these totals have only been validated for older people. Use your judgement for other age groups

or affix label here

Weight

Appearance

Underweight

Average

Overweight

Consider referral to specialist / comprehensive service if significantly under or over weight

Physical Activity

Would you do at least 30 minutes of moderate physical activity (such as walking or yard work or any other type of exercise) on most days of the week?

Yes No

Consider referral if 'no'.

Physical fitness

During the past 4 weeks...what was the hardest physical activity you could do for at least 2 minutes?

Very heavy (for example) run, fast pace; carry a heavy load upstairs or uphill (25 lbs, 10 kg)

Heavy (eg) jog, slow pace; climb stairs or a hill at moderate pace

Moderate (eg) walk, medium pace; carry a heavy load level ground (25 lbs, 10 kg)

Light (eg) walk, medium pace; carry a light load on level ground (10 lbs, 5 kg)

Very light (eg) walk, slow pace; wash dishes

Consider both activities of daily living and need for referral if response is 'light' or 'very light'.

Comments, including other relevant issues (eg, other substance use, safe sex practices, mens health issues) and opportunities for health promotion

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