# PCP Integrated Chronic Disease Management - Case study template

## Details of PCP contact

<table>
<thead>
<tr>
<th>Name of PCP</th>
<th>Frankston Mornington Peninsula Primary Care Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Person</strong></td>
<td>Lyn McKay</td>
</tr>
<tr>
<td><strong>Position/Title</strong></td>
<td>Service System Redevelopment Coordinator</td>
</tr>
<tr>
<td><strong>Phone No.</strong></td>
<td>9788 1544</td>
</tr>
<tr>
<td><strong>Email Address</strong></td>
<td><a href="mailto:lmckay@phcn.vic.gov.au">lmckay@phcn.vic.gov.au</a></td>
</tr>
</tbody>
</table>

## Identified Partners

<table>
<thead>
<tr>
<th>Partner Organisation</th>
<th>Roles and responsibilities with regard to the project</th>
<th>Contact person details (name, position)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Health Community Health</td>
<td>Project Manager</td>
<td>Julie White, Chronic Disease Coordinator PHCH &amp; PCP ICDM Support Officer</td>
</tr>
<tr>
<td>Peninsula General Practice Network</td>
<td>Member of working group contributing to tool development- Practice Nurse involvement</td>
<td>Leisl Jackson, Senior Program Manager Peninsula General Practice Network</td>
</tr>
<tr>
<td>Peninsula Health Mental Health Service</td>
<td>Member of working group development of Mental Health and Well being section</td>
<td>Dr Priscilla Yardley, Head of Psychology</td>
</tr>
<tr>
<td>Dental Health Service Victoria</td>
<td>Contributed to development of Oral Health Component of Broader Needs Assessment Tool</td>
<td>Marianne Beaty, State Manager Quality Improvement Projects</td>
</tr>
<tr>
<td>Peninsula Health Complex Care Program</td>
<td>Member of working group</td>
<td>Karen Bull, Program Manager Complex Care</td>
</tr>
<tr>
<td>Peninsula Health Community Health</td>
<td>Member of working group</td>
<td>Team Leaders Early Intervention in Chronic Disease Programs</td>
</tr>
<tr>
<td>Peninsula Health – Chronic Disease &amp; Aged Services</td>
<td>Member of working group</td>
<td>Iain Edwards, Director</td>
</tr>
<tr>
<td>Peninsula Health Planned Activity Groups</td>
<td>Member of working group</td>
<td>Kay Wrangles, Coordinator</td>
</tr>
<tr>
<td>Peninsula Health Acute- Allied Health Department</td>
<td>Member of working group</td>
<td>Karen Edis, Head of Dietetics</td>
</tr>
<tr>
<td>Pendap</td>
<td>Member of working group</td>
<td>Stephen Bright OWL</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Advisor</td>
<td>Dr Sarity Dodson, Industry Advisor, ICDM PCP Support</td>
</tr>
<tr>
<td>Frankston Mornington Peninsula Primary Care</td>
<td>Member of working group</td>
<td>Lyn McKay, SSR Coordinator</td>
</tr>
<tr>
<td>Partner Organisation</td>
<td>Roles and responsibilities with regard to the project</td>
<td>Contact person details (name, position)</td>
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<tr>
<td>Partnership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frankston Mornington Peninsula Primary Care Partnership</td>
<td>Member of working group</td>
<td>Amy Moore, IHP Coordinator</td>
</tr>
</tbody>
</table>

**Phase 2 - Broader Rollout – Part 1 – Tool Adaption, Pilot and Evaluation**

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Role</th>
<th>Contact person details (name, position)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mornington Peninsula Shire</td>
<td>BNA Project Group</td>
<td>Peter Cracknell, Team Leader, Mornington</td>
</tr>
<tr>
<td>Mornington Peninsula Shire</td>
<td>BNA Project Group</td>
<td>Julie Cahill, Team Leader</td>
</tr>
<tr>
<td>Frankston City Council</td>
<td>BNA Project Group</td>
<td>Leonie Rients, Manager</td>
</tr>
<tr>
<td>Frankston City Council</td>
<td>BNA Project Group</td>
<td>Gretchen Strauss, Coordinator, Community Care</td>
</tr>
<tr>
<td>Frankston City Council</td>
<td>BNA Project Group</td>
<td>Isobel Siebel, Assessment Officer</td>
</tr>
<tr>
<td>Frankston Mornington Peninsula Primary Care Partnership</td>
<td>Project Facilitator</td>
<td>Lyn McKay, SSR Coordinator</td>
</tr>
<tr>
<td>Peninsula Health Community Health</td>
<td>Project Facilitator</td>
<td>Julie White, Chronic Disease Coordinator PHCH &amp; PCP ICDM Support Officer</td>
</tr>
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</table>

**Phase 2 - Broader Rollout - Part 2 – Assessment Practice Mapping**

See list of partners identified in project participants section below below.

<table>
<thead>
<tr>
<th>Case Study Title</th>
<th>Project Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>BROADER NEEDS ASSESSMENT PROJECT</td>
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</table>

**Summary/Abstract (200 words)**

The development, piloting and broader rollout of a Broader Needs Assessment Tool has been an important step in fulfilling an identified need for a more holistic, coordinated and systematic approach to client care and a move away from the current problem-oriented/discipline-specific focus on health.

The primary purpose of the Broader Needs Assessment Tool is to identify the broader needs of the client beyond their presenting issue. The aim is to do this in a structured, systematic and evidence based approach which is sensitive to the uniqueness of the client and the social context in which they live. It also provides opportunity for early identification of social, lifestyle issues and individual capacity to support appropriate chronic disease management.

The development of a Broader Needs Assessment Tool and supporting framework for use by service providers has been undertaken to:

- enable greater access to primary health care services for the broader health needs of chronic and complex clients
- minimise the impact of physical health issues on clients and improve quality of life and health outcomes
- embed a client centred approach to assessment across services
- provide a holistic assessment which improves and more effectively support care
Name of Project | Broader Needs Assessment (BNA) Project
---|---
**Target client group** | The target population is:
- Diabetes
- Cardio Vascular disease
- COPD
- Mental health conditions
- Aboriginal and Torres Strait Islanders (ATSI)
- Family Violence
- HACC clients
- HARP Frequent Presenters

**DHS ICDM expectations 2009-12** | The Broader Needs Assessment project has been undertaken to:
- enhance, strengthen and support improved assessment care planning and care coordination practice using a PDSA approach
- provide the tools and agreements which enhance the capacity of the local workforce
- provide best practice care and support for client self management
- improved capacity to identify complex client needs beyond presenting issue and support early identification and intervention capability to enhance client care
- measure and monitor the impacts of activity supporting organisational change, continuous quality improvement and improved quality of care delivered to clients with chronic disease

**Background** | PHCH in partnership with other PCP members has undertaken the development of the Broader Needs Assessment tool over the last 18 - 20 months via a rigorous development processes. Assessment was identified as one of the priority work focuses of the PCP. This project is part of the FMPPCP strategic planning and vision for a more streamlined approached to client care.

This project capitalises on the work undertaken through Community Health. Initially, a decision was made to examine broad assessment practice in Community Health. The intention from the beginning was to then extend the work of the development of an appropriate tool to other FMPPCP service providers.

It also results from a collaborative review of the FMPPCP catchment EIICD, HIP and ASM Implementation plans along with the findings of the Client Journey Experiential Study and SC/ICDM DH Surveys findings which identified the need to strengthen assessment processes beyond the presenting issue to enhance care planning and care coordination for clients with chronic and complex conditions.

The project is an ongoing 3 phase project consisting of:

- **Phase 1 – Initial Development & Pilot** - The development of the initial tool for use within Community Health. The tool has been subsequently
assessed for use by other services within Peninsula Health supporting the notion of the use of a common tool for the identification of needs beyond the presenting issue and to reduce duplication in clients needing to tell their stories repeatedly.

- **Phase 2 – Broader Rollout - Part 1 Tool Adaptation, Pilot and Evaluation** - the further adaption/development and piloting of a ‘Living at Home’ Assessment tool for use in Local Government by assessment officers providing HACC services and supporting ASM implementation. The tool is currently being piloted within local government. The results of the pilot should be available in October/November 2011.

- **Phase 2 - Part 2 – Assessment Practice Mapping** - intended to:
  - document and analyse current assessment as well as care planning and E-Referral processes, practices, tools, client focused care and self management supports for Assessment, Care Planning and E Referral, and
  - provide more detailed benchmarking data against service practice standards and information to inform the advancement of client centred chronic disease management and service coordination allowing more specifically targeted work to be undertaken in the FMPPCP catchment.

- **Phase 3 - Catchment Wide Rollout of BNA** - longer term process - establishment of a catchment wide plan for further rollout of tool among other agency/service types – yet to be undertaken.

Consumers were engaged in providing feedback during the developmental and pilot phases of the project giving valuable information about the usefulness of the tool in its various phases.

In its development and piloting the BNA tool has been subjected to an audit and benchmarking process against evidence based practice. This has included a focus on:

1. Identifying evidence to support a client centred approach
2. Identifying which broader needs of the client are flagged during the current assessment practice
3. Clarifying and identifying domains identified as necessary for holistic assessment processes
4. Identification of the links required from assessment to improve care planning
5. Integrating self management prompts into the assessment process
6. Identifying a clear evidence base to direct appropriate client pathways

A document titled ‘The Review of Existing Validated Comprehensive Assessment Tools” By the Australian Institute
of Primary Care, in conjunction with the WHO social determinants of health, were used to benchmark all current assessment tools in Community Health and informed the development of the domains contained in the original tool template. The Broader Needs Assessment tool has also been successfully used in the quality improvement initiative for EQUIP accreditation in 2011 at Peninsula Health.

The tool was used as the basis of a review and adaption of the existing “Living at Home” Assessment tool used within Local Government HACC services to ascertain the expanded and adapted version usefulness and applicability. It also moved these services along the path to providing a common assessment standard format which would enable a more effective tool for their use.

An audit & evaluation framework was also developed linking chronic disease best practice (WAGNER et al) to the existing EQUIP framework. The Victorian Service Coordination Practice Manual standards were also utilised in benchmarking for the framework. The audit and evaluation framework was subsequently modified to suit the audit and evaluation process to evaluate the pilots run within two local governments.

All phases of this project have been, and continue to be, supported by a robust governance and reporting structure through the FMPPCP Service System Redevelopment Committee comprising a broad range of PCP member agency types. This reporting structure has enabled feedback into the process with a view that, following piloting of the tool both within Community Health and Local Government further broader deployment may occur across the other PCP member agencies.

To date the tool has been piloted by the following services:

- Peninsula Health Community Health:
  - HARP
  - EIICD
  - Koori
  - Drug & Alcohol
  - Counselling
  - DOMCARE
- Local Government
  - Frankston City Council
  - Mornington Peninsula Shire Council

**Objectives**

The Broader Needs Assessment Project aims to support clients by doing the following:

- Increasing capacity for early identification of factors which may be impacting on the clients ability to self manage their condition/conditions and which may place them at risk
- Integrating a health promotion approach within the assessment phase of the client journey
- Encouraging the adoption of a common and standardised approach to client care which can be
• tracked and measured

• Supporting the provision of integrated care between settings and services by raising awareness of existing services and how they can contribute to a multi disciplinary approach to client care

• Improving access to primary health care for all people with an emphasis on clients who are marginalised and vulnerable

• Embedding a client centred approach to assessment across a broad range of health services

• Developing an assessment framework and tool which:
  o Enables effective identification of needs beyond the presenting issue
  o is inclusive of process, practice and protocols to support implementation
  o enables a systematic and evidence based approach to identifying the broader needs of the client
  o integrates self management in to the assessment process
  o could be easily used by a range of service providers and services providing a common platform for improving assessment practice
  o provides systems and tools that promote information sharing and care coordination between services
  o ensures that the Victorian Service Coordination tools and templates are integrated within the Broader Needs Assessment process, protocols and practice adopted.

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Project participants

**Phase 1 – Community Health – Initial Development & Pilot**

• Dr Sarity Dodson – Industry Advisor ICDM PCP Support
• Dental Health Services Victoria – State Manager, Quality Improvement Projects
• Vicki Davies – Manager Falls Prevention Service, Peninsula Health Sub Acute
• Karen Edis – Director Dietetics, Peninsula Health Acute
• Dr Priscilla Yardley – Peninsula Health Mental Health Coordinator
• Emma Harris – Team Leader, Health Promotion PHCHS
• Karen Bull – Program Manger, Complex Care PHCHS
• Dean Gresle – Physiotherapist, PHCHS
• Lyn Murdoch – Team Leader Early Intervention In Chronic Disease, PHCHS
• Erin Farnbach Team Leader Early Intervention in Chronic Disease, PHCHS
• Iain Edwards – Director Chronic Disease & Aged Services, PHCHS
• Kay Wrangles – PAG Coordinator PHCHS
• Jean Phillips, Program Manager Mi Health PHCHS
• Dion Davis – ATSI Program
• Kate McCabe – Podiatrist PHCHS
• Dave Kelly – Peninsula Drug and Alcohol Program PHCHS
• Susan Dal Lago – Team Leader, Counselling, PHCHS
• Leisl Jackson – Senior Program Manager, Peninsula General Practice Network
• Stephen Bright – OWL Project Coordinator
• Jenny Collins – Dual Diagnosis Project
• Lyn Gray – Program Manager, Cognition and Dementia and Memory Service
• Lyn McKay – Frankston Mornington Peninsula Primary Care Partnership
• Julie White – ICDM Coordinator, PHCH/ICDM Support Officer, FMPPCP
• Amy Moore – Frankston Mornington Peninsula Primary Care Partnership

**Phase 2 - Broader Rollout**

**Part 1 – Tool Adaption, Pilot and Evaluation**
• Peter Cracknell – Team Leader, Mornington Peninsula Shire
• Julie Cahill – Team Leader, Mornington Peninsula Shire
• Leonie Reints – Manager Aged Services, Frankston City Council
• Gretchen Strauss – Coordinator, Community Care, Frankston City Council
• Isobel Siebel – Assessment Officer, Frankston City Council
• Lyn McKay – Frankston Mornington Peninsula Primary Care Partnership
• Julie White – ICDM Coordinator, PHCH/ICDM Support Officer, FMPPCP

**Part 2 – Assessment Practice Mapping**
• Brotherhood of St Laurence
• Commonwealth Carer Respite & Carelink Centre
• Frankston City Council
• Mind Australia
• Mornington Peninsula Shire Council
• Peninsula GP Network
• Peninsula Health:
  o HARP
  o Service Access
  o PENDAP - Anxiety & Depression – Youth
  o EIICD
  o Koori
  o Community Mental Health Services
• Peninsula Support Services
• RDNS
• Villa Maria Southern
• Southern Cross Care

**Methodology & Approach**

**APPROACH**

We have taken a multi phased approach to this project over a 3 year period which commenced in 2010:

- Phase 1 - Community Health – Initial Development & Pilot
- Phase 2 - Broader Rollout
  - Part 1 – Tool Adaption, Pilot and Evaluation – pilot beyond Community Health
  - Part 2 – Assessment Practice Mapping – multi agency/services Ax/Care Planning/E-Referral & Feedback audit
• Phase 3 - Catchment Wide Rollout of BNA – this phase incorporates the development of a further rollout implementation plan to be undertaken following successful completion of Phase 2 – Part 1 & 2

METHODOLOGY
The project has conducted been via:

• **Phase 1 - Community Health – Initial Development & Pilot (see Appendix 1)**
  o Steering Committee and an external consultant was utilised to identify the domains for inclusion in the template. Task teams were convened to:
    • progress the template domains
    • provide input on the following areas of Health Conditions, Psychosocial Wellbeing and Health Related Behaviour
  o Pilot evaluation conducted and report write up via project manager
  o Documented clinician/management involvement at all stages of development

• **Phase 2 - Broader Rollout – Part 1 - Tool Adaption, Pilot and Evaluation (see Appendix 1)**
  o Working Group comprised of Local Government, Community Health and PCP to:
    • Conduct a review of currently utilised templates against a variety of other template sources including the tool developed and implemented in Phase 1
    • Establish agreements around conduct of pilot and tool modifications/adaptions
    • Modify ‘Living at Home’ Assessment tool
    • Pilot of new BNA tool
    • Evaluate pilot
    • Deploy consultant to conduct independent evaluation of pilot and report write up

• **Phase 2 - Broader Rollout Part 2 - Assessment Practice Mapping**
  o Deployment of a consultant to conduct the mapping process via face to face interviews with a raft of PCP members agencies/services across a range of service types

• **Phase 3 - Catchment Wide Rollout of BNA** – methodology yet to be determined. There will be a process to develop a rollout strategy for the catchment.

FRAMEWORK
The BNA project implemented the following framework for Phase 1 with similar framework for Phase 2 – Part 1:

1. **Consumer Input**
2. **Service Provider**
   • Pre Pilot Survey “Client Centred Care” / “Applicability and Practicability” of the template
     / Client Journey
   • Post Pilot - Focus group following pilot/ tool/ “Applicability and Practicability” of the template Inter rater reliability of the tool
3. **Audits**
   • Medical or client Record file audit pre and post implementation identifying compliance with minimum agreed practice standards
4. **Training and workforce development**
5. **Continuous improvement framework**
   • Development of key performance indicators for annual review based on above
6. **Project evaluation**
   • Utilisation of the FMPPCP Project Evaluation Framework identifying strengths and gaps of project process and methodology at various stages of the project
RESOURCES:
Project implementation supported by well developed resources such as:

Broader Needs Assessment (BNA) Broader Rollout – Project Brief
Outlined details of the Assessment Project relating to the broader rollout of the Broader Needs Assessment (BNA) tool).

BNA project Workplan/Gantt chart
This included details of activities relating to the project and indicative timelines.

Pilot Evaluation Framework (see Appendix 3)
The Evaluation Framework supports service provider feedback in relation to the common assessment tool pre and post the pilot implementation phase. It is made up of differing elements in the form of a questionnaire. It is designed to determine the veracity of the assessment tool being piloted including impacts, if any, on:

- the assessment process
- the client in the provision of a holistic process and approach to identifying needs beyond the presenting issue
- improving care planning processes
- improving appropriate referral processes

Mapping Tool
Developed for the use in Phase 2 – Part 2 – Mapping of Assessment to identify current practice and tools used. Includes obtaining information about:
1. assessment policy and procedures
2. types of assessment carried out in the organisation
3. strengthening assessment
4. staff undertaking assessment
5. tools used
6. staff practice – use of work instructions, practice manual, discipline specific guidelines
7. How assessment of self management capacity and interest is built in to assessment processes and tools
8. How is assessment is linked to care planning
9. Use of any of the following processes to evaluate assessment practice in an organisation?
   - File audits
   - Supervision
   - PDSA cycles

FMPPCP Project Evaluation Framework
Developed for the purpose of assessing the effectiveness of the project across a raft of project work parameters.

Results

<table>
<thead>
<tr>
<th>Service improvement and innovation</th>
<th>The Varying Nature of a BNA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The tool has required modification to reflect the varying need of different service types, the level of staff and the scope of practice in the staff understanding of the Ax process.</td>
</tr>
<tr>
<td></td>
<td>In all cases the tool has embedded self management supports into the assessment process.</td>
</tr>
<tr>
<td>Innovation Examples Across Diverse Settings</td>
<td>Community Health</td>
</tr>
<tr>
<td></td>
<td>Innovations include:</td>
</tr>
<tr>
<td></td>
<td>• The 5 A’s model utilised to promote motivational interviewing and</td>
</tr>
</tbody>
</table>
Health Coaching approaches

- A visual scale identifying perceived importance of the health issues. Previously there was no way of demonstrating client involvement in the assessment processes. Now there is a systematic way of identifying client needs based on their wishes and perceived needs
- also embedded a stage of change indicator to assist with motivational interviewing
- development of mechanisms to audit assessment processes and practices which previously did not occur

Local Government

Innovations include:

- The review and adaption of each of their tools to suit community based HACC services identified differing levels of information reflected in different tools used by each of the local governments. Subsequently, a joint agreement to use the same tool for the pilot phase of the project was made. This meant the inclusion of specific information domains not previously used in the tools of each Local Government.

The adapted tool has been instrumental in providing a common assessment platform for Local Government. This has resulted in an improved tool for their use which identified the broader needs of clients allowing earlier identification of issues for complex clients with multiple needs.

Client Engagement

Clients have been an active part of this service development initiative.

Workforce Capacity Building

- Prior to the pilot or use of the template training and workforce development was utilised and evaluated
- In Community Health position descriptions were amended and supported by a recommendation that all people coming into community health have either health coaching or motivational interviewing experience. If a person comes into community health with no experience of the above it will be achieved within 6 months of employment. This has become a performance standard.

Service Improvement

Organisationally the Broader Needs Assessment will aid in raising the platform for clients within a number of key population health groups conditions. For example, those with:

- Diabetes COPD
- Cardio vascular
- Mental health conditions
- Family violence/Elder abuse
- ATSI program

It is anticipated that, following further discussion and clarification about the inclusion/ exclusion criteria, resulting from the running of both pilots and their evaluations to date, clients entering programs/services will continue to have a Broader Needs Assessment conducted.

With the development of the Broader Needs Assessment Tool we believe that these agencies can now progress to care planning knowing that it is being informed by a truly client centred approach.

Outcomes

1. Broader Needs Assessment Tool developed and piloted within Community Health using PDSA approach.
2. Broader Needs Assessment Tool adapted for use by HACC service providers and piloted in two local governments using PDSA approach.
3. The Broader Needs Assessment tools developed to meet HACC compliance requirements.
4. Ax documented in a common, standardised format.
5. Key medical, functional, lifestyle, social and psychological information included within tool to enable documentation.
6. Self management supports embedded into assessment tools.
7. Pilot supporting strategies developed and implemented.
9. Key performance indicators developed for each domain and an ongoing continuous improvement framework developed for Community Health.
11. A training and workforce development strategy developed for use in Community Health to support full implementation of tool. LGA piloting tool also developed workforce support strategy in use of new tool.
12. Change Management strategy developed to support implementation.
13. Pilot evaluation tool developed and used.
14. Mapping of existing Ax tools & practice across a broad range of service provider/services types currently being conducted to provide baseline data to enable further broad BNA rollout.

**Preliminary Pilots Findings**
Following are some preliminary findings resulting from the pilot. The full pilot results from Phases 1 & 2 will be available later in 2011.

**Peninsula Health Community Health**

**Initial Survey**

In response to an initial survey conducted of those trialling the tool:

- 57.1% believe the BNA identifies the broader needs of the client more efficiently than the template previously used.
- 66.6% stated that the BNA usually (of the 66.6%, 13.3% stated always) identifies client needs and capacity.
- 66.6 % stated that the BNA usually (of the 66.6%, 20% stated always) helps to determine other services that may be required. This increases the potential and capacity for making more appropriate referrals.
- 66.7% identified that the BNA enables the discussion of care goals with the client and relevant others.
- 66.7% identified that the BNA helps to inform the development of a care plan.
- 57.2% identified that the BNA assists clients in determining their issues and identifying their needs.

**File Audit Results**

Below is a sample of the pre and post file audit results as part of the pilot evaluation process indicating substantive improvement in the identification of needs beyond the presenting issue and providing increased opportunities for appropriate early intervention, referral, care planning support for clients:

<table>
<thead>
<tr>
<th>HEALTH</th>
<th>% of files that asked</th>
<th>% of files that</th>
</tr>
</thead>
</table>

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### CONDITIONS Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>% of files that asked about the domain PRIOR to the BNA template</th>
<th>% of files that asked about the domain WITH the BNA template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring Signs and Symptoms</td>
<td>29.1%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Ability to get to appointments (transport)</td>
<td>6.25%</td>
<td>77.7%</td>
</tr>
<tr>
<td>Confidence at appointments (client engagement with service questions)</td>
<td>2.08%</td>
<td>77%</td>
</tr>
</tbody>
</table>

### MENTAL HEALTH & WELLBEING Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>% of files that asked about the domain PRIOR to the BNA template</th>
<th>% of files that asked about the domain WITH the BNA template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Activities (isolation flag)</td>
<td>39.5%</td>
<td>80.50%</td>
</tr>
<tr>
<td>Culture, Values and Religion</td>
<td>0%</td>
<td>50%</td>
</tr>
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### HEALTH RELATED BEHAVIOUR Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>% of files that asked about the domain PRIOR to the BNA template</th>
<th>% of files that asked about the domain WITH the BNA template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health</td>
<td>17.0%</td>
<td>87.87%</td>
</tr>
<tr>
<td>Gambling</td>
<td>0%</td>
<td>73.5%</td>
</tr>
</tbody>
</table>

**Interesting point:**

- 100% of staff identified in the pilot that they were able to collect the information with their current level of training. However, the qualitative responses demonstrated repeatedly a lack of understanding around decision supports for social determinants screening and rationale beyond presenting issue.

The variation in staff perceptions, as opposed to actual practice, has previously been identified in the FMPPCP ‘Client Journey Experiential Study’ in relation to other practice issues. This finding also supports the Client Journey Study findings.

The construct and use of the tool also presented challenges which will be addressed in a modification process yet to be undertaken.

**Local Government**

The pilot phase is still being completed. It is yet to be formally evaluated. However, the following preliminary comments from a pilot phase joint meeting of the two local government during trialling the tool gives a sense of the results from the BNA pilot.

- General agreement that the tool provides a clear and common framework standardising assessments.
- Supports focussed and improved information obtainment.
- Proactive use of the BNA tool is key.
- All the domains included in the tool are considered to be relevant.
- There is agreement that Ax workers wish to continue to use the BNA tool – following some modifications (see challenges below).
- All assessment officers are individuals with different personal styles, different ways of engaging with people – this is reflected in
how the tool has been used. Therefore use of the tools needs to allow for ability of Ax officers to be flexible, accommodating the needs of both client and Ax officer in the Ax process.

- Proposal for the development of a narrative for staff use in training has been made to support tool use.
- Some of the challenges in using the tool include:
  - Flow of tool – suggestions for modifications to the sequencing of the questions have been made which will make the flow of the tool more relevant for use by Ax Officers.
  - Length of tool – some Ax Officers find it good and manageable others too long.
  - Social environment area needs greater depth.
  - Not child friendly – difficult to use when doing a Respite for a child. This will require further work.
  - Formatting – requiring more space within some questions to allow more commentary as required to support Ax process/information by HACC providers.

### Status and sustainability

It has been proven that the tool has applicability across various health care and community settings following some modifications to suit the service provider type using the tool but with the maintenance of key common domains.

Currently the compilation of the pilot findings is being completed. Sharing our experience and outcomes once complete will be given priority.

We are also planning to share the learnings and disseminate the tool more broadly across other PCP organisations for their use if/as applicable and/or undertake further developments to encourage broader adoption.

### Conclusions

#### Key success factors

- The development and piloting of actual broader needs assessment tools which are robust and suitable for use by diverse services.
- Movement towards achieving a common vision for assessment practices for all clients among a diverse range of service providers demonstrated by buy-in to all the relevant processes required to achieve the vision.
- The goodwill demonstrated by all participants.
- Commitment to participating in working groups, mapping processes and other key activities relating to the process.
- The willingness of service providers to utilise the same tool (as in the case of the LGAs) so as to:
  - maintain the timelines for the pilot phase
  - provide opportunity for an ‘apples with apples’ comparisons for the pilot analysis and evaluation processes

#### Key challenges

- Constraints of current system policy practice/programmes within some services functioning as silos and not integrated in their approach.
- Large scale mapping processes to provide sufficient baseline information to continue to support rollout process.
- To meet the goal of fully achieving the broader rollout of a BNA that suits all providers in light of the variable needs of differing service/program/agency types.
- Maintaining the integrity of the BNA and the inclusion of important domains in light of the challenge of broad rollout because of the variable needs.
• Maintaining momentum over a multi-phased project taking several years to implement.

Limitations of the project
• It is challenging to meet all service provider expectations to have enough but not too much information in the tool.
• Development and provision of the tool is only the beginning. The uptake and consistent use of the tool by practitioners is out of the control of the project parameters.

How activities and improvements will be sustained
The Broader Needs Assessment Tool is being embedded into the broader health care system by the following means:

• **In Peninsula Health Community Health**
  1. It is an identified Quality Improvement Initiative linked into organisational quality Frameworks.
  2. It is documented as an organisational wide intended improvement for EQUIP Accreditation in 2011 and beyond
  3. Clinical Practice Guidelines have been developed

• **In Local Government**
  1. The BNA has been designated as the preferred tool for use by all Assessment Officers by both local governments
  2. Will be supported by appropriate workforce development.

• **Other Service Providers - Assessment Mapping/Audit Process** (current activity): will provide the detailed information and impetus for more service providers looking at implementing a BNA tool. It will also provide opportunities to establish agreement to use a common tool to enhance care planning and referral practice among specific service providers in partnership with one another where there are shared client.

Future directions.
• Implementation of Phase 3 which is the further development and rollout of the Broader Needs Assessment tools across a raft of service providers in the catchment.
• The encouragement of the continued embedding of BNA use within the piloting agencies.
• The development and dissemination of a report which outlines the pilot findings from piloting agencies to date.
• The development and dissemination of a report detailing results of the Ax mapping (which also includes care planning & referral/feedback).
• Relevance of findings to other areas of PCPs activity: we aim to disseminate more broadly the findings of this project, there is great emphasis on Care Planning yet a comprehensive accountable assessment process is required to enable good care planning. It is hope that through the dissemination of the learnings and tool more broadly that other organisations will be encouraged to utilise the audit templates and evaluation framework to self assess their own environments.
Appendix 1
Community Health Broader Needs Assessment Tool – Pilot Tool - SAMPLE
This tool is subject to further review and refinement.

<table>
<thead>
<tr>
<th>Name of Agency</th>
<th>UR NUMBER</th>
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<tbody>
<tr>
<td>BROADER NEEDS ASSESSMENT TOOL</td>
<td></td>
</tr>
<tr>
<td>SURNAME ..................................................................................................</td>
<td></td>
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<tr>
<td>GIVEN NAMES ...............................................................................................</td>
<td></td>
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<tr>
<td>DATE OF BIRTH ...............................................................................................</td>
<td></td>
</tr>
</tbody>
</table>

Please fill in if no patient label available

Assessment Date: ……../……/……… Completed by: .................................................................

Discipline: .............................................. Referral Source: .................................................................

SECTION A: HEALTH CONDITIONS

What are your main concerns? .................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

MEDICAL CONDITIONS

Please list all relevant medical conditions
☐ Arthritis ☐ Chronic Lung Disease
☐ Heart Condition ☐ Chronic Pain
☐ Please list other ☐ Do you have allergies? List
☐ Diabetes ☐ Cancer
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Are you able to monitor the signs and symptoms of your condition/s?
☐ Yes  ☐ No

When you notice your early warning signs and symptoms worsening, do you feel confident in managing your condition?
☐ Yes  ☐ No

Do you have a plan to follow if your symptoms get worse?
☐ Yes  ☐ No

Are you able to get to your appointments?
☐ Yes  ☐ No

Do you feel confident in seeking help related to your needs?
☐ Yes  ☐ No

Do you make regular check ups?
☐ Yes  ☐ No

Do you have any problems communicating how you feel at your appointments?
☐ Yes  ☐ No

**MEDICINES**

*Please list current medications including any natural/complementary therapies.*

Do you have difficulty swallowing medications?
☐ Yes  ☐ No

Are you taking your medicines as prescribed?
☐ Yes  ☐ No

Do you get any side effects from your medicines?
☐ Yes  ☐ No  Describe .................................................................

Do you use a Webster/dosette pack/box?
☐ Yes  ☐ No

Do you ever forget to take your medicines?
☐ Yes  ☐ No

Do you regularly miss taking medicines?
☐ Yes  ☐ No

When you feel better do you sometimes stop taking your medications?
☐ Yes  ☐ No

**CARING**

*Do you care for someone who has difficulty caring for themselves?
Do you have any paid help such as Centrelink, HACC, Registered Carer, Respite Care?

☐ Yes  ☐ No
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Do you receive any support from other areas such as church, private help, friends?

☐ Yes  ☐ No
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Do you feel that caring has affected your health or lifestyle

☐ Yes  ☐ No
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

If yes, I am going to read a list of things that other people have found difficult. Would you tell me if any of these apply to you?

☐ Sleep is disturbed
☐ It is a physical strain
☐ There have been changes in personal plans
☐ There have been work adjustments
☐ There have been family adjustments (helping disrupts routine)
☐ There have been other demands on my time (other family members)
☐ There have been emotional adjustments (severe arguments)
☐ It is upsetting to find x has changed so much from their former self
☐ Feel completely overwhelmed
☐ It is inconvenient (helping takes so much time)
☐ Some behaviour is upsetting
☐ It is a financial strain

Any positive answers may require an intervention in that area. A score of 7 indicates a high level of stress.

Consider referral to a counsellor or Carer Advisory and Counselling Service, Planned Activity Groups

PAIN

Do you have any pain? If yes, please rate your pain on average over the last week

☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>Pain as bad as you can imagine</td>
<td></td>
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</tbody>
</table>

Has this pain changed recently?
Describe ........................................................................................................................................
........................................................................................................................................
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Tell me how your pain interferes with your normal activities around the house eg getting up from bed/chair, walking, washing, cooking, toileting.
........................................................................................................................................
........................................................................................................................................
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Have you received treatment for this problem in the past?

☐ Yes  ☐ No

Describe ........................................................................................................................................
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What strategies do you use to help manage pain?
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Do you feel you could use further assistance to manage your pain?
THINKING SKILLS AND MEMORY

*Do you or anyone close to you have any concerns about your memory and thinking with regards to e.g. increased forgetfulness, repeated questioning, wandering.
If yes, has the change been slow in onset or sudden?

Consider referral to CDAMS / GP / OT

FALLS

*Have you had a fall or near miss in the last 6 months?

Do you know what caused the fall or near miss?

- Trip
- Slip
- Blackout
- Dizziness
- Don’t know
- Other

Did you sustain any injuries as a result of a fall?

Do you have a fear of falling?

Have you restricted your activities because you have a fear of falling?

Do you have a personal alarm?

Consider referral to the Falls Clinic / GP / Physio

SELF EFFICACY

*Do you have difficulty carrying out your normal activities/tasks?
e.g. dressing, showering, grooming, toileting, preparing meals, caring for others or shopping?

*Have you had a change in your ability to manage around the home?
e.g. difficulty getting to the shower/toilet, can’t safely exit or walk within the house?

Do you have equipment at home to help you with daily tasks or walking?
e.g. shoe horn, wheelee walker, walking stick?

Do you have any outside assistance (formal through the Council to complete any of the above activities?

Consider referral to Occupational Therapist / local council / GP

EYESIGHT

*When was the last time you had your eyes checked?

< 2 years

> 2 years

Consider Eye Specialist Referral if >2 years

HEARING

*Do you often ask people to repeat themselves?
*Do you find it difficult to follow conversations when there is background noise?  
☐ Yes  ☐ No

*Do others complain that you turn the TV up too loud?  
☐ Yes  ☐ No

*Do you have trouble hearing the phone ring?  
☐ Yes  ☐ No

Consider Audiology / GP feedback/referral

SLEEP

*Do you experience any difficulties sleeping?  

Can you think of anything that is making it difficult to sleep?  
☐ Yes  ☐ No

Have you tried anything to help?  
☐ Yes  ☐ No

Do you use medication to assist you?  
☐ Yes  ☐ No

If yes does the medication work?  
☐ Yes  ☐ No

Would you like to talk to someone about trying to improve your sleep?  
☐ Yes  ☐ No

Consider referral back to GP / relaxation group/ etc for discussion.

MAIN CONCERNS

CLIENT

What are your main concerns in relation to your health and wellbeing?

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CLINICIAN (summarise the key issues)

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AGREED ACTIONS (plan and referrals)

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Clinician: .......................................................... Date: ..........................................................

SECTION B: EMOTIONAL AND SOCIAL WELLBEING

YOUR HOME

*Can you tell me about your current living arrangements?  
* Who do you live with?

..........................................................................................................................................................................................
"How would you describe the relationships with the people you live with or your family?"

☐ Concerns  ☐ No Concerns

Would you like to talk with a counsellor about this?

☐ Yes  ☐ No

"After paying your rent/mortgage do you have enough money for food, bills, and medicines?"

☐ Yes  ☐ No

*If the client is in insecure housing because of inability to pay rent, refer to M.I. Health Program.

### YOUR HEALTH AND WELLBEING

"Over the last two weeks have you felt sad, depressed, stressed or anxious?"

☐ Most of the time  ☐ Sometimes  ☐ No, not at all

"What about in the past?"

If most of the time or sometimes, would you like to talk to a counsellor about this?

☐ Yes  ☐ No

### FRIENDS AND SUPPORTS

"Do you have any hobbies or special interests, such as groups/regular outings with friends?"

☐ Yes  ☐ No  Describe ...........................................................

"How often do you attend these?"

Would you like to talk to someone about this?

☐ Yes  ☐ No

### CULTURAL OR RELIGIOUS NEEDS

"Do you have any cultural, religious values or beliefs that you think are important for us to know?"

If you have trouble communicating, what can we do to help?

☐ Yes  ☐ No

* Do you have difficulty in expressing yourself? (e.g. finding right words)

☐ Yes  ☐ No

* Do you have trouble understanding what others say?

☐ Yes  ☐ No

* If you have trouble communicating, what can we do to help?
MAIN CONCERNS

CLIENT
What are your main concerns in relation to your health and wellbeing?

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CLINICIAN (summarise the key issues)

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AGREED ACTION (plan and referrals)

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Clinician: ................................................................. Date: .............................................................

SECTION C: HEALTH RELATED BEHAVIOUR

SMOKING

*Do you smoke? □ Yes □ No
*Have you ever smoked?
□ Yes □ No □ Previous Years Smoked ………… Years Quit…………

Number of cigarettes per day
Previous QUIT attempts – what worked well? ..........................................................................................................................
..........................................................................................................................................................................................
..........................................................................................................................................................................................

Are you willing to try to stop smoking now or in the near future (i.e. the next 30 days). □ Yes □ No

Explore barriers to quitting, triggers for smoking (e.g. social situations, stress, negative emotions, social support)
..........................................................................................................................................................................................
..........................................................................................................................................................................................

Suggest referral to local QUIT programs/Quitline, GP, give information pack
PHYSICAL ACTIVITY

*What physical activity do you do most and how much do you do each day?*
(e.g. walking, gardening and housework) *(30 min in incremental components per day on at least 5 days per week)*

*Are you interested in becoming more active?*
☐ Yes  ☐ No

What type of physical activity do you most enjoy? (group or alone), hobbies. Explore barriers
............................................................................................................................................................................................
............................................................................................................................................................................................

Consider referral to exercise physiologist/group programs/physiotherapist/GP.

ALCOHOL

*How often do you have an alcoholic drink?*
☐ Never (0)  ☐ < Monthly (1)  ☐ 2-4 times per month (2)
☐ 2-3 times per week (3)  ☐ > 4 times per week (4)

*How many drinks do you have on a typical day?*
☐ 1-2 (0)  ☐ 3-4 (1)  ☐ 5-6 (2)  ☐ 7-9 (3)  ☐ >9 (4)

*How often do you have more than six standard drinks?*
☐ Never (0)  ☐ <Monthly (1)  ☐ Monthly (2)  ☐ Weekly (3)  ☐ Daily or almost daily (4)

If SCORE >6 (or >3 if over 60 years)................................................................................................................................................

Total Score = ..................................................

Your score indicates that alcohol may be impacting on your health. Would you like to talk to our PenDAP/OWL counselors/GP?
☐ Yes  ☐ No

ILLICIT DRUG USE

*Do you use any illicit drugs?* Cannabis, Speed (or Amphetamines), Ecstasy or Heroin
☐ Yes  ☐ No

*Are you concerned about your use of painkillers or prescribed medication?*
☐ Yes  ☐ No

On a scale of 1-10, with 10 being very concerned, how concerned do you feel about your drug use at the moment?
Would you like to talk to our PenDAP counselors about this? □ Yes □ No

Suggest referral to PenDAP/completion of oral health section / GP

---

**GAMBLING**

*Do you or your family have any concerns regarding gambling?*

□ Yes □ No  go to next section

*If the person has concern regarding a friend or family member, suggest referral to Gambler’s Help.*

*If the person has concern regarding their own gambling problem or are unsure if it is a problem, suggest use of the following quiz:*

Thinking about the last twelve months

Have you ever bet more than you could afford to lose? ................................................ 0 1 2 3

Have you ever needed to gamble with larger amounts of money to get the same feeling of excitement? ................................................................. 0 1 2 3

Have you gone back on another day to try and win back the money you have lost? .............. 0 1 2 3

Have you borrowed money or sold anything to gamble? ................................................... 0 1 2 3

Have people criticised your betting or told you that you might have a gambling problem whether or not you thought it true? ................................................................. 0 1 2 3

Have you felt guilty about the way you gamble or what happens when you gamble? ........... 0 1 2 3

Has your gambling caused any health problems, including stress or anxiety? ..................... 0 1 2 3

Has your gambling caused any financial problems for you or your household? .................... 0 1 2 3

0 = never  1 = sometimes  2 = Most of the time  3 = Almost always  TOTAL SCORE:...........

8 or over indicates this may be a high risk problem

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**NUTRITION**

*Has your appetite reduced in the last three months*

□ Yes □ No

* Without wanting to, have you lost or gained more than 3kg over the last three months?*

□ Yes □ No

*Do you have difficulty shopping for food?*

□ Yes □ No

*Do you have trouble swallowing?*

□ Yes □ No

*Do you have difficulty chewing food?*

□ Yes □ No

*Do you cough or choke when eating or drinking?*

□ Yes □ No

*Do you have difficulty preparing food?*

□ Yes □ No

*Do you follow a special diet?*

□ Yes □ No  □ Coeliac  □ Diabetes  □ Other .................................................................

Would you like to see a dietitian?
If you have diabetes, have you seen a dietitian within the last 12 months?  
☐ Yes  ☐ No  

Yes to one or more of the first 5 questions means that nutrition risk exists. Suggest review by dietitian.  

No to last question, suggest dietetic review Complete oral health section

**ORAL HEALTH**

*Do your teeth/dentures have an impact on your eating?*
☐ Never  ☐ Sometimes  ☐ Constantly  
Please describe how........................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

*How much dental pain have you had in the past month?*
☐ None  ☐ A bit  ☐ Lots

*Do you feel uncomfortable when meeting people due to problems with your teeth/dentures?*
☐ No  ☐ Yes  
If yes, describe ........................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

*Do you feel that your dental problems will affect your employment prospects?*
☐ Yes  ☐ No

*If you have diabetes, have you had a check up in the last 12 months?*
☐ Yes  ☐ No  (if no, refer to dental reception)

A healthcare or Pension card is necessary for public dental clinic use.

**MAIN CONCERNS**

**CLIENT**

What are your main concerns in relation to your health and wellbeing?
........................................................................................................................................................................
........................................................................................................................................................................
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........................................................................................................................................................................

**CLINICIAN** (summarise the key issues)
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**AGREED ACTIONS** (plan and referrals)
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Clinician: ................................................................. Date: .................................................
Appendix 2
Local Governments - Broader Needs Assessment Tool – Pilot Tool - SAMPLE
This tool is subject to further review and refinement.

Aged & Disability Services

<table>
<thead>
<tr>
<th>LIVING AT HOME</th>
<th>ASSESSMENT / REASSESSMENT</th>
</tr>
</thead>
</table>

Date of assessment: ________________________
Assessed by (name): ________________________

(NOTE: TOOL NORMALLY INCLUDES INSTRUCTIONS SPECIFIC TO INDIVIDUAL AGENCY)

Who else present at assessment (name): ________________________
Relationship to client: ________________________

SCTT Pages to be printed and reviewed

- Consumer Details
- Caring Arrangements
- Consumer Consent to Share Information (only if need to generate referral)

This tool is to be used by Assessing Officers undertaking assessments and reassessments. Information to be entered into Carelink Plus and then this form attached to the client file.

This tool is flexible in how it is to be used eg it is a prompt so that all areas of assessment are covered and is only a suggested order of questioning.

Consider how the client is presenting and what information the client is presenting. Eg appearance, speech, emotions expressed, thought process and content, sensory perception, mobility, functional and mental capacities.

Active Service Model Principles

1. People want to remain autonomous
2. People have the potential to improve their capacity
3. People’s needs should be viewed in a holistic way
4. HACC services should be organised around the person and carer; the person should not be slotted into existing services
5. A person’s needs are best met where there are strong partnerships and collaborative working partnerships and collaborative working relationships between the person, their carers and family, support workers and between service providers.

ACCESS ISSUES TO PROPERTY
(eg long drive, how to find house, no house number)

- Yes  - No  - Not Explored

(Put details in Carelink Plus “Access Notes”)
ENGAGING CLIENT / CARER / FAMILY

□ Yes  □ No  □ Not Explored

Explain purpose of this visit.

Relate overview of the HACC Program eg enabling people to remain in their own home, funding from Federal, State, and Local Government and eligibility criteria

What are your main concerns in relation to your health and wellbeing?

What do you think you need to remain in your own home?

What has led you to requesting services?

What has changed for you?

If you were healthier, what sort of things would you like to do?

Confirm information referral?

OTHER SERVICES BEING RECEIVED or RECENTLY RECEIVED

□ Yes  □ No  □ Not Explored

Do you have other people visit and provide services?

□ Personal Alarm – please state if MEPAC’s, VitalCall, other (enter under “Equipment” in Carelink Plus)
□ Physiotherapy
□ Falls Clinic
□ Occupational Therapy
□ RDNS – please state service?
□ Careline
□ Services post surgery / PenPAC
□ Podiatrist
□ Palliative Care
□ GP
□ Aged Care Assessment Service (ACAS)
□ Centrelink
□ Dietitian

Other:

SUPPORT AND INTERESTS

□ Yes  □ No  □ Not Explored

What supports do you have (family, neighbours, social networks, church groups etc)?

Do you have any hobbies or special interests groups? How often do you attend?

□ Yes  □ No

Are there any barriers that prevent you accessing your community?
LIVING SITUATION (Accommodation type, condition - hoarding? no. of bedrooms, bathrooms, living areas, volume of hard floors? Planning to move? Geographical location e.g. walk to shops or 5 min drive to shops, lives alone / with partner, family or others)

☐ Yes  ☐ No  ☐ Not Explored

Can you tell me about your current living arrangements?
Who do you live with and how would you describe these relationships?

After paying your mortgage do you have enough money for food, bills and medicines?

☐ Yes  ☐ No  ☐ Not Explored

If NO discuss issues with client and consider referral for counselling and need for material or other support.

If the client is in insecure housing consider referring to M.I Health Program

CARING

☐ Yes  ☐ No  ☐ Not Explored

Do you care for someone who has difficulty caring for themselves?

Do you feel that caring has affected you health or lifestyle?

If yes what has impacted:
☐ Sleep is disturbed
☐ It is a physical strain
☐ There have been changes in personal plans
☐ There have been work adjustments
☐ There have been family adjustments (helping disrupts routine)
☐ There have been other demands on my time (other family members)
☐ There have been emotional adjustments (severe arguments / grief and loss / household disharmony / relationship issues)
☐ Feel completely overwhelmed
☐ It is inconvenient (helping takes so much time)
☐ Some behaviour is upsetting
☐ It is a financial strain

Any positive answers may require an intervention in that area (Consider referral to a GP, counsellor or Carer Advisory and Counselling Service 1800 242 636)

HEALTH CONDITION (List all relevant health conditions)

☐ Yes  ☐ No  ☐ Not Explored

☐ Arthritis  ☐ Disability
☐ Asthma / breathing difficulties  ☐ Do you have allergies - List
Cancer  Heart Condition  
Chronic Lung Disease  Joint Replacement 
Chronic Pain  Memory Loss 
Diabetes  Mental Health Issues 

Please provide details or list other conditions

Do you have any concerns with your health?

Do you have difficulty with your normal activities? 
*E.g. Dressing, showering, grooming, toileting, preparing meals, sleeping, caring for others or shopping?*

Yes  No 

If yes tell me how your health conditions impact on your normal activities with in the house and outside the house?

Do you have equipment at home to help you with daily tasks or walking?

Yes  No 

Are you interested in becoming more active?

Yes  No  
*(If YES provide information / referral for activities and explore options.)*

Have you had a fall or near miss in the last 6 months?

Yes  No 

Have you restricted your activities because you have a fear of falling?

Yes  No  
*(observe clients mobility and environmental factors that may lead to falls risk) (Consider referral to the Falls Clinic / GP / Physiotherapist)*

Do you have trouble with your hearing?

Yes  No 

Do you have trouble with your eyesight?

Yes  No 

Do you have difficulty with continence (bowels and / or bladder)?

Yes  No 

Are you able to get to your appointments?

Yes  No  
*(If No consider Dial A Bus, Disability Parking Permit, Taxi concessions, public transport etc.)*

Have you had a general health check up in the last 5 years?

Yes  No  
*(If NO consider referral to GP)*

**NUTRITION**

□ Yes  □ No  □ Not Explored 

Has your appetite reduced in the last three months?

□ Yes  □ No  

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Page 28 of 39
Without wanting to, have you lost or gained more than 3kg over the last three months?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

Do you have difficulty shopping for food?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

Do you have difficulty preparing food?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

Do your teeth / dentures have an impact on your eating?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

(If YES to one or more of the above questions means that a nutrition risk exists. Suggested review by dietitian.)

EMOTIONAL HEALTH  
(Depressed, teary/upset, cause - loss of loved one, side effects of medical condition e.g. stroke, adjusted to living alone?)

☐ Yes  ☐ No  ☐ Not Explored

Over the last two weeks have you felt sad, depressed, stressed or anxious?  
☐ Most of the time  ☐ Sometimes  ☐ No, not at all

If ‘Most of the time’ or ‘Sometimes’, would you like to talk to someone about this?  
☐ Yes  ☐ No  ……………………………………………………………………………………………………………………………

PAIN

☐ Yes  ☐ No  ☐ Not Explored

Do you have any pain?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

Has the pain changed recently?  
☐ Yes  ☐ No  ………………………………………………………………………………………………………

What strategies do you use to help manage pain?  
…………………………………………………………………………………………………………………………………………

(Consider referral to physiotherapist / GP / Pain Clinic)

THINKING SKILLS AND MEMORY

☐ Yes  ☐ No  ☐ Not Explored

Do you or anyone close to you have any concerns about your memory and thinking e.g. increased forgetfulness, repeated questioning, wandering?

If YES, has the change been slow in onset or sudden?  
…………………………………………………………………………………………………………………………………………

Is there any concern that the client is not capable of making their own decision?  
☐ Yes  ☐ No  ……………………………………………………………………………………………………………………………

List Medications and what they are for.  
…………………………………………………………………………………………………………………………………………

Do you have a Webster Pack or doset box?  
☐ Yes  ☐ No

Do you need prompting with your medication?  
☐ Yes  ☐ No

(Consider medication review)

(Medication details may be needed for a PAV or RDNS referral)
SMOKING
☐ Yes ☐ No ☐ Not Explored

Do you smoke? ☐ Yes ☐ No

(If YES please explain Shire policy “Smoke Free Work Environment”)

(If client interested refer to local QUIT programs / Quitline, GP, provide information)

ALCOHOL
☐ Yes ☐ No ☐ Not Explored

How often do you have an alcoholic drink?
☐ Never ☐ Monthly ☐ 2 - 4 times per month ☐ 2-3 times per week

☐ More than 4 times per week

Would the consumption of alcohol present a risk to service delivery?
☐ Yes ☐ No If YES how will this risk be managed?

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

(Put details on Care Plan)
(If Client interested refer to Pendap)

GAMBLING
☐ Yes ☐ No ☐ Not Explored

Do you or your family have any concerns regarding gambling?
☐ Yes ☐ No

(If Yes consider referral to gambles help or give client information)

POWER OF ATTORNEY
☐ Yes ☐ No ☐ Not Explored

The appointment of a power of attorney allows someone else to make decisions on your behalf.

Do you have any of the following?
☐ Yes ☐ No General Power of Attorney
☐ Yes ☐ No Enduring Power of Attorney (Financial)
☐ Yes ☐ No Enduring Power of Attorney (Medical Treatment)
☐ Yes ☐ No Guardianship

(If Yes sight the original and gather a copy of the information)

…………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

CULTURAL / SPIRITUAL / BELIEF CONSIDERATIONS
(Language and dialect - needs CCW who speaks same language, customs / practices / religion)
☐ Yes ☐ No ☐ Not Explored

Do you have any cultural, religious values or beliefs that you think are important for us to know?

…………………………………………………………………………………………………………………………

FUNCTIONAL CAPACITY - How does client manage / how do they participate in their own care?
☐ Yes ☐ No ☐ Not Explored

1 Independent 2 With some help 3 Full assistance required
<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>House work / Laundry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(able to drive, has Disability Parking Permit,)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(unable to drive, taxi concession, public transport, dial-a-bus)</em></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Shopping for food / household items</td>
<td></td>
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<tr>
<td>Eating / Meal Prep</td>
<td></td>
<td></td>
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<tr>
<td><em>(able to cook - able to stand for extended periods)</em></td>
<td></td>
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<tr>
<td>Managing Money</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(change of address form, Centrepay)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility / Walking</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Mobility / Transfers</td>
<td></td>
<td></td>
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<tr>
<td>Equipment / Safety Aids</td>
<td></td>
<td></td>
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<tr>
<td>Self Care - Showering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Care - Dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet Use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Bowels/ bladder)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><em>(Hearing/visual impairment, speech deficit, CALD)</em></td>
<td></td>
<td></td>
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<tr>
<td>Memory problems / Confusion</td>
<td></td>
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<tr>
<td>Does the person have any behavioural problems that may impact on service delivery eg aggression, wandering or agitation?</td>
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<tr>
<td><em>(Put details on Care Plan, Consider appropriate support services)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>(Check that all “Consumer Information” from SCTT has been collected)</em></td>
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</tr>
</tbody>
</table>

**EMERGENCY CONTACT DETAILS**

Explain reason for emergency contact details and how they are used in the event of client not at home. *(Where possible person not living at same address)*

**Emergency Contact 1**

Name: ........................................................................................................................................
Phone Number
Address
Relationship to client

Emergency Contact 2
Name
Phone Number
Address
Relationship to client

Emergency Contact 3
Name
Phone Number
Address
Relationship to client

OUTCOMES / ACTIONS FROM ASSESSMENT (rationale for priority and services)

Assessed Priority

☐ High
☐ High - Short Term
☐ Medium
☐ Low

A&DS HACC Care Plans to be completed / Services to be Provided

☐ General Home Care
☐ Delivered Meals
☐ Personal Care
☐ Respite Care
☐ Home Maintenance

External Referrals to be completed

BRIEFING WITH TEAM LEADER REQUIRED PRIOR TO SERVICE ALLOCATION - (Short-term and High priority MUST be discussed)

☐ Yes  ☐ No
ROSTERING INFORMATION (frequency and service length e.g. times wkly x 30 mins per visit, days NOT available, exclusions e.g. male carers only, short-term service, priority & brief rationale)

POST ASSESSMENT AND REASSESSMENT ACTIONS CHECKLIST

Client:………………………………… Assessment/ Reassessment date: ………………

<table>
<thead>
<tr>
<th>Yes</th>
<th>N/A</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>All contact details correct</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Advised System Officer of address/billing address change</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Client status Active</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Funding details completed</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>End date deselected</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>End date - send reminder</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Task list created and comments added</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Debtor number and charge rate completed</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Days selected as per service needs</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Assessment and review date completed (referrals page)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Assessment shift created</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Assessment date completed (in client tree)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Relevant documents electronically attached in CI + e.g. care plans, referrals letters, copies of faxes</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Access notes to properly updated</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>SCTT fully completed as appropriate</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Language, disability, medical condition selected as appropriate</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Preferences selected</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Client notes updated</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Links set</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Equipment / training noted (and organised)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Team Leader briefed (and given copy of Care Plan(s))</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Delivered meals plan (hard copy) given to and reminder sent CFSO</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Home maintenance requests managed</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>All messages / reminders / alerts set as appropriate</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>External referrals made / current client consent in place and documented</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>OH&amp;S issues addressed as appropriate - Identified and risk management in place</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Client details place on allocation list</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Care plans / fee for service forms posted to client</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hard copy file updated</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Followed up with referring organisation as required</td>
</tr>
</tbody>
</table>

Assessing Officer:     Date:
Appendix 3
Broader Needs Assessment Tool Pilot Evaluation Framework

The following evaluation framework is being used to evaluate the BNA pilot with local government. It has been adapted from evaluation framework used for Community Health for use in LGA pilot.

Broader Needs Assessment Tool Evaluation Framework

The Evaluation Framework supports service provider feedback in relation to the common assessment tool pre and post the pilot implementation phase.

The Evaluation Framework is made up of differing elements in the form of a questionnaire. It is designed to determine the veracity of the assessment tool being piloted including impacts, if any, on:

- the assessment process
- the client in the provision of a holistic process and approach to identifying needs beyond the presenting issue
- improving care planning processes
- improving appropriate referral processes

Section A: Practicability /Applicability

Section A of the questionnaire aims to document and analyse the practical application and applicability of the template.

Section B: Assessment and Care Coordination

The Assessment/Care Coordination portion of the questionnaire documents and analyses practice in relation to use of the tool. It has been developed utilising current practice standards from the Victorian Service Coordination Practice Manual 2009.

It is proposed that Section B will be conducted post the pilot trial and compared against results of Section C of the BNA Assessment tools.

Section C: Client Record Audit template

- The Client Record Audit forms a comparative against the service provider’s responses from Section B.
- It is proposed that Section C will be conducted both pre and post the pilot trial.
- The pre and post audits will be conducted on files of the same Ax worker.
- The pre audit will include client files older than 12 months – can be done on different clients.
- The post section will include client files less than 4 months and included in the assessment trial.

**Formula:**

\[
\text{Total # files} = \frac{\text{X Time} + 1}{2}
\]

Pre Audit - # client files – prior to pilot (eg. 12 months over a 3 month period)
Post Audit - # client files (new clients) – pilot period to benchmark old against new

**RECORDING RESPONSES**

If an item is not relevant, please mark as N/A on the audit form and adjust the totals accordingly when calculating the percentage score

- √ = for fully compliant
- N/A = Not relevant
- x= Not compliant

If the auditor is unclear whether compliance is satisfactory, unsatisfactory or if extenuating factors precludes compliance, please note this in the audit summary on the final page of the audit tool and discuss this with the person coordinating the audit.

---

1 Adapted from work prepared by: Julie White, Integrated Chronic Disease Management Coordinator & FMPPCP ICDM Support Officer on behalf of the Broader Needs Assessment Working Group - PHCH - September 2010

2 The questionnaire portion of this document has been sourced and adapted from FMPPCP Service System Redevelopment Client Journey Project, “Service Provider Questionnaire” prepared by Lyn McKay, FMPPCP SSR Coordinator and Julie White, FMPPCP SSR Chronic Disease Support Officer on behalf of the Client Journey Questionnaire Task Team and the Client Journey Working Group.

3 Primary Care Partnerships, Victoria, Victorian Service Coordination Practice Manual 2009
## SECTION A: APPLICABILITY/PRACTICABILITY

<table>
<thead>
<tr>
<th>Q1</th>
<th>Did the domains in the BNA support the identification of your client’s needs beyond their presenting issue?</th>
<th>All required domains were relevant</th>
<th>Most of the required domains were relevant</th>
<th>Some of the required domains were relevant</th>
<th>Very few of the required domains were relevant</th>
<th>Please comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>[ ]</td>
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</tr>
<tr>
<td>Q2</td>
<td>Was the depth of information collected appropriate to your programs needs?</td>
<td>Too much</td>
<td>Appropriate</td>
<td>Insufficient</td>
<td>Please comment</td>
<td></td>
</tr>
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<td></td>
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<td>[ ]</td>
</tr>
<tr>
<td>Q3</td>
<td>Was the language in the tool appropriate to A&amp;O officers in speaking with the client?</td>
<td>Language is appropriate</td>
<td>Language is not appropriate</td>
<td>Please comment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>[ ]</td>
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<td></td>
<td></td>
<td>[ ]</td>
</tr>
<tr>
<td>Q4</td>
<td>How would you rate the effort in completing the BNA?</td>
<td>Too much effort</td>
<td>Appropriate Effort</td>
<td>Too little effort</td>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ]</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Q5</td>
<td>Were you able to collect information with your current level of training?</td>
<td>Yes</td>
<td>No</td>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If No please comment on what additional training might be useful</td>
<td>[ ]</td>
<td></td>
<td></td>
<td></td>
<td>[ ]</td>
</tr>
<tr>
<td>Q6</td>
<td>Does the BNA identify the broader needs of the clients more efficiently than previous templates?</td>
<td>Better</td>
<td>Same</td>
<td>Worse</td>
<td>Comments:</td>
<td></td>
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</tbody>
</table>
## SECTION B: ASSESSMENT & CARE COORDINATION ...

<table>
<thead>
<tr>
<th>Q1</th>
<th>Care coordination should be an equal partnership between clients and service providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
</tr>
<tr>
<td>----</td>
<td>----------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2</th>
<th>The broader needs assessment process identifies clients needs and capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>----</td>
<td>-------</td>
</tr>
</tbody>
</table>

Comments:

| Q3 | The BNA is inclusive of the following elements:  
- Social context  
- Psychological context  
- Medical and physical aspects of care  
- Health related behaviour |
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>----</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4</th>
<th>The BNA process enables the discussion of care goals with the client and relevant others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>----</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5</th>
<th>The BNA process helps to determine other services that may be required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td>----</td>
<td>-------</td>
</tr>
<tr>
<td>Q6</td>
<td>The BNA helps to inform the development of a care plan</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Q7</td>
<td>The BNA is sensitive to cultural requirements and language issues</td>
</tr>
<tr>
<td>Q8</td>
<td>The BNA assists clients in determining their issues and identifying their needs</td>
</tr>
</tbody>
</table>
| Q9 | The BNA takes into account:  
  • Health promotion & prevention opportunities  
  • Early intervention approach  
  • Self management capabilities | Always | Usually | Sometimes | Rarely | Never | Don't know |
| Q10| We feedback to the General Practitioner where there are identified medical issues | Always | Usually | Sometimes | Rarely | Never | Don't know |
| Q11| Is there enough information to make appropriate referrals to other services as required? | Always | Usually | Sometimes | Rarely | Never | Don't know |
| Q12| Does the client record include the following:  
  • Client stated agreed issues or problems  
  • Client stated agreed objectives or goals  
  • Client stated and agreed strategies or actions | Always | Usually | Sometimes | Rarely | Never | Don't know |
<table>
<thead>
<tr>
<th>Q13</th>
<th>Are your clients actively involved in developing their treatment/care plans?</th>
<th>Very involved all of the time</th>
<th>Involved some of the time</th>
<th>Told what to do</th>
<th>Not involved at any time</th>
<th>Involved most of the time</th>
<th>Never involved</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Q14</th>
<th>We ask carer/s what their goals are for the care of the client.</th>
<th>Always</th>
<th>Usually</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q15</th>
<th>We are satisfied that our clients’ health needs are well coordinated between services within our agency and with other service providers through appropriate referral. What could be done to improve coordination between our agency and other service providers?</th>
<th>Very satisfied</th>
<th>Mostly satisfied</th>
<th>Mostly dissatisfied</th>
<th>Unhappy</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

Comments:
Recording Responses

- √ = for fully compliant
- N/A = Not applicable
- X = Not compliant

<table>
<thead>
<tr>
<th>SECTION C: CLIENT RECORD AUDIT</th>
<th>File 1</th>
<th>File 2</th>
<th>File 3</th>
<th>File 4</th>
<th>File 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. An assessment form is complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2. The assessment documents the social context in which the client lives</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Q3. The assessment documents medical and physical aspects of care</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4. The assessment documents health related behaviour impacting on client e.g. alcohol/physical activity</td>
<td></td>
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<tr>
<td>Q5. The assessment documents psychological wellbeing of the client</td>
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<tr>
<td>Q6. Client stated needs and goals are documented</td>
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<td></td>
</tr>
<tr>
<td>Q7. The assessment tool has taken into account: •Health promotion &amp; prevention opportunities •Self management capabilities/readiness</td>
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<td></td>
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<tr>
<td>Q8. Outcomes of assessment are clearly documented</td>
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<tr>
<td>Q9. There is evidence of feedback to the G.P. following initial assessment</td>
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</tr>
<tr>
<td>Q10. Where applicable there is evidence that the client has been provided with information e.g. Quit Smoking/Health behaviour modification literature</td>
<td></td>
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<td></td>
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</tbody>
</table>