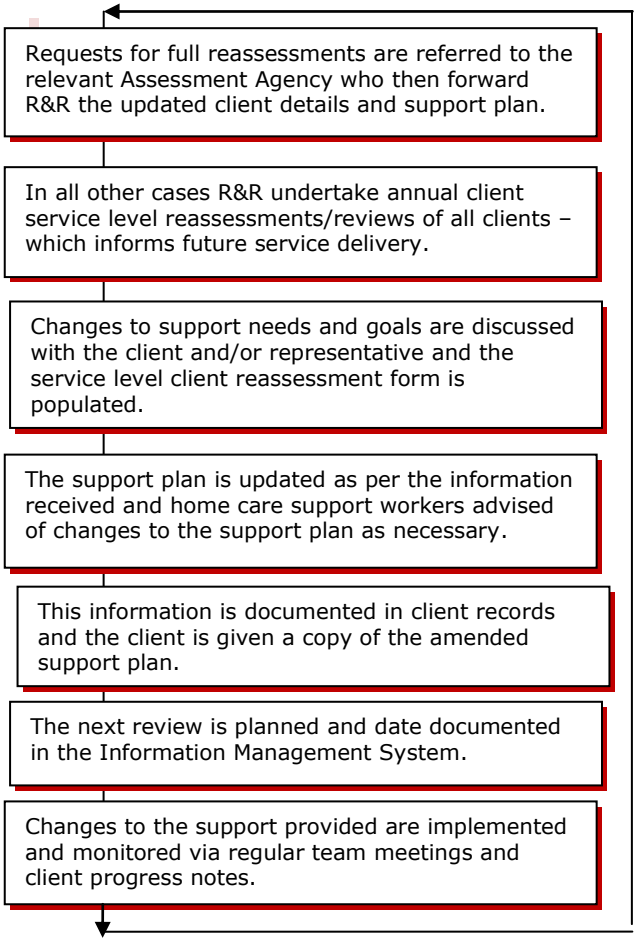
CLIENT REASSESSMENT

Rural & Remote ensures that each client's needs are monitored and regularly reviewed. Each client's care plans are reviewed in consultation with them or their designated representative. If a full and formal reassessment is required, this is done by referring clients back to the relevant authority. The Department of Veteran's Affairs regularly completes 6 monthly client reassessments and the amended support plans are forwarded to the service for action.



FORMS AND RECORDS

Client Assessment Reassessment Form	Client records
Client Assessment Reassessment Checklist	Client records
Client Disaster Management Survey	Client records
Home Safety Checklist	Client records
Reassessment schedule	Information Management System
Referral to Another Agency form	Client records
Client Support/Care plan	Client records

12.1 Client Reviews

12.1.1 REVIEW AND REASSESSMENT PLANNING

All service level assessment/re-assessment and client care/support plan documentation is completed in partnership with the client/carer or nominated representative, has a wellness focus and incorporates the following considerations, in particular those outlined in ***Standard 1 & 2 of the Aged Care Quality Standards:***

- ***Each client is treated with dignity and respect – with their identity, culture and diversity valued***
- ***Care and services provided, are culturally safe and appropriate***
- ***Each client is supported to exercise choice and independence, including to – make decisions about their own care and the way such care and services are delivered; make decisions about when family, friends, carers or others should be involved in their care, and; communicate their decisions, and; make connections with others and maintain relationships of choice, including intimate relationships***
- ***Each client is supported to take risks to enable them to live the best life they can (Dignity of Risk) See Section 11 – Support Planning and Delivery.***
- ***Information provided to each client is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice***
- ***Each client's privacy is respected and personal information kept confidential***
- ***Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services***
- ***Assessment and planning identifies and addresses the client's current needs, goals and preferences, including advance care planning and end of life planning if the client wishes***
- ***Assessment, planning and review is based on an ongoing partnership with the client and others that the client wishes to involve, and includes other organisations and individuals/providers of other care and services that are involved in the care of the client***
- ***The outcomes of assessment and planning (including any identified risks and mitigation strategies) are effectively communicated to the client and documented in a care/support plan that is readily available to the client, and***
- ***Care and services are reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the client.***

And Standard 3 & 4 of the Aged Care Quality Standards:

- ***Each client receives safe and effective care (personal) that is best practice, tailored to their needs and optimises their health and wellbeing***
- ***There is effective management of high-impact or high-prevalence risks associated with the care of each client***
- ***Deterioration or change of a client's mental health, cognitive or physical function, capacity or condition is recognised, recorded and responded to in a timely manner***
- ***Information about the client's condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared***
- ***Each client receives safe and effective services and supports for daily living that meet the client's needs, goals and preferences and optimise their independence, health, wellbeing and quality of life***
- ***Services and supports for daily living promote each client's emotional, spiritual and psychological wellbeing***
- ***Services and supports for daily living assist each client to participate in their community within and outside R&R's service environment, have social and personal relationships and do the things of interest to them***
- ***Timely and appropriate referrals are made to individuals, other organisations and providers of other care and services***
- ***Where meals are provided, they are varied and of suitable quality and quantity, and***

- ***Where equipment is provided, it is safe, suitable, clean and well-maintained.***

All clients are reviewed annually (generally between July and December of each year) and/or reassessed either at our or the client/carer's request if client's needs & circumstances have altered. This internal annual review may trigger the need for a more formal reassessment (where there have been significant changes in function or other capacity), and in this case the client will be referred to the relevant authority.

The need for a more frequent reassessment is triggered by a request for additional supports; a report of hospitalisation, illness or accident; a report of a decline in physical or mental health from:

- Client
- The carer, family or other representatives
- The home care support workers/cluster team leaders/RnR team leader
- A medical practitioner/health or allied health professional or
- Another agency.

The Cluster Team Leaders have responsibility for monitoring and managing the completion of annual client reviews/reassessments in conjunction with support from the RnR Team Leader and Program Manager.

The client support/care plan is then updated to reflect client requirements and a copy is placed in the client file; scanned and attached to the RnR client management system and a copy is given to the client. Home care support workers are also informed by the Cluster Team Leaders of any changes to rosters and services provided and given a copy of the updated plan.

Home care support workers are required to note any changes in client circumstances in progress notes and provide these at least fortnightly to their Cluster Team Leader or immediately if circumstances warrant.

12.1.2 PURPOSE OF REASSESSMENT

The review process involves a reassessment of the client's current circumstances, wellness goals, functional capacity and expressed needs with reference to:

- Their last assessment or review
- Current support/care plan
- Feedback from the client/carer and/or representative
- Input from other health care professionals/agencies and
- Client records which include observations from support staff (home care workers, cluster team leaders or RnR team leader).

The depth of the review is based on the degree of support being provided:

CHSP, QCSS & NDIS Clients

- Clients are normally reviewed annually. Typically interviews occur face to face, however phone reassessments may occur where time or distance preclude the former, or the client receives minimal services and feedback from home care staff suggest that circumstances have not changed.
- If significant changes are identified by the RnR Team Leader/Cluster Team Leader, an in-depth reassessment is completed face to face or the client is referred back to the relevant authority for a more formal reassessment.
- For in-home support clients, if additional reviews are scheduled between annual reviews, they may be conducted by telephone, depending on the clients' requirements. However, if a review occurs a year after the last review, it is conducted face to face to ensure that a new Home Safety Checklist can be completed.

12.1.3 REVIEW PROCESS

Key points of the review process are:

- An interview time is arranged by telephone by the Cluster Team Leader/RnR Team Leader, and the interview takes place at the clients' home and includes an invitation for the clients' representative to be present if required or desired.
- Consideration is given to any special needs the client may have in the review process eg. an interpreter is arranged if necessary, or an advocate or representative is present.

- The review includes:
  - Completion of the Client Assessment/Reassessment Checklist to ensure all relevant documentation is checked, updated or replaced as required
  - Explanation of the purpose of the Assessment/Reassessment
  - Completion of the reassessment form which includes an overview of their activities of daily living, satisfaction with services and staff, and whether there are any other measures that could be taken to improve and support client independence, wellbeing and re-ablement.
  - The clients living situation – who resides with them, do they have anyone to support or assist them, the living environment, safety concerns.
  - The clients current health issues or concerns and whether additional comprehensive assessment is needed.
  - Identification of carer supports and any needs in this area and/or assistance with securing mobility aids etc.
  - Validating and/or changing relevant information e.g. client disaster management survery, NoK information, emergency contact details, client consent, medical practitioner and medication list etc.
  - Checking and/or replacing other client information in the Client Folder e.g. Client Charter of Rights and Responsibilities, Complaints and Advocacy process and contacts, Privacy and Confidentiality, Client contribution guidelines.
  - Referral to other services if required.
  - Support staff feedback.

NOTE: If a review is repeated within a 12 month period, it may be conducted by telephone if appropriate to the needs of the individual.

12.1.4 RESPONSIBILITY FOR REASSESSMENTS

R&R Senior staff (RnR Team Leader, Cluster Team Leaders, Respite Supervisor and Assistant) are trained in completing client assessment/reassessment documentation and any changes to internal or external requirements are communicated well in advance to the staff responsible.

Only staff trained in assessments conduct full/formal reassessments of clients & this is done only by the relevant authority, external to R&R.

R&R annual client reviews are conducted by our Cluster Team Leaders and/or RnR Team Leader if requested by the cluster team leaders.

12.1.5 RECORDING REASSESSMENTS INFORMATION

Client reassessment forms inform the client support/care plan and any changes to the type and frequency of home care service delivery. Once the client reassessment form is completed a new support/care plan is made if there are changes following reassessment or review. Both documents are included in the electronic/information management system and paper records of the client.

12.1.6 INFORMING THE CLIENT

- Changes to service delivery are made in consultation with and explained to the client and/or their representative.
- The client receives updated copies of all relevant information (to be retained in their Client Kit) as soon as possible after the review/reassessment has taken place.

12.2 Monitoring Client Reassessment Processes

Client reassessment processes and systems are regularly audited as part of the R&R audit program and staff, clients and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements can be made (see Corporate Calendar and Section 5: Continuous Improvement).