Department of Communities, Child Safety and Disability Services

Ongoing Needs Identification in Queensland

PART 1

Queensland Government

Ongoing Needs Identification (ONI) in Queensland

PART 1

Core ONI

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Part 1

Ongoing Needs Identification (ONI) in Queensland: How to use the ONI assessment and referral tool

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1 Introduction

The Ongoing Needs Identification (ONI) tool is designed to prompt timely and appropriate service delivery, referral and/or further assessment based on the issues and needs that are identified for each service user.

The term *service user* is used to identify the service user being assessed for services.

The aim of assessing is to differentiate between service users who have:

- low intensity needs and require services
- medium to high needs and require a comprehensive assessment.

This tool can be used in either a telephone or face-to-face interview.

Service providers are encouraged to use this tool when:

- a service user contacts a service provider to request a new service
- a carer, friend, or other service user contacts a service provider to request a new service for a potential service user
- an existing service user contacts a service provider to change any current service or to request a new service
- sharing service user information with other services, with permission, for referrals
- a carer, friend, or other service user contacts a service provider to change a current service or request a new service for an existing service user
- on review.

There are many uses for the ONI information that can be combined in different ways to prompt further action. For example, the information collected can be used to establish a service user's priority rating category, and to describe situations where alerts maybe raised. The information can also be used to establish a care plan or a multi-service provider service coordination plan.

1.1 Glossary of terms — general (A–Z)

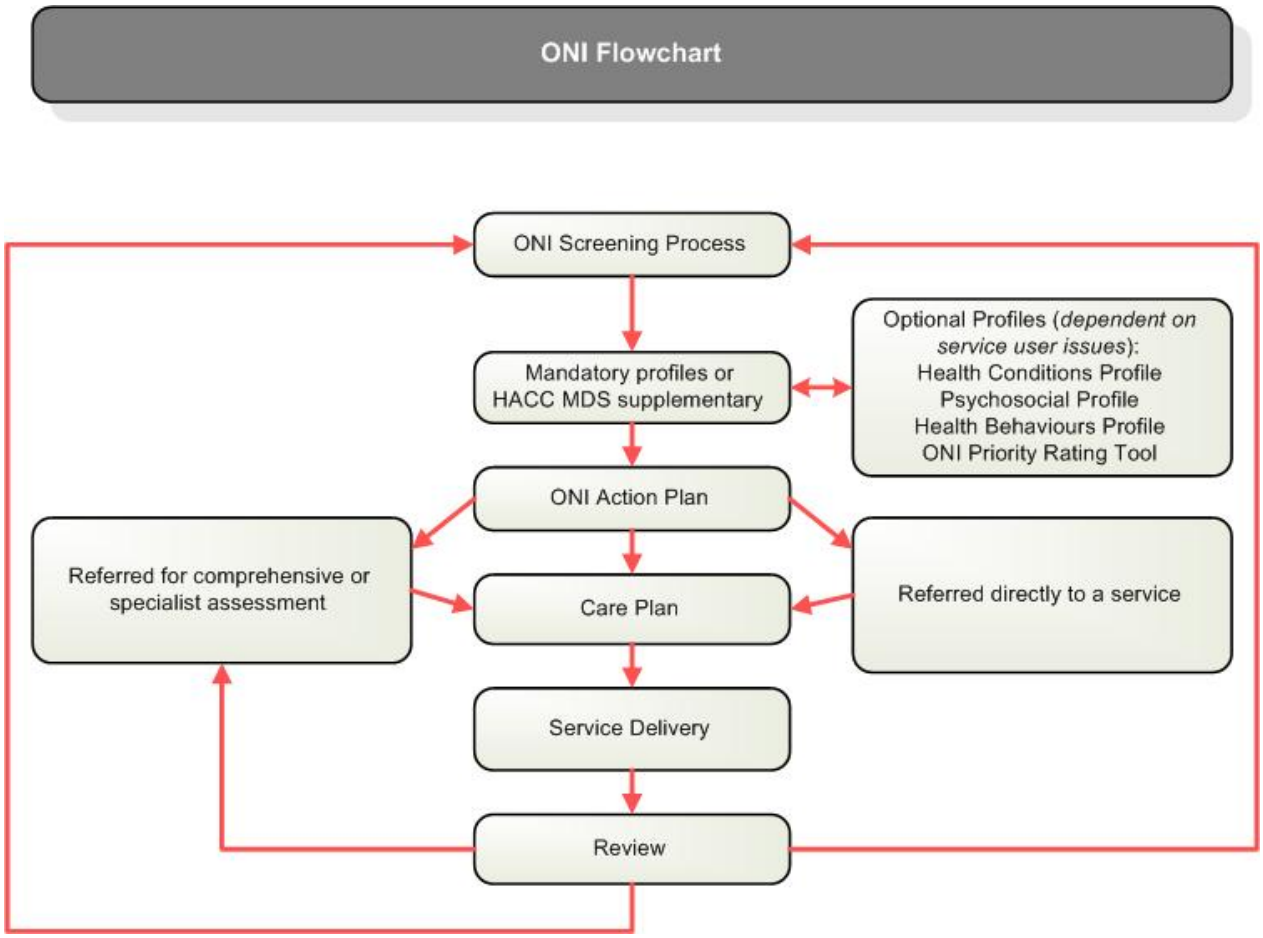
Term	Description
Aged care (Commonwealth HACC)	Service provision for people over 65 and Aboriginal and Torres Strait Islander people over 50.
Assessor	The person assessing the service user.
Care plan	Detailed account of services to be provided by an individual service to a service user.
Community care (Queensland Community Care)	Service provision for people under 65 and Aboriginal and Torres Strait Islander people under 50.
Culturally and linguistically diverse (CALD)	People from culturally or linguistically diverse backgrounds.
Home and Community Care Minimum Data Set (HACC MDS)	Data collected by the Australian and Queensland Governments for reporting and statistical purposes.
Ongoing Needs Identification tool (ONI)	Tool to assist to determine eligibility, to assess and refer for services and standardise how information is collected and shared between service providers.
Referral action plan	Describes the referral pathway for the service user.
Service coordination plan	A detailed plan on how multiple agencies will be involved in the care of a service user.
Service entry data set	Items that are coded and form part of an electronic information system.
Service user	The person being assessed.
Specialist assessment	Mental health or specialist disability assessments conducted by suitably trained people.
ONI assessment	Initial assessment.
Comprehensive assessment	Comprehensive assessment conducted by clinicians.

1.2 ONI profiles (numbered 1–8)

ONI profile	Description	Use
1. Functional profile (FP)	Functional assessment tool that identifies equipment and/or aids the service user may use, and triggers comprehensive/specialist assessment if required.	**Mandatory**
2. HACC MDS supplementary items (HS)	Identifies HACC MDS items if the living arrangements profile and carers profile not completed.	**Mandatory** if the living arrangements profile and/or carer profile are not completed.
3. Living arrangements profile (LAP)	Identifies service user's living arrangements, legal and financial management status.	**Mandatory** if the HACC MDS Supplementary Items form not completed.
4. Carer profile (CP)	Identifies carer arrangements, carer issues and the sustainability of carer arrangements.	**Mandatory** where a carer exists and if the HACC MDS Supplementary Items form is not completed.
5. Health conditions profile (HCP)	Identifies issues about the service user's health and physical wellbeing and will trigger appropriate referral.	**Optional** depending on identified service user issues.
6. Psychosocial profile (PP)	Identifies issues about the service user's social, emotional and mental health and will trigger appropriate referral.	**Optional** depending on identified service user issues.
7. Health behaviours profile (HBP)	Identifies service user's lifestyle behaviours and will trigger issues and appropriate referral.	**Optional** depending on identified service user issues.
8. ONI priority rating (OPR)	Includes options for establishing a service user priority rating based on the information collected in the ONI.	**Optional** depending on identified service user issues and service provider policies.

2 How to use the ONI

The flowchart below outlines the Commonwealth HACC and Queensland Community Care service user journey.



2.1 Key points to remember when using the ONI

The ONI is a tool to aid decision making and standardise how information is collected and shared.

With the service user's consent, share information with other service providers to minimise duplication of assessment. If referring a service user to another service provider, provide that service provider with relevant profiles.

The ONI can be completed by clinical and non-clinical staff.

The ONI may be completed by non-clinical staff provided they have received adequate training.

The ONI is designed for use during either a telephone or a face-to-face interview.

Those service users with a cognitive impairment, language or cultural barriers may benefit from a face-to-face interview.

Appendices 3, 4, 5 and 6 provide further information about communicating with and assessing service users:

- from Aboriginal and/or Torres Strait Islander backgrounds

- from culturally and linguistically diverse backgrounds
- living with dementia
- who are homeless or at risk of being homeless

Service providers may also have their own policies/procedures.

Use the ONI to guide a conversation with the service user.

The tool should not be used as a structured interview; rather, it should be used to guide a conversation with the service user.

Note: The exceptions to this point are where a scale requires a more structured approach to ensure a reliable score — for example, on the functional profile and the Kessler Psychological Distress Scale (K10) screening tool on the psychosocial profile.

The ONI is designed for completion based on a broad range of sources of information available to the assessor.

This includes observations, answers to questions, information contained in a referral letter, service user's personal notes, and information provided to the assessor by a carer or referring service provider.

Assess for all of the service user's needs, not just those your service provider can meet.

The purpose behind using the ONI is to support consistent sharing of information and avoid duplication for both the service user and the relevant service providers.

Some items in the ONI may not be relevant to every service user.

If this is the case then simply follow the instructions on the tool about how to note any issues that you have not addressed or that are not relevant for the service user.

Most quality accreditation agencies have standards that do not allow sections of the ONI to be left blank. Missing data may also pose a problem for computer programs that combine different items to determine a priority rating.

Additional information may need to be collected.

This may include service specific assessments that are required for specific service types (for example, transport, meals, and allied health) and/or population groups (for example, service users with cultural considerations or mental health issues).

Responses need to be based on the service user's social and/or cultural context.

Make sure the ratings relate to the service user's situation — for example, the functional profile questions are based on the service user's own social and/or cultural context, not your own.

Younger service users with a disability may require additional assessment.

The functional profile was initially designed for the frail elderly, but it is also used for young service users with disabilities. The design of the ONI assumes that it is suitable be used for anyone being assessed for services.

However, for younger service users with a disability, a specialist disability assessment may be required in addition to the ONI. A separate tool for this group is not included because it is assumed they will be referred directly to a Disability Service Centre for assessment.

As you complete the profiles consider whether the service user requires particular types of assessments even though this may be beyond the scope of the assessor's organisation to provide.

Service users should be informed about the range of service options that are available to them, not just the services provided by your organisation. Consider the wider range of services, supports and resources available in your community that may assist the service user.

To obtain an ONI priority rating, a range of profiles will need to be completed.

The approach to assigning a service user a priority rating requires the use of information gathered in a number of the profiles including: the functional, living arrangements, carer, health conditions, and psychosocial profiles.

Note:
Determining a service user's priority for receiving a service depends on a mixture of need and risk. A service user's priority is not determined from one particular score alone — for example, the functional profile or the K10 scale as included in the psychosocial profile.

A service user's priority depends on: what services are already in place, how stable the carer arrangements of the service user are, and the availability of a particular service.

If the service required is a high-demand service, the service user priority rating will determine which service user should receive the service immediately and which service user can be placed on a waiting list.

The tool is designed for ongoing use.

Archiving the results of profiles that are superseded optimises review processes and can indicate progress or outcomes. Used in this way the ONI becomes a history of the service user's needs.

What if a service user requires urgent assistance?

During the assessment process you need to consider if the service user requires an urgent intervention that cannot wait for a formal assessment process to be completed.

2.2 Documentation standards

Each page on the ONI has a box on the bottom to record if new information has been added. Signing and dating every form that has been updated is required to meet the Australian Standards for service user records (AS 2828).

You should leave no empty fields, record N/A or the relevant code for 'not applicable', or 99 for not stated / inadequately described or DK for 'don't know'.

2.3 Confidentiality issues

Only information relevant to the referral is to be shared with the service provider.

Collection and sharing of any service user's information must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated regulations.

2.4 Consent

Verbal consent cannot always be obtained from a service user who has either diminished capacity or language and literacy difficulties.

Cues for seeking verbal consent in ONI

Does the service user have capacity to consent to the following:

1. being referred to, and to receiving services from the service providers documented in the action plan (subject to cancellation/refusal by the service user at any time in the future)
2. all service providers documented in the action plan to collect, disclose and use the information for the purposes of:

- sharing information relating to the service user's care
- planning, coordinating and delivering services to the service user
- evaluating the delivery of services to the service user
- reporting and/or research purposes in relation to de-identified service users information — for example, the HACC Minimum Data Set).

Note:
The following key points need to be adhered to by an assessor when seeking and recording service user consent. The consent must be:

- *Informed* — the assessor must provide an adequate explanation of the need for the proposed disclosure of information.
- *Freely given* — the service user must be made aware of their right to refuse consent.
- *Specific* — consent must relate to the agencies and actions specified in the action plan.
- *Current* — the consent must remain current and be reviewed on a regular basis. In practice this means that where a subsequent referral is being proposed then an updated consent form must be completed. In addition, a service user can revoke their consent at any time.

3 How to complete the ONI

3.1 Core ONI

Contact information (Core ONI Page 1 of 4)

- Contact information can be completed by an assessor or by the service user themselves.

Unique consumer record number and agency logo

- This area is for the client identification number or label issued by the initial contact service for use in identifying a consumer. Any interchange of consumer identifier numbers must be performed in accordance with relevant government legislation.

Title

- The title the service user commonly uses.

Family name

- This is the service user's family name or surname.

Given names

- Record the service user's given name(s).

Preferred name/s

- The name commonly used by the service user. This can also be used to record any other names the service user commonly uses.

Sex (gender)

- Record either the birth gender of the service user, or the gender with which the service user identifies.

Date of birth

- Record the service user's date of birth as accurately as possible in dd/mm/yyyy format.
- If the actual date of birth of the service user is not known (for example, if the person is a refugee) then talk to carers or family to obtain either their actual date of birth or date of birth that the service user may have been assigned.
- Alternatively you may need to calculate an estimated date of birth in the following way:
    - If the age of the service user is known, it should be used to derive the service user's year of birth.
    - If the service user's age is not known, an estimate of their age should be used to calculate an estimated year of birth.
    - An actual or estimated year of birth should then be converted to an estimated date of birth according to the following convention: 01/01/estimated year of birth.
    - If the service user knows their year of birth, but no other details, again record the day and month as 1 January. For example, a service user who has a year of birth of 1942, but doesn't know any other details, will have their date of birth recorded as 01/01/1942.
    - If you have estimated the date of birth make sure you record this in the date of birth estimate flag element.

Date of birth estimate flag

- The date of birth estimate flag records whether or not the service user's date of birth has been estimated.

Usual address

- This is the address where the service user normally lives, however it is important to determine if this is the preferred for contact and case management purposes.

Note:
If the service user is homeless, it is important that you develop an initial action plan on the spot. Maintaining contact with a homeless service user is difficult, as is organising services for them. Take the opportunity while you have it.

If the service user is homeless, the usual address should be used to record a particular venue where contact can be made. Some service users may not wish to have a contact address disclosed, and you may only be able to record a postcode.

Contact address

- Only record if different from 'usual address'. Otherwise, record N/A.

Contact phone number/s

- Record phone numbers for contact and case management purposes.

Who the service provider can contact if necessary

- Record the name of a contact person and state their relationship to the service user (i.e. case manager, next of kin, carer, guardian or friend, someone with an enduring power of attorney or an emergency contact). Record a second contact if required, otherwise record N/A.

General Practitioner (GP) (if no GP, write N/A)

- Record the name and contact details of the service user's regular GP.
- If the service user does not have a regular GP, do not leave blank, write N/A.
- If the service user sees more than one GP, record the one identified as their regular or preferred GP. If they see a GP in more than one place, record the most common place.

Comments

- Record any relevant directions, contact issues or requirements — for example, 'Mrs Brown does not answer phone, contact daughter only' or 'person is homeless, leave message at the neighbourhood centre'.

Service entry data set (core ONI page 2 of 4)

- This page must be completed by the assessor. When completed it is to be forwarded or e-mailed to the service provider who is accepting the referral, together with other relevant profiles.

Source of referral

- Record the individual or organisation that referred the service user to the service provider by choosing from one of the16 pre-coded choices.

If not self-referred, has service user given consent for referral?

- Confirm, the service user has given consent to be referred. Any interchange of a service user's personal information must be performed in accordance with Australian Government Privacy Legislation and associated guidelines.

Source of referral contact details

- Record relevant referral contact details.
- If the referral is from a GP, code (3) is used as the source of referral.

Country of birth

- Record the country in which the service user was born. The codes are (1) Australia and (2) Other.
- If code is (2) write country of birth in the space provided.
- If an electronic information system is being used all responses can be coded to the Standard Australian Classification of Countries (SACC) (ABS 1269.0).

Aboriginal & Torres Strait Islander status

- A service user may be recorded as being of:

  (1) Aboriginal but not Torres Strait Islander origin

  (2) Torres Strait Islander but not Aboriginal origin

  (3) both Aboriginal and Torres Strait Islander origin

  (4) neither Aboriginal nor Torres Strait Islander origin

  (5) not stated or inadequately described.

- When collecting this data, assessors should approach the question in a sensitive manner. A service user's Aboriginal/Torres Strait Islander status should never be assumed.

Note:
Not all Aboriginal or Torres Strait Islanders will choose to identify. This is a personal choice and the service user's choice must be respected.

- This data, with service user consent, is used to inform the future funding of services to Aboriginal and Torres Strait Islander people and communities.
- The collection of this data provides an avenue to identify service users who may be at high risk of chronic diseases and would benefit from early detection and intervention.
- The collection of this data does not negatively impact on access to or the quality of services that the service user is eligible to receive.

In relation children, it is important to record the Aboriginal and Torres Strait Islander status of the child. You cannot assume their Aboriginal and Torres Strait Islander status based on their carer or their parent — for example, the child's carer or parents may be from differing backgrounds or the child may be adopted. Again, the question should be asked in a sensitive manner, fully explaining why this information is being collected.

Do you ever need help to communicate?

- Record the extent to which the service user can understand or be understood by others.

  Ask the service user, 'Do you ever need help to communicate (to understand or be understood by others)?'

  (1) no

(2) yes, sometimes

(3) yes, always

Main language spoken at home

- This is the main language spoken by the service user to communicate with family and friends. The item has codes for (1) English and (2) Other.
- If code is (2) other, record the language spoken in the space provided.
- If an electronic information system is in use (but not on this form) all responses can be coded to the Australian Standard Classification of Languages (ASCL).

Interpreter required

- This service maybe required where English is not the first or primary language spoken by the service user.

Preferred language

- Do not assume that the first or primary language spoken at home is the service user's preferred language — for example, a young service user from a CALD household may prefer to speak English.
- Record the service user's preferred language.
- If the service user requires a signing interpreter, record 'sign language' as their preferred language.
- Use this box to also record any other relevant particulars — for example, the service user might prefer an interpreter of a particular gender or religion, or may use speech or hearing devices.

Government pensioner/benefit status

- Record whether the service user receives a pension or other benefit from the Australian Government by selecting the code for the pension or benefit type.
- Record any relevant Medicare and (if relevant) Health Care Card numbers in the boxes provided.

Australian DVA card status

- Record the service user's Department of Veterans' Affairs (DVA) card status by using the code set. If the card is not gold or white, specify what other card is used and record the card number.

Insurance status

- The purpose of this section is to inform the assessor if the service user is eligible for private services such as dental and allied health.
    - Record the current private health insurance status of the service user by ticking all boxes that apply.
    - Include the level of private health insurance (if any) and/or whether the service user is eligible for services paid by a third party payer such as motor vehicle accident insurance or workers compensation.
    - Where relevant, record the card number.

Why the service user is seeking services (core ONI page 3 of 4)

- Use this page to record presenting problem/s and issues of relevance for the service user. Most information on this page will be completed at the end of the initial interview or contact process.
- This page is completed by the assessor and either faxed or emailed to the service provider who is accepting the referral, together with other relevant sections of the ONI.

Alerts box — using the ONI to record risks and urgency

- To be completed only after completing the relevant supplementary profiles.
- Use to note risks and any matters of urgency.
- Summarise any issues here of possible risks to the service user, loss of social participation or reduction in health status.
- Consider whether to trigger your own service provider's alert procedures.

Service user's priority category

- A service user's priority rating cannot be determined until you have finished the ONI.
- Information from a range of profiles is required as indicated in the ONI priority rating section.

Description of problem or issue

- Record the service user's own description of the problem/issue in one or more short statements which describe why the service user is seeking services.
- The need for optional profiles may also be identified in this section.
- If issues are identified, consider completing other relevant ONI profiles.

Description of other issues as identified by the service user

- List other problems that are identified by the service user.
- Record all issues which may be unrelated to the reason the service user is seeking services.
- This information might be based on: your discussion with the service user, observing the service user, information contained in a referral letter, the service user's personal notes, or information provided by a third party such as a friend, relative, or carer.

Note:
List the issues in priority order. For example, the first issue listed is the one that is of most importance to the service user or use the order of priority as identified in the ONI process. The list of problems and issues can be updated over time (use the 'information updated' section at the bottom of each form to indicate that the situation has changed).

Action required

- The ONI has ten codes to indicate possible actions associated with the problems or issues identified. They fall into three types of action (service provision, specialist assessment or comprehensive assessment) and seven types of 'nil' action.
- Code:

  (1) Service provision — see 'action plan'. If you use this code, record what is required in the action plan.

Note:
There are 2 reasons that this code is used:

1. The service user has a need that is straightforward and no further assessment is indicated. For example, a service user may only need a food service. Code 1 is used to indicate that the service user is being referred to Meals on Wheels. Meals on Wheels will do their own service-specific assessment of the service user's requirements.
2. The service user has a need that is urgent and cannot wait for an assessment to be completed. For example, the carer of a highly dependent service user has a fall and is admitted to hospital. Code 1 is used to indicate that the service user is being referred personal care, meals and domestic assistance to allow them to stay in their own home while their carer is in hospital.

(2) Specialist assessment (for example, mental health or disability assessment) OR

(3) Comprehensive assessment

Use the above two codes to indicate that a service user is being referred for a specialist and/or comprehensive assessment.

Specialist assessments are required when the service users needs indicate a specialist service such as specialist disability, continence services, mental health services, women's health services, sexual assault or drug treatment services are required. These codes aim to indicate the service user's specialist needs and may include clinical assessment and treatment as well as community support and assistance with daily living.

A specialist assessment is undertaken by a service that has the relevant skills, knowledge and expertise. It usually occurs as part of specialist service delivery. Most service users who use specialist services engage with those services directly.

Comprehensive assessment consists of advanced history taking, examination, observation and measurement/testing. It is used when service users have multiple, complex or unclear needs or require long-term and/or intensive service provision.

- Nil action - no further action is planned.
Record why no action was taken in relation to each problem or issue identified by the service user. Information collected using these codes can be analysed to measure unmet need.

(4) Nil: service user ineligible for service

Use when a service user is not eligible for a specific service they have requested. For example, a service user identifies that they have dental problems and requests a referral to a free public dental clinic. You are unable to identify another service that may be able to help. Code 4 is used to indicate that you have not referred the service user for a dental service.

Note:
If the service user is ineligible for free dental and allied health treatments refer them to their GP as they may be eligible for the Enhanced Primary Care (EPC) program. This program is available to older Australians to improve coordination of care for people with chronic conditions and complex care needs. *Medicare rebates are available for a maximum of five allied health services and/or three dental services per patient in a calendar year.*
The service user should talk to their GP about the services accessible under the program.

(5) Nil: referred elsewhere

Use when you refer a service user to another service provider. For example, a service user identifies that they have dental problems and requests a referral to a free public dental service. You give the service user contact details on possible dental services they can contact to make inquiries about the availability of free dental treatment.

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

Use when the service user only requires advice or information. The needs of the service user have been met and no further action is necessary.

(7) Nil: service user declines further referral or service

Use when the service does not want at a service that is recommended to them. For example, a service user identifies that they have a drug or alcohol problem. You suggest referral to a specialist substance abuse service and the service users declines the referral.

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

Use when the issue or problem is resolved. For example, a carer reports that they do not know the correct technique for assisting the person being cared for with their walking difficulties. The assessor shows the carer the correct technique. The issue has been resolved and no further action is necessary.

(9) Nil: requested service not available

This code is used when a service user has requested a non-existent service. For example, a service user asks whether the service provider will pay for them to travel to another country to visit a sick relative. No such assistance is available.

(10) Nil: requested service not accessible (for example, due to long waiting time, inaccessible location)

Code 10 is used when a service user has requested a service that they cannot practically access. For example, a service user living in a rural area requests access to a specialist service. The closest service is in a capital city 400 kilometres away and the service user indicates that they are not prepared or able to travel that distance. Alternately, a service user requests access to public podiatry. There is a shortage of podiatrists in the local area and the appointment books are currently closed to new referrals and it is likely to be a year or more before the service user can obtain an appointment.

Current services

- Use this box to record details of services used by the service user in the last three months and/or on a recurring basis. The sustainability of the carer arrangements is important in determining a priority rating and as such a full picture of the support network is essential
- Ask the service user if they have used any other services in the last three months or on a recurring basis. If the service user reports that they have used other services, record the service type and if they are still using the service. Regular contact with their GP should also be documented here.

Action plan (core ONI page 4 of 4)

- A service user's eligibility for services is determined in this section. An option to summarise the functional profile is also available in this section to streamline information transfer.
- This section cannot be completed until all other relevant profiles are completed. The action plan for a service user is based on services currently in place and issues/needs identified in all the profiles.

Note:
Some agencies may have their own versions of care plans and service-specific plans. Please check your agencies policies and procedures.

Is this service user eligible for Queensland Community Care or Commonwealth HACC care services?

- Tick relevant box to indicate eligibility for services. Options include (Y) = yes (N) = no (DK) = don't know.
- A service user is Queensland Community Care eligible if they are either under 65 years or 50 years if of Aboriginal and/or Torres Strait Islander descent and they have a moderate, severe or profound disability or a condition which makes it difficult to perform the tasks of daily living.

- A service user is Commonwealth HACC eligible if:
  - they are either over 65 years or 50 years if of Aboriginal and/or Torres Strait Islander descent and they have a moderate, severe or profound disability or a condition which makes it difficult to perform the tasks of daily living

    and
  - they would be at risk of premature or inappropriate long term residential care in the absence of basic maintenance and support services

    or
  - they are a carer for a service user specified in the above categories (in this case a carer would be eligible to access funded respite care, counselling/support, information and advocacy services).

Could the service user be eligible for specialist disability services in Queensland?

- If the service user may be eligible for disability services, tick the box.
- A service user is eligible for specialist disability services if they meet all of the following criteria. The service user:
  - is an Australian citizen or permanent resident with a suitable visa
  - is a Queensland resident
  - is under 65 years of age at the time of application
  - has a disability attributed to an intellectual, psychiatric, cognitive, neurological, or physical impairment, or a combination of these
  - has an abovementioned disability which is permanent or likely to be permanent
  - has substantially reduced capacity for communication, social interaction, learning or mobility.

Could the service user be eligible for other services?

- If the service user might be eligible for other services, tick the box and record type of service.
- Two examples are given on the form:
  - DVA (Department of Veterans Affairs) - services funded by DVA such as Veterans Home Care
  - NRCP (National Respite for Carers Program) - respite services funded under the NRCP.
- Do not limit your response to these two programs as special programs and eligibility criteria change from time to time.

Functional profile completed and attached?

- A summary of the functional profile (activities of daily living) scores can be recorded here. This section enables you to condense the information and the number of pages forwarded when referring to other service providers.
- Ticking the (Y) box indicates you do not want to complete this section and a comprehensive and/or specialist functional profile (activities of daily living) will be sent with the referral.
- Alternatively, tick the (N) box and record individual item scores for each of the sections of the functional profile in the corresponding item box.

Action plan

- This section of the ONI collects key information for use in an action plan.

- The boxed columns capture more detail on what information the service user has consented to share and has codes for how the referral is to be made, what form of transport is required, and the scope of feedback they should expect to receive.
- This action plan has eight components. These components and the codes relevant to each are outlined below the action plan box.
- Each component is mandatory unless otherwise stated.

Service provider/health professional

- Use this column to record details of the service provider and the health professional's title where the service user will be referred.
- If you will be continuing to see the service user, include yourself in the list of agencies/professionals for referral
- Use this column to record the purpose of the referral — for example, diabetic advice, community transport, GP assessment.
- If there is some reason for urgency, write 'urgent' in this column — for example, urgent assessment.
- If appropriate, use the alerts box to draw attention to the reason for the urgent response — for example, carer admitted to hospital today.

Service user consent

- The ONI registers a service user's verbal consent to collect information and share that information between agencies.
- Local agencies will have other uses for a service user's information such as planning services and quality assurance. If necessary, written consent should be obtained at a local service provider level. See below for additional information on verbal consent.
- Record the code from the options of:
  - (1) yes, service user consents to referral and to sharing of information as specified
  - (2) yes, service user consents to referral but not to sharing of information
  - (3) no, service user has not consented to this referral.

Referral method

- Record method of referral to relevant service
- Record the code from the options of:
  - (1) this form faxed to service provider
  - (2) letter (copy on file)
  - (3) electronic (fax and email)
  - (4) verbal request – face to face or phone call
  - (5) other (include refer to self).

Transport method

- Record a code for how the service user will get to the service.
- Record the code from the options of:
  - (1) staff travel – service delivered in home
  - (2) staff travel – service user too unwell to travel
  - (3) staff travel – service user has no transport

(4) service user travel – own car

(5) service user travel – family/friends

(6) service user travel – public transport or taxi

(7) service user travel – walk

(8) community transport

(9) ambulance

(10) hitchhike

(11) none.

Feedback required

- Record the agencies, service providers or significant others that may require feedback regarding the service user.
- Record the code from the options of:

(1) to initial referral service provider

(2) to GP

(3) to service provider completing ONI

(4) to carer/ guardian

(5) other

Note:
If feedback is required, contact details will be required on the ONI page 2.

Date

- Record date referral actually made. If no referral is actually made, leave this field blank.

Review date

- Record date proposed action is to be reviewed. If no review is required, leave this field blank.

Frequently asked questions about the core ONI

Q: Can the service user fill in part of the ONI?

A: This is up to individual services to decide in the context of their local service coordination models and agreed practices, processes and protocols. The service user can complete the section that includes the contact information (page 1 or core ONI) and the K10 scale which is within the psychosocial profile.

Q: Can the ONI serve as a service user led record with a copy left in the service user's home?

A: Yes, however it depends on individual services to decide in the context of their local service coordination models. Service user and community consultations will be helpful in considering any requirements of service users to hold their own records. Their records have to be held within the context of privacy guidelines and legislation.

Q: How do I determine whether or not a person requires an interpreter?

A: Remember that even though a person may be able to carry out a simple conversation in English, they may not be able to comprehend or express themselves well enough to participate in a screening process that requires detailed information sharing and consent.

Also, it is necessary to consider that people often lose their ability to communicate in a second language in times of stress, illness and/or cognitive impairment. They may require an interpreter for this process, as well as for future comprehensive assessment, reviews, health education and consent for treatment.

If a person does not require an interpreter for day to day services but does for complex communication situations, then this should be rated as needing an interpreter.

The following may help you to judge if a person needs an interpreter:

- ask the person questions that require an answer in a sentence, not yes or no answers
- ask the person to repeat a message that you have given him/her back to you in his/her own words
- if a person is unable or struggling to answer these questions then an interpreter is required.

4 Mandatory profiles

4.1 Functional profile (activities of daily living)

This profile is suitable for assessment of a service user, and can be completed with the assistance of a carer, friend or care coordinator who may be contacting your service on a service user's behalf.

The functional profile (activities of daily living) is designed for use as either a telephone assessment or a face-to-face assessment.

It consists of two pages (nine questions) to determine the functional ability of a service user. The results of the functional profile can be included as a summary on the last page of the ONI.

How to complete the functional profile (activities of daily living)

- The assessor should inform the service user that this is a brief assessment comprising of some basic questions.
- Located on the top left-hand corner of page 1 is a suggested script the assessor can read out to the service user.
- The assessor should read each item, together with the options, to the service user.
- The questions should be asked word-for-word the way they are written.

Note:
The questions ask: 'Can you…?' rather than 'Do you…?' The rationale for this is that some service users might not carry out the activity even though they are capable — for example, they may not do housework as their spouse or carer does it for them, yet they are quite capable of doing it themselves.

The purpose of these questions is to rate what a service user 'can do' rather than what they 'do do'.

Individual items

- Items 1- 5 on the functional profile (activities of daily living), page 1, are organised in sequential order.
- Do not ask about items 6–7 (mobility and bathing) if the service user does not need help with the activities of daily living (items 1–5), as they can obviously carry out these activities.
- Items 8 and 9 are about cognition and behaviour and are asked of third party informants, not the service user themselves. These items are completed based on all information available to you. Your score should be based on interviewing or observing the service user, information contained in a referral letter, personal notes or information provided by a friend, relative, carer or referring service provider.
- If the score is a (0) for items 8 or 9, avoid elaborating further on the 'why?' or 'how much?'

Allocation of a score

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

- If the service user does not answer with an option, or qualifies the option, the options should be repeated and the service user asked to select the option which best describes the situation.

  There are four main points to emphasise when scoring in the functional profile:

  1. Consider the help that is required and the amount of prompting. If a service user can do something but has chosen to have someone else do it (like dressing), rate as independent. If help or prompting is involved, rate as (1). If unable to do the task, rate as (0).
  2. Where an item is not relevant (for example, service user does not use medicine), rate what the service user would be capable of doing if the item were relevant to their situation.
  3. Make sure the ratings, especially of items regarding standards of cleanliness, are based on the service users' own social or cultural context, not your own.
  4. Item 6 (walking):
     - service users who are independent with use of a mobility aid should be rated as a (2)
     - service users who are in a wheelchair should be rated as a (1) if they are independent including taking corners in their wheelchair etc. or (0) if they are not wheelchair independent.

Recommended functional assessments based on this functional profile

- Use the instructions on the form to guide your decision about whether the service user requires a more comprehensive assessment in any of the functional areas of domestic, self-care, cognition or behaviour.
- The scores on the items are guidelines only and you should consider the total situation. For example, practical issues such as the availability of comprehensive assessment services and the urgency of the service user's needs should also impact on the scores.
- If the service user has low or moderate functional needs and does not need a comprehensive assessment, use the information to decide whether the service user requires services and, if so, what type? The functional assessment results alone will not be sufficient for this as you will need a range of other information — for example, information about carers and social supports, financial resources. This information is collected in other ONI profiles.
- You will need to use all the information to develop an action plan or care plan.

Aids and equipment currently used

- The last section of the functional profile (activities of daily living - page 2 of 2) has tick boxes to record aids and equipment that the service user currently uses.
- Record the specific type of aid used in the comment box.
- Each of the aids has a code label. Definitions are contained in the following table.

Code label	Code label definition
Self-care aids	These aids assist the service user in their day-to-day routines (cooking/eating and personal hygiene). Examples of such aids are special crockery/cutlery, bath rails/shower rails, buttonhooks, bowel and urinary appliances etc.
Support and mobility aids	Aids mentioned here provide the service user with ease of mobility as well as supportive mechanisms while at rest. Support aids include callipers, splints, special beds, cushions/pillows etc. while mobility aids include belts, braces, crutches, wheelchairs (manual and motorised) etc.

Code label	Code label definition
Communication aids	These aids help the service user with their inter-personal interaction and are inclusive of telephone attachments, writing aids, speaking aids (electro larynx), intercom etc.
Aids for reading	These are reading specific aids provided to the service user and comprise of items like magnifying/reading glasses, Braille books, reading frames etc.
Medical care aids	Aids described in this category serve to provide assistance to people with specific medical conditions. They include breathing pumps, pacemakers, Ostomy/Stoma appliances etc.
Other goods/ equipment	This category of aids includes all items which lie outside the range of the above mentioned codes.

Comments

- In addition to recording aids or equipment, use the comment box to summarise the findings on the functional profile and include in the action plan on the ONI page 4 of 4.
- Your comments should include a recommended action. Ensure all the service users' needs are considered in the action plan — for example, the recommendation of a comprehensive assessment.

Frequently asked questions about completing the functional profile

Q: Disability without incapacity. What about a service user who is partially vision-impaired and has practical aids in place like informal financial arrangements or a Webster pack?

A: They should score (2) on items 4 and 5 on the functional profile without help because they have the functional capability. For example, this score is similar to a service user with a lesser level of disability who uses glasses and large digit phones and clocks.

Q: What about a service user who is vision impaired but uses a magnifying glass and a Webster pack?

A: This service user would score (2) without help on item 4. In this profile the assessor is not scoring the service user's need for an intervention, only their level of functional dependency with their current aids and appliances in place.

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

A: In both cases, rate the service user at their worst over a one month period. If a service user cannot do the entire task without it resulting in significant pain and fatigue, rate as a (0 - cannot do). If a service user is unable to undertake all of a task and needs help to complete it, rate as a (1 - needs some help).

Q: My issue with the functional profile is how to determine if a service user is low, medium or high need. From what I understand, a trigger for a comprehensive assessment for self-care would immediately classify the service user as high/complex needs.

A: The concept of high, medium or low need is used to formulate a priority rating for specific services. The ONI assesses the service user's needs relative to their priority for receiving a service as determined by a combination of need and risk factors. Priority also depends on how many services are available to meet the service user's needs in the local area. The ONI priority rating tool will provide a rating for a particular service user, relative to all other service users. Rating service users enables the service providers to determine who should

receive services as a priority and who may be able to be placed on a waiting list if no services are currently available.

Q: I have a number of service users living in an Aboriginal community out of town. How can I ask them about mobility and self-care when their facilities and transport are poor?

A: You rate them as if they had access to facilities and ask if they can do the particular tasks. It is important to remember that this profile aims to identify a service user's level of function using four domains of domestic, self-care, behavioural and cognitive functioning.

The assessor's questions may need to be adapted to the context of the service user's situation and where they live (i.e. remote community) to obtain a more accurate picture of a service user's functional status.

Q: What considerations need to be taken into account when screening individuals who have significant language barriers?

A: Language and cultural barriers are not seen as a functional incapacity. However, a service user may need additional assistance during an assessment such as an interpreter. The assessor may note in the action plan that a referral to a culturally specific service is required.

4.2 Living arrangements profile

The first two items on this profile are mandatory items for service users. If this profile is not completed, you must complete the HACC MDS Supplementary Items page to satisfy reporting arrangements.

How to complete the living arrangements profile

Living arrangements

- Find out what living arrangements the service user has (for example, whether they live alone, with family, or with others) by asking questions like 'who lives in the house with you?'
- The service user's living arrangements need to be considered when completing the action plan and, if necessary, developing a care plan. It will often flag risks and urgency.
- Make any comments or summary notes on living arrangements and family situation in the box provided. Note that there is a separate carer profile that might also be relevant.

Accommodation

- Codes are provided to record the service user's accommodation type. There are 11 different possibilities listed using HACC MDS codes.
- Use the information in this item for home modification requirements. Record any relevant comments on accommodation issues in the comment box.

Employment status

- Ask about the service user's current employment status and occupation, record status using the codes, and record any relevant comments or notes.
- The now obsolete term 'sheltered' refers to 'supported employment'.

Financial and legal profile

- The service user's financial situation may need to be considered when assessing risks and urgency. It should also impact on the assessors recommendations in an action plan and, if necessary, a care plan.
- Legal issues should be summarised in the comment box.
- Include Mental Health Act status, which might be an involuntary treatment order in hospital or an involuntary order for community treatment.
- Include any relevant court orders, enduring power of attorney, guardianship, or financial management orders depending on the service user's circumstances and presenting problems.

Mental Health Act status

- This section describes any formal legal arrangements to be considered when developing an action plan. This information is usually provided by the referring body — for example, a regional assessment service.
- Record the code from options outlined on the form.

Decision-making responsibility

- Consider whether the service user is capable of making decisions on their own. If the assessor records 'not sure' or 'no', consider the need for assistance, the need for a cognitive assessment and the implications for consent.
- If there are no formal orders in place, the service user may have given someone else a Power of Attorney, or may have informal arrangements in place to safeguard their interests.
- In some cases the service user may already have a decision-maker appointed under Enduring Power of Attorney or guardianship arrangements.
- Consider referral for assessment — for example, GP, social worker, mental health or psychiatric assessment if the person's capacity to make decisions is questionable and there are no existing arrangements.

Financial decisions

- Financial issues might include whether a service user is capable of making their own decisions about financial matters or whether there is some financial risk in their immediate circumstances.
- If the service user is not capable of looking after their own finances, they may have granted a Power of Attorney, appointed a financial manager, or had one appointed under the guardianship legislation.
- Consider referral for assessment — for example, GP, social worker, mental health or psychiatric assessment if the person's capacity to make decisions is questionable and there are no existing arrangements.

Cost of living decisions

- It is sometimes useful to inquire as to whether there are any trade-offs the service user makes because of financial difficulties. This question can generate important information to allow you to assess both risk and urgency.
- If the answer to the above dot point is 'yes', discuss the issues with the service user and consider the need for counselling (for example, health-related, financial, gambling), and the need for material support.

Comments

- Consider all the issues such as the need for material assistance and any implications from items on decision-making.
- Use the box at the bottom of this section for any relevant comments and to summarise the required action.
- Issues to do with the home environment may be recorded here and this might prompt a service provider's use of its own assessment tools for home safety, or for investigating occupational health and safety issues.

4.3 The carer profile

Use this profile if the service user has caring arrangements in place. If the response to the carer availability question is 'has no carer', then the other items relating to an informal caring situation do not need to be answered.

The carer profile identifies the need for a carer, availability, residency and the relationship of the carer to the service user. There are also items in this section that identify supports available for the carer, current threats to carer arrangements and whether the carer arrangements are sustainable.

The items - carer availability, carer details, carer for more than one service user, carer residency status, and relationship of carer to service user - on this profile are mandatory items for service users.

If this profile is not completed, you must complete the HACC MDS Supplementary Items page to satisfy reporting arrangements.

Keep in mind the wide range of possible caring arrangements including people with serious illness or disabilities caring for others, and children who may be caring for adults.

Note:
In the ONI carer profile, the additional code (98. not applicable - paid carer) has been added to three HACC MDS questions that relate to carers for the purpose of identifying whether a service user has one or more paid carers in place. As code (98) is not a HACC MDS code, it cannot be reported in a service provider's HACC MDS data reports.

How to complete the carer profile

Carer availability

- This item records whether the service user has someone they identify as their carer, regardless of whether they need a carer or not. If the service user is unsure about whether they have a carer, ask questions such as 'the last time you got sick, who looked after you?'
- There are 4 possible options in recording whether a service user has a carer:
  - (1) has a carer
  - (2) has no carer
  - (3) not applicable – no carer required
  - (98) not applicable – paid carer.
- Carers may be family, friends or neighbours who help the service user informally with managing their lives. This help may be on an occasional or regular basis.

In many situations people residing together (typically a married couple) look after each other. Both may be receiving funded assistance, but are each other's carer. In this case, for each service user the following would most likely apply:

- each service user is recorded as a service user, receiving assistance due to their condition or disability
- each service user would be recorded as having a carer.

Note:
A service user may in fact have several carers who share the role, but the number of carers is less important than simply whether the service user has a carer or not.

For example:

- If an elderly service user has care provided by both their spouse and their son, the response to this item will be (1) has a carer.
- Similarly, for a young disabled service user, if care is shared between both parents, the response will be (1) has a carer.
- If care is provided by both an informal and formal carer, record (1) has a carer.
- If care is provided on a formal basis only (for example, by a paid carer), record (98) not applicable – paid carer.

Details of formal paid care and the service provided need to be recorded in the comment box of the carer profile; the identification of sustainability issues must also be noted. Current services also need to be recorded in the ONI page 3 *'current services'* section.

Points of clarification about the carer

- If a service user is the main (or only) carer, they will be eligible for assistance if they look after a service user who is eligible. The assistance provided to this carer is to assist them to cope in their caring role. Refer to the relevant guidelines for more detailed information.
- By definition, the carer is not paid a wage or salary to assist, but they may receive a carer benefit. To be eligible for a benefit or to take on other responsibilities like decision-making for others (for example, to take on a position of 'person responsible' under the relevant guardianship legislation) the carer must have a continuing relationship to the service user. This does not mean the carer has to be 'next of kin'.
- The definition of a carer for the ONI is different to the response recorded for the HACC Minimum Data Set. In the HACC MDS, paid carer arrangements are recorded as (2) has no carer. However, in assessing the sustainability of care arrangements for ONI priority rating purposes, the answer would be (98) not applicable – paid carer.

Carer details

- Family name, given names, date of birth, usual address, country of birth, gender, language spoken at home and Indigenous status are recorded in this section. For a description on the methodology to capture these data items, refer to the ONI explanations of the same data items.

Carer for more than one service user

- Record whether a primary carer is providing assistance on a regular and sustained basis to more than one service user. The easiest way to ask this question is to ask: 'do you care for more than one service user with a disability or chronic illness?'

Need for a carer

- This question seeks to identify if a service user needs a carer. If a carer is unable to assist the service user, you must determine if the service user could manage independently. If a service user requires assistance with any area of function (excluding the use of equipment/aids) outlined in the functional profile, this indicates that they need a carer. Allocation of a code of (1) or (2) is based on whether a carer is required all of the time or just some of the time.
- Knowledge of whether or not a carer is needed will be of relevance when allocating a priority rating for the service user using the ONI priority rating tool.
- Record the relevant code in the box:

  (1) the service user cannot be left on their own at any time (day or night)

  (2) the service user can only be left on their own for some, but not all, of the time (day or night)

  (3) nil, no carer required

Carer residency status

- Knowledge of carer residency status can assist with identifying if arrangements can be sustained. Ask 'does your carer live with you' or 'do you live with the person you care for?'
- Record the response using the 4 code options:
  - (1) yes, co-resident carer
  - (2) no - non-resident carer
  - (3) not applicable – the service user has no carer
  - (98) not applicable – paid carer.
- Where a service user has several carers, ask about the carer who does most of the caring and if the two carers live apart.
- Sometimes, the case may be that a service user stays at the carer's home, or the carer may stay at the service user's home, but the carer is not a co-resident. In this situation, record that the service user has a non-resident carer.

Relationship of carer to service user

- Record the relationship of the carer to service user using one of the seven code options:
  - (1) spouse / partner
  - (2) parent
  - (3) son or daughter
  - (4) son-in-law or daughter-in-law
  - (5) other relative
  - (6) friend / neighbour
  - (98) Not Applicable - paid carer.

Note:
In addition to the HACC MDS codes, a code of (98. not applicable – paid carer) has been added, so if the service user only has a paid carer/ care arrangements then you would choose (98. not applicable – paid carer).

Carer support

- There are four dimensions used to identify carer support including whether:
    1. they have someone to support them
    2. they receive a payment or allowance
    3. they have been given information about support services such as respite
    4. they need any practical training in tasks such as lifting or managing medicines.
- Responses to this set of items are recorded as ‘yes’, ‘no’, ‘not sure’ or ‘no carer’.

Current threats to carer arrangements

- Current threats to carer arrangements are described by a series of six self-explanatory codes.
- Tick all that apply.

Are carer arrangements sustainable without additional services or support?

- Sustainability of the care arrangements is determined by considering whether the paid or formal carer arrangements are likely to be sustainable, and for how long.
- These codes can be used as prompts to guide your conversation with the carer or referral service provider.
- Based on your conversation, determine if current carer arrangements are sustainable without provision of additional services or support and record one of the five following codes:
    - (1) no, arrangements have already broken down
    - (2) no, carer arrangements likely to break down within weeks
    - (3) no, carer arrangements likely to break down within months
    - (4) yes, carer arrangements are sustainable without additional support
    - (5) don’t know.
- If the answer is (5) consider the need for referral to, and assessment by, organisations established to support carers — for example, Commonwealth Respite and Carelink Centres (CRCC), or a Queensland Community Care respite service provider.
- Record a code of (99) in the box if carer issues are not relevant.

Carer issues

- If there are significant carer issues, complete a separate ONI on the carer, refer as appropriate to a carer support service provider.

Comments

- Use the box in this section to summarise the actions required for the carer.
- Consider all the issues, emergency arrangements, material assistance required, and decision-making components.

Frequently asked questions about the carer profile

Q: The service user lacks the energy required to do household chores. They have angina problems, fluid around heart and lungs, and they live alone in private accommodation, with no carer. The service user is reliable with medication, has a K10 score of 16 and friendships are maintained although there are some psychosocial problems. On the functional profile they are rated as high function. The outcome of the ONI process is that they not referred (for further assessment). Does the service user need a carer or not?

A: If this service user lacks energy but is still capable of performing household chores, there is no need for a carer. If lack of energy and medical problems prohibit the ability to complete household chores then a carer is needed. If the service user needs help from someone some of the time, and therefore needs a carer, they would be rated as (2. they can be left on their own for some, but not all of the time - day or night).

The concept is that a service user needs a carer if they need someone to help them manage their tasks of daily living (for example, domestic and/or self-care activities) and cannot be left alone all of the time. In this scenario, if no carer is needed for domestic and personal care assistance, then consider whether there is a need for some other service — for example, a volunteer visit, or day respite.

Q: The service user requests a service for vacuuming, heavy cleaning and washing. Her functional profile shows high function but on the medical side there is bone marrow cancer, plus stents placed in her heart, rheumatoid and osteoarthritis. She is reliable with medication, has a K10 score 43. She would not provide information on family and personal relationships, lives alone in private accommodation, and has a carer. The carer is her daughter who works. Carer sustainability is unknown under the circumstances.

A: This is a service user with relatively high function, but their other problems suggest further investigation is needed. The K10 score suggests that a referral for a mental health assessment might be useful. It also seems the carer issues need to be looked into further before you can safely say how the service user is likely to manage under the current circumstances.

You will need to make sure the health aspects of both the service user and their carer are well documented and supported, i.e. GP and community nursing involvement. Their priority rating may be determined more by the mix of other problems than the functional profile item scores.

Q: How would I rate a service user who has a spouse or relative living with them that assists with some functional tasks but does not provide assistance with all functional tasks (for example, housework and/or personal care due) to role relationships within the family?

A: When completing the assessment, consider the role/s of the service user and their carer/s. The service user’s spouse, children or other relatives/friends may appear to be carers but if they are unable to assist the service user with some, or all of their functional needs, then their carer arrangements should be considered unsustainable without extra assistance. For example, when assessing people from different cultural backgrounds, carer availability should be assessed on the carer’s ability to perform the caring role.

5 Optional profiles

These profiles may need to be completed if identified as required in the mandatory profiles.

5.1 The health conditions profile

How to complete the health conditions profile

- This profile records information about a service user's health status: self-rated health, bodily pain, interference with normal activities, vision, hearing, teeth, speech, swallowing, falls, feet, vaccinations, driving, continence, height, weight, blood pressure, and pulse.
- Additionally, it records a summary of self-reported health conditions, confirmed medical diagnoses, current medicines, assistance, and referral options.
- It provides prompts for further enquiries about activities of daily living and cross checking with the functional profile. (Cross checking data already collected is beneficial as some conditions are episodic and recurrent and functional levels may vary considerably over time).

Note:
Any issues identified from the health conditions profile need to be recorded in the 'description of other issues' in the ONI.

Health conditions profile (HCP Page 1 of 2)

Overall health

- When asking about a service users overall health, ask how they are feeling/coping in general and if they have experienced any recent changes in their health.
- If the service user reports having had significant changes to their health, ascertain if they have already notified their medical practitioner.
- If the service user reports poor health, cross check with data collected in the functional profile and consider completing the psychosocial profile.

Bodily pain

- Record if the service user is experiencing any bodily pain. If yes, ask questions such as 'how much bodily pain have you had during the past four weeks?'

  Tick the box indicating the degree of pain.
- If the service user reports that they have had significant bodily pain, identify if the service user has already told their medical practitioner about their pain. If not, refer the service user back to their GP.
- Consider if their pain is impacting on their ability to manage activities of daily living (see functional profile) or on their personal or social relationships (see psychosocial profile). If so, complete the relevant profile.

Interference with normal activities

- Use the question 'how much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?' to score the service user on the scale.
- Score from 'not at all' to 'quite a bit'. Identify and record any issues that may require action.
- If problems are identified, capture them on the functional profile in the areas of activities of daily living.

Vision, hearing

- Tick the box to indicate the service user's situation. If the question is irrelevant or the information is not known, record N/A.
- If problems are identified, capture them on the functional profile and consider a referral for assessment — for example, to an optometrist or GP.
- If a service user is legally blind, rate their vision as 'poor' and record their visual impairment in the health conditions profile under the list of health conditions.
- Cross check this entry with the end of the functional profile if visual aids/appliances/self-care tools are either in place or required.

Oral health

- Tick 'yes' or 'no' to indicate self-reported problems like missing teeth, untreated dental cavities or other oral health problems such as gum disease.
- Use the comment box to note significant oral health issues and to identify whether the service user is eligible for any free or subsidised oral health services.
- If a service user has health insurance, is covered by Department of Veterans Affairs, or is able to pay for their own dental care refer them to a private dentist. If not, refer them to a public sector dental therapist.

Note:
The Enhanced Primary Care (EPC) program is available to older Australians to improve coordination of care for people with chronic conditions and complex care needs.

Medicare rebates are available for a maximum of five allied health services and/or three dental services per patient in a calendar year.

The service user should talk to their GP about the services accessible under the program.

Speech/swallowing

- Tick 'yes' or 'no' to indicate problems with speech or swallowing.
- Use the comment box to note significant issues. Consider the need for a referral for assessment — for example, to speech pathologist or GP.
- Cross check that items of relevance are captured on the functional or health behaviours profiles.

Falls

- Ask about the incidence of falls in the last six months.
- Tick 'yes' or 'no' in the relevant box, and indicate the number of falls.
- If the service user has had a number of falls, refer them for assessment and intervention by a GP.
- All service users are at some risk of falls, and even if a service user has not had a fall, a number of factors such as: poor vision, podiatry issues, continence problems, use of more than five medications, low levels of physical activity, and postural hypotension can place a service user at higher risk.
- Consider the need for further investigation (activities of daily living) by using the functional profile or a comprehensive assessment tool.

Feet

- Use the tick boxes to record whether the service user has any foot problems — for example, problems that are causing pain or interfere with mobility including foot irregularity.
- Use the comment box to record the details, and consider a referral for assessment — for example, to a podiatrist, GP, foot clinic, orthotic specialist, physiotherapist, etc.

Note:
Prior to conducting a podiatry referral, ensure that the service user meets the eligibility criteria for entry. For information on eligibility, contact the podiatrist service relevant to your area.

Vaccinations

- Tick any vaccinations that the service user has had and record the date of inoculation. If the actual year or date is not known or if there has been no vaccination, record no.
- If the service user has never been vaccinated against any of the items listed, or if the date of immunisation is unknown, refer them to their GP or an immunisation service provider.
- The National Health and Medical Research Council (NHMRC) recommends the Australian Standard Vaccination Schedule (ASVS). A detailed list of this schedule is available on http://www.immunise.health.gov.au or by ringing the Immunisation hotline 1800 671 811.
- Consider a referral to GP or an immunisation service provider if the service user's vaccination schedule is not up to date.

Some common vaccinations include:

Vaccination	**Additional information**
Influenza	Recommended annually for those 50 years and over, people with severe asthma, children with cystic fibrosis, pregnant women who will be in the second or third trimester of pregnancy during the influenza seasons, including those in the first trimester at the time of vaccination.
Pneumococcus	Refer to a GP or an immunisation service provider for vaccination or revaccinating eligibility. This vaccine has a schedule for all age groups, each with specific eligibility criteria and a recommended schedule.
Tetanus	For fully vaccinated people, a tetanus booster is recommended at age 50 unless a booster dose has been documented within the last 10 years.
Other	See Australian Standard Vaccination Schedule guidelines.

Source: The Australian Immunisation Handbook 9th Edition 2008.

Driving

- Indicate if the service user drives a motor vehicle.
- Indicate if the service user is fit to drive. If the assessor has any concerns that a medical condition (refer to note below) may affect a service user's ability to drive safely, consultation with the service user's GP is recommended.
- Use the comment box to note any issues.
- Referral to other health disciplines for assessment relating to driving may include an occupational therapist, physiotherapist, GP or optometrist.

Note:
If a service user has a mental or physical incapacity that is likely to adversely affect their ability to drive safely, or if they are 75 years or older, they will require a medical certificate from a general practitioner as evidence that they are fit to drive.

Refer to the AustRoads Guidelines or your local Queensland Transport Centre for further information.

Continence

- The Incontinence Severity Index Scale screens for urinary incontinence and its severity, whilst the Wexner Scale gives a total faecal incontinence score. These are validated tools and provide a baseline for comparison post intervention.
- For each of the scales tick the correct answer.
- To tally the Severity Index the formula is: Frequency X Amount = Severity Index.
- Use the comment box to note any health risks and problems that may need further investigation — for example, chronic or degenerative disease, diabetes, cardiovascular disease, neurological disease, lung function, obesity, falls, history of urinary tract infections etc.
- Consider the sensitivity of this topic when screening. You may like to consider using the following phrases:
  - 'Are there any times when you may leak a bit of urine before making it to the toilet?'
  - 'When you cough or sneeze – is there any loss of urine?'
  - 'Are there any occasions when bowel motions come away before making it to the toilet?'
- Consider a referral to a GP or specialist continence adviser should the service user identify incontinence issues and/or where changes/concerns in bowel opening regularity are evident.
- To find local resources for continence management, contact the National Continence Foundation of Australia's Helpline Number 1800 33 00 66.

Height and weight

- The completion of this item is optional except where this form is completed as part of an Enhanced Primary Care (EPC) program assessment.
- Record actual height and weight and use these to calculate the Body Mass Index (BMI).
  - The BMI formula is as follows:
    BMI = Weight in kg ÷ Height in metres ^{2}

    An example:
    BMI = 40 kg ÷ 1.53 ^{2}m = 40 ÷ 2.34 = 17 (underweight).

Score range	
18–20	Underweight
20–25	Normal range
25–30	Overweight
30–40	Obese

- Consider a referral to: a dietician, diabetes clinic, Meals on Wheels, weight management clinic, speech pathologist.

Blood pressure/pulse

- The completion of this item is optional except where this form is conducted as part of an Enhanced Primary Care (EPC) program assessment.
- Record actual readings and consider checking for postural hypotension.

Health conditions profile (HC page 2 of 2)

Health conditions as reported by service user or carer

- Record any long-standing, persistent or recurrent conditions of the service user. Use questions such as: 'Do you have any health conditions that interfere with your normal activities that are long-standing or recurring?'
- Check and record any problems that occurred in the past that may have contributed to, or be related to, their present problem. For example, ask about overall health, hospital stays, medical interventions, and other conditions or disabilities.
- Record any allergies or other medical conditions that should be known by a health professional treating the service user.
- If the service user has a chronic condition, identify if they are already under the care of a medical practitioner and if there is a plan for long-term management, coordinated care or self-help activities that are already in place.
- If the service user is pregnant, record the details and make sure that they are receiving antenatal care. If there is no plan, make the necessary arrangements.
- Record health conditions as reported by the service user or carer in the table provided.

Medical diagnoses

- A medical diagnosis can only be recorded if there is written evidence that a medical practitioner has confirmed the diagnosis. If not, record the condition under 'health conditions' (see above) and record the condition based on what the service user tells you.
- If a medical practitioner is completing the health conditions profile, use this section to record the diagnoses.

Current medicines

- The medication section relates to all medicines including over the counter, bush medicine, and alternative treatments.
- Record the names of the medicines the service user is taking based on the service user's self-report.
- More reliable information may be obtained by viewing the medications and/or reading the information from the back of a Webster Pack or pillbox.
- Use questions like:
    - 'Please tell me the names of your prescription medicines and how often you take them?'
    - 'Please tell me the names of your medicines for which you do not need a prescription (i.e. over-the-counter)?'

- You may consider checking if the service user knows why they take certain medication. If it is identified that the service user is unclear about what his/her medication is for, consider a referral to a GP or a pharmacist. Asking this question may identify useful information about cognitive function and ability to manage medications; it may be useful for the action plan.

Note:
In some cases a service user may be taking another service user's medicines or they may be sharing medications with a partner or spouse.

If appropriate to the conversation you are having, or if there is some suggestion that circumstances such as this might apply, explore whether any problems exist from issues such as sharing of medicines.

Consider if the financial profile (cost of living decisions) on the living arrangements profile would elicit further useful information.

Cooperation with treatment

- There are three questions about cooperation with treatment; two of which relate to medicines.

  Circle the response for each of the three questions located within this box. Responses are on a scale of 0 to 3.

  - **Question 1** asks if the service user takes their own medication.

    For example: 'Is there someone who helps you take the medicines the way your doctor wants you to, or do you handle this yourself?'

  - **Question 2** asks if the service user is willing to take their medication.

    For example: 'Do you take them the way your doctor wants you to take them? If not, why not?

    Note:
    A service user may not manage their own medicine even though they are willing to do so (for example, if the service user has memory problems, they might just forget). The inability to manage their own medicine (the right medicine, in the right dose, at the right times) is an indicator of problems in managing activities of daily living.

    If problems are identified check this is reflected in the functional profile. In some cases, it may also indicate cognitive impairment. If there are no physical reasons why the service user cannot manage their own medicine, consider the need for a cognitive assessment.

  - **Question 3** asks about general cooperation with health professionals. This question is intended to identify if the service user is cooperating with their current service provider or health professionals and if not, why not? A need for culturally appropriate or more accessible services may be identified. Take these factors into account when formulating your ONI action plan.

Webster Pack or similar

- This question asks whether the service user has pre-packaged medicines. If the service user's compliance with medicine would improve with pre-packaged medication, you should refer for a Home Medicines Review (HMR).

Review of medications

- A Home Medicines Review (HMR) is a service provided to the service user by their GP/pharmacist to review medication management needs at home. A HMR is recommended where there is evidence of one or more of the following:
  - use of multiple medicines (more than five medications taken per day/polypharmacy)
  - use of single medicines over a long period
  - confusion regarding medication
  - episodes of forgetting to take medication
  - visiting more than one GP
  - recent discharge from hospital following an acute episode.
- If there is any evidence of the above, record 'yes' and consider a referral of the service user back to their GP.

Note:
Polypharmacy means ‘many drugs’ and refers to problems that can occur when a patient is taking more medications than are actually needed.

Comments box

- Use this box to summarise information and actions required on health conditions, or to capture any new information from questions such as ‘can you think of any other issues that interfere with your normal activities?
- Any health risks and problems that might need further investigation — for example, a chronic or degenerative disease, diabetes, cardiovascular disease, poor lung function, falls, and so on can be noted in the comment box.

Note:
Some conditions may be episodic in nature, recurring, or degenerative and the impact on function could be commented upon here. In variable disability and illness, consider rating the service user at their worst in the last three months.

Frequently asked questions about the health conditions profile

Q: Should I document the service user’s past surgical or medical history as part of the list of health conditions (as reported by the service user or carer)?

A: Only document the surgical procedures and/or medical conditions that are relevant to the service user’s current situation.

Q: Can non-clinical staff fill out the medication list and if so, would they be responsible for medication errors.

A: The list of medications is collected based on all sources of information available at the time. This would include asking the service user and/or looking at the labels on the back of a Webster Pack or pill bottles. Reviewing medication bottles/boxes and/or Webster Packs may help to determine whether the information you are receiving from the service user is accurate.

However, it is not the responsibility of the assessor to pick up medication errors or have knowledge of the usage and/or dosage of medication. If a service user does not understand their medication schedule, or are not adhering to their medication schedule, refer them to their GP and/or pharmacist.

5.2 The psychosocial profile

This is a profile that can be used to screen for psychosocial issues related to emotional and mental well-being, personal and social support, family and personal relationships, and relationships with service providers.

It provides a means of capturing some common risk factors associated with emotional and/or mental health problems (such as lack of social supports). This profile enables the assessor to consider and discuss referral options that may address the service user's issues.

It includes an assessment named the K10. This assessment can be used for the early identification of individuals who may have, or are at risk of developing, common psychological problems such as anxiety and depression.

How to complete the psychosocial profile

Mental health and wellbeing (K10)

- This profile has 10 questions on non-specific symptoms of psychological distress. It aims to measure the level of current anxiety and depressive symptoms a service user may have experienced in the four weeks prior to assessment.

  The questions asked are: 'In the past four weeks about how often did you feel…'

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

  For each item on the profile, there is a scaled response based on the amount of time the service user reports they experience the particular problem. This scale includes:

  1. none of the time
  2. a little of the time
  3. some of the time
  4. most of the time
  5. all of the time.

  The number is marked in the box dependent on the response received.

  Questions 3 and 6 are not asked if the service user answered 'none of the time', to the previous questions.

- The 10 items take about two minutes to complete.
- The K10 can be completed by choosing either of the following options:
  - self administered by the service user
  - administered by the assessor as a series of structured questions as detailed in the profile. It may assist the service user if you give them a copy of the scale to look at while you are asking the questions.
- A suggested approach to using the K10:

  You may like to lead into these questions with a comment such as:
  - 'I'd like to ask you some questions about how you've been coping over the last month'
  - 'We routinely ask these questions of everyone…'
    - 'who is caring for another service user',
    - 'who has had a recent illness',
    - 'who is seeking counselling services' or whatever is appropriate in the circumstances.

  This approach is more likely to be perceived by the service user to be non-judgemental and will assist them to feel more comfortable (i.e. not singled out).
- In some cases a service user may become upset or distressed when completing the K10. It is important that the service user is made to feel comfortable should this occur. A skill that may be useful in knowing how to respond to a service user in distress is active listening.

  Active listening is a way of listening and responding to a service user in a non-judgemental way that improves mutual understanding. It is a structured form of listening and responding that focuses the attention of the assessor (listener) on the service user (speaker). The listener aims to understand clearly what is being said by the service user by rephrasing or repeating what they hear the service user say to them.

  This technique encourages the service user to talk further about what is troubling them, discourages assessors from imparting their personal opinions and maximises effective listening and need identification. More information on *active listening* is available at www.studygs.net/listening.htm .
- The K10 will not diagnose particular issues, but can provide a trigger that there may be a problem that requires further investigation.
- When item scores have been marked a total score is obtained by adding together all item responses.

K10 Score	**Risk Level of anxiety or depressive disorder**
10–15	Low or no risk
16–29	Medium risk
30–50	High risk

- It is recommended that the GP be advised if the total score for this scale is 16 or over.
- Total scores of 30 or more would indicate a need for a specialist mental health referral. A service user with a score in the medium or high risk range should be referred to the most relevant service, i.e. a community health service.

Sleeping difficulty

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

Personal and social support

- Use this question if relevant to the service user's presenting problems:
  - 'During the past four weeks…was someone available to help you if you needed and wanted help?'

    If clarification is needed ask 'for example, if you felt very nervous lonely or blue etc.'

    Tick one of the five responses outlined. Record additional information in the comment box.
- If the service user has little support, recommend a referral and check the scores on the functional profile. This information should be considered when you formulate an action plan and, if necessary, a care plan.
- The level of support is also a useful indicator of both risk and urgency.

Family and personal relationships

- This area contains two questions with coded answers about friendships and personal relationships with others.
- Record a code from 1 to 4 in the box provided.
- If the service user indicates they are experiencing any particular difficulties that might be related to their presenting issue, record this information and any action required in the comment box.

Relationships with service providers

- Establish if the service user mistrusts health and community service providers because of what they see as bad experiences with providers and government agencies in the past. This might include legal services (police, custody disputes in court, divorce), health services (hospitals, doctors), schools, community services (health, welfare) or social security (pensions, benefits or other entitlements).
- Document any issues relevant to service providers in the 'alerts' section of the ONI.

Frequently asked questions about psychosocial issues

Q: On occasions a service user may become upset or distressed when completing the K10 screen. How would you manage this?

A: Each situation should be managed on an individual basis. If a service user becomes upset or distressed, modify your approach. Engage active listening skills. Ask if there has been help sought for their issue. Continue the profile questions when the service user is able, and consider discussion of referral options as appropriate.

5.3 The health behaviours profile

This profile is used to record information about the service user's lifestyle and identify what could be done to improve their health and well being.

The questions are in the form of tick boxes, except for malnutrition, which records a total score to indicate risk.

How to complete the health behaviours profile

Regular health checks

- This question identifies if the service user has regular health checks.
- If any checks have been undertaken, tick 'yes' and establish who conducted the check. Note the relevant information in the box.
- Consider a referral to a GP if there is a need for a regular health checks.

Smoking

- This question clarifies if the service user is a smoker or has a history of smoking. For a service user currently smoking, this question provides an opportunity to discuss referral options — for example, to a quit smoking program or GP.

Alcohol

- This item asks if the number of drinks consumed exceeds recommended standards and enables consideration of the impact of drinking patterns on overall health and well being. If excess alcohol consumption is an issue, consider a referral to an alcohol and drug service, or a GP.
- Australian standard drinks (in common containers of various alcoholic beverages):

Light beer (2.7per cent alcohol): 1 can or stubbie = 0.8 of a standard drink	**Wine (9.5 – 13per cent alcohol):** 750ml bottle = approximately 7 to 8 standard drinks 4litre cask = approximately 30 to 40 standard drinks
Medium light beer (3.5per cent alcohol): 1 can or stubbie = 1 standard drink	**Spirits:** 1 nip (30 ml) = 1 standard drink
Regular beer (4.9per cent alcohol): 1 can or stubbie = 1½ standard drinks 1 jug = 4 standard drinks 1 slab (cans or stubbies) = approximately 36 standard drinks	**Pre-mixed spirits** **(around 5per cent alcohol):** 1 can (375 ml) = 1½ standard drinks

Malnutrition

- This item identifies service users who are at risk of malnutrition. The malnutrition assessment consists of three questions that identify weight loss and/or appetite loss.
- If a service user reports they have lost weight without trying, a score is allocated based on the amount of kilograms lost.
- If a service user is unsure of any recent weight loss a score of (2) is allocated
- The sum of the three individual scores provides a total score.
- A total score of (2) or more indicates the service user is at risk of malnutrition. Consider referral to a dietician or GP for assessment.

Hydration

- Depending on the service user's situation and presenting problems, ask the question: 'do you regularly drink at least eight cups of fluid every day?'

  If the response is 'no', ask the following question: 'have you recently decreased your fluid intake?'

  If the response is 'yes' to the second of these questions, consider referral to a GP or other professional.
- When defining the term 'fluids' for a service user, explain that this includes all types of drinks, including water and other drinks.

Note:
When identifying a need for an action plan in relation to hydration, consider environmental temperatures and the risk of dehydration — for example, extremes of temperature. Additionally, consider any fluid restrictions in place based on medical direction.

Weight

- This section requires the assessor to judge the appearance of the service user and record in a tick box if they are underweight, average or overweight.
- Note that it is important to use your own judgement about whether a service user has significant weight problem before prompting further investigation. Whether the weight loss or gain has taken place over a short period of time will be relevant. There may be additional information from other ONI profiles.
- Consider discussing referral options for specialist or comprehensive follow-up services if the service user is significantly under or over weight. Refer to service providers the service user agrees to, for example: a dietician, speech pathologist, diabetes clinic, Meals on Wheels, single serve meals, weight management clinic, etc.
- Cross check your observations on weight with the medications and health conditions information contained in the health conditions profile and anything relevant that might have come up in the psychosocial profile and consider referral to a GP.

Physical activity

- Physical activity includes leisure, gardening and yard work, household chores, active transport and occupational physical activity.
- Tick the box that identifies the response to the question: 'would you do at least 30 minutes of moderate physical activity (such as walking or yard work or any other type of exercise), on most days of the week?' Consider a referral if appropriate — for example, to a diversional therapy program, walking program, or GP.

Physical fitness

- Tick the box that identifies the service user's response to the question.
- Ensure the consistency of the responses with screening for activities of daily living in the functional profile and consider the need for a referral if the service user's response can be judged as 'light' or 'very light'.
- The comment box should be used as a place to summarise the information gained or to record any other relevant issues about health behaviours and risks. These should then inform the ONI action plan and if necessary a care plan.
- Use your own judgement to probe for sensitive issues such as substance use.

5.4 The ONI priority rating tool (OPR)

The ONI priority rating tool provides a way of defining individual service user needs, risks and priority for services. It is an optional tool for service providers.

People are assigned to one of nine service priority categories based on the information collected throughout the ONI process.

A service user with no carer or unsustainable carer arrangements will be rated as having a higher priority as they will have higher risks.

People with a lower functional capacity will be rated as having a higher priority as they will have higher needs.

Note that each service will establish service entry and cut off points on the scale based on its own policies and resources. What follows from a particular service user's rating depends on the level of resources available.

For example:

- ONI priority rating of (1) would indicate the service user is unsafe and has a very high priority for care.
- ONI priority rating of (2) would indicate the service user is at risk and has a high priority for care.
- ONI priority rating of (3) or more are managed in order of date of presentation and based on need for care. This level of need would range from medium, to low and very low priority for care.

While need and risk can be objectively measured it is inevitable that the assessment of priority for services (i.e. combining need and risk) will involve value judgements at service provider level to determine the level of services offered.

Two options for determining the OPR are available and both will identify the same information. Only one version needs to be used to determine a priority rating category, and you may use the

version you find easiest or the one your service provider has chosen to use. The format is either a *decision tree flow chart, or a decision-making matrix*.

The decision tree flow chart uses a step by step process to determine the priority rating. The decision-making matrix uses one axis for risk and the other axis for need. In the matrix, the number in the cell where the two relevant categories meet determines a rating.

How to use the ONI priority rating tool

- The definitions of psychosocial and other problems are detailed in ONI priority rating. The priority rating score obtained can be recorded on the ONI.
- If the relevant ONI profile has not been completed, or no issues are evident in the completed profile, the service user should be rated as having no problems in that area.
    - *Option 1* *Decision tree flow chart*

      Follow the flow chart, circling each category that applies. An ONI priority rating score will be identified on completion of the flow trail.
    - *Option 2* *Decision-making matrix*

      There are two axes. On the far left column, identify the service user's category in relation to their carers based on information collected in the carer profile. In the top row, identify the service user's category of function and need. The ONI priority rating is the score in the box where these axes cross.

Definition of terms used in ONI priority rating tool

<u>Function:</u> (Identified in the functional profile)

- Low function: the total score on all nine items is (<6) or the total for items 6 and 7 is (<2)
- Medium function: does not meet criteria for Low or High function
- High function: no cognitive or behaviour problems, a score of (2) on three or more domestic functions (items 1 to 5) and a score of (2) on both items 6 and 7.

<u>Need for a carer:</u> (Identified in the carer profile)

- A service user will rate as needing a carer, if they have a code of:

  (1) the service user cannot be left on their own at any time (whether by day or night)

  or

  (2) the service user can only be left on their own for some, but not all of the time (whether by day or night) in item one of the carer profile.

<u>Psychosocial problems:</u> (Identified in psychosocial profile)

- K10 score of (30) or more

  and/or
- no personal and social support

  and/or
- significant family and personal relationships problems - score of (4) on both items.

Other problems:

- Service user mistrusts health and community service providers (psychosocial profile)

  and
- does not cooperate with health services (health conditions profile)

  or
- significant behavioural problems (functional profile)

  or
- significant cognitive problems (diagnosis of dementia in health conditions profile or cognitive problems (functional profile)

  or
- decision-making problems (living arrangements profile).

Carer sustainability: (Identified in carer profile)

- There is no carer able to provide necessary care, or the care arrangements have broken down - carer availability item score (2) or carer sustainability item – score (1)
- Carer arrangements exist but they are unsustainable without additional resources (they are likely to break down in weeks to months) - carer sustainability item score (2) or (3)
- Carer arrangements suitable and sustainable - carer sustainability item score (4) or (5).

Note:
Two people may have the same priority rating but require different types and levels of service.

There are several reasons (including combinations of reasons) why a service user might be categorised as a particular priority. Taking into account multiple reasons for assigning a priority rating is important. It means that we are no longer confined to responses based on whether a service user is high, medium or low need, but can assign a service user to a category based on both their need and risk. Both need and risk lead logically to defining the goal of care in a care plan.

While some people might have a number of characteristics that lead them to a particular priority category, they will not always be the same as all the other people in the same category.

For example, consider the different mix of a service user's characteristics that might lead to assigning the same priority category:

- A service user may be classified as high priority because they have low physical function and no carer.
- Alternately, a service user may be classified as high priority because they have medium physical function, have other problems and no carer.

While both are high priority, they will have different care needs and will need different services.

Frequently asked questions about priority rating

Q My service user is female, lives alone, has arthritis, a pinched nerve in her back, severe pain for four weeks but intermittent (good and bad days with the pain). She needs help doing heavy cleaning, is able to do shopping on good days. She has high function, no carer, no family close, no social support, K10 score of (11), but has the pain issue and psychosocial issues. I have given this service user a priority rating (5). Pain management is the main issue at the moment.

A: We cannot expect that different service types will respond in the same way to the one priority rating. In this example the service user is medium priority for domestic assistance because of high function. A referral to a rehabilitation service may also be required because one of their issues is intermittent low function because of a need for pain management.

Q: I'm assessing a mental health service user who has a paid carer that does more than their designated role. There may be some dependency on this carer. My issue is how to prioritise this service user with the other supports already in place. Maybe this is not a sustainable arrangement. There are few other support systems in place.

A: If the service user has a paid carer or a formally arranged volunteer carer, the answer when determining an ONI priority rating is 'has a carer'. Note that this is different to the response recorded for the HACC Minimum Data Set (MDS). In the HACC MDS, paid care arrangements are recorded as 'has no carer'. If the paid care arrangements provide service for a functional need and because we are interested here in assessing the sustainability of care arrangements, the service user would be rated as 'has a carer'. In these cases, the sustainability of the care arrangements will be determined by whether or not the paid or formal care arrangements are likely to be sustainable and, if so, for how long. If the situation with the paid carer changes in the future, update the information and assign a new priority rating.

Q: Using the ONI for both the service user and the carer has highlighted how the priority rating system is different for both, and this presents difficulties in interpreting how to score the combination of carer and the service user with different priority ratings for each.

A: There will sometimes be uncertainty about how to score for priority, given the complexity of the relationships being explored and the mix of needs and risk factors. There are a number of issues here. The first is the fact that the service user and the carer may each end up with a different ONI priority rating. For example, the carer may be seeking respite and have a priority rating of (5) while the service user may be seeking personal care and have a priority rating of (2).

This is not a problem, it is just a matter of accepting the idea that carers and service users may have different needs and different priorities for service.

Another issue is that a high priority rating does not necessarily mean more costly interventions. The ONI priority rating is designed to give an objective assessment of priority, but a judgement is then involved in determining what type and intensity of services are required.

Having assessed that, for example, the carer has a priority rating of (5) and the service user has a priority rating of (2), the next task is to consider what package of care will meet both of their needs. This might involve respite for the carer and personal care for the service user. We do not want the carer and the service user to be competing for services. Instead, the key idea is that you need to know the priority rating of both to work out both what they need and when they need to get it.

Q: Because the ONI is not identical to the HACC MDS, I'm confused about how to rate a service user who has a paid carer or formally arranged volunteer care.

A: In the HACC MDS (version 2), paid carer arrangements are recorded as 'has no carer'. Determining a service user's ONI priority rating involves assessing the sustainability of carer arrangements, and therefore the standard HACC MDS item is not useful. To address this, a code (98. not applicable – paid carer) has been added to the 'Carer Availability' and 'Relationship of Carer' items of the carer profile. This code will identify whether paid carers are in place and currently providing assistance/ support to the service user, enabling this significant information to be captured when determining an ONI priority rating.

Identifying whether paid carer (service) arrangements address a service user's functional needs, and checking the sustainability of these arrangements is required when determining an ONI priority rating. In these cases, the sustainability of the carer arrangements will be determined by whether or not the paid or formal carer arrangements are likely to be sustainable and, if so, for how long.

The different approaches may cause confusion for assessors (having one rule for the MDS and another for the ONI) but it doesn't make sense to rate a service user with a paid carer as having no carer, especially when trying to determine priority for service.

5.5 The HACC MDS supplementary Items

The completion of these supplementary items supports the HACC Minimum Data Set (MDS) mandatory reporting requirements, if the living arrangements and carer profiles are not completed.

Note:
If only one profile is completed (living arrangements/carer) by the assessor, complete the remaining items on the HACC MDS supplementary items page.

- This section is most suitable for services that provide a single service type such as home maintenance, home modifications or transport services, and do not have the capacity to fully assess people.
- Leave this tool blank if it is not required.

How to complete HACC MDS supplementary items

- Record code as appropriate from the lists provided. The comment box can be used to summarise relevant information as required.

5.6 Using the ONI to develop an action plan

Using ONI items as prompts for referral and further assessments

- When all the relevant information has been collected, the action plan and appropriate referrals should be considered. This might not be done at the point of initial contact, but at a later time when sufficient information is available.
- To develop an action plan, the assessor is expected to take into account the service user's:
  - presenting problems and issues
  - currently accessed services
  - other information available.

- Other information might be based: on their discussion with the service user, direct observation, information contained in a referral letter, personal notes or information provided by a third party such as a friend, relative, carer or referring service provider.
- On each profile, an identified need, issue or concern may trigger:
  - a referral to an appropriate service provider or specialist service for assessment
  - the completion of the relevant additional profiles or a comprehensive assessment.
- The profile contains prompts for further assessment, referral or more action on behalf of the assessor. The end section of the ONI page 3 provides options to consider on specific health and community service domains that may be relevant to the service user's identified problems or issues.

Using the ONI to record risks and urgency

- Page 3 of the ONI section has an alerts box on the top left-hand side. This box may be used to record any concerns identified in relation to danger, loss of social participation or reduction in health status.
- Further information about contact details can also be added here.
- Agencies and organisations will have their own related forms and scoring procedures for environmental assessments, occupational risk and incident reporting, and the ONI tool is not meant to replace these.
- If you trigger your own service provider's alert procedures, consider indicating this in the box.
- Note that the description of risks and the urgency of a service user issues can be considered under four main headings:
  1. Situations in which the service user is at risk for any reason
  2. Situations in which the service user presents a physical or emotional risk to other people, including family, friends and neighbours. It excludes risks to care workers
  3. Situations in which the service user represents a possible risk to a health professional or care worker, whether intentional or unintentional
  4. Situations in which there is an occupational health risk to a care worker or health professional for any other reason
- Even if an alert system is not being used for this particular service user, it is sometimes useful to consider if any low-level risks of the types described above are worth mentioning in this box. Examples of this might be something like: 'note that service user reports poor relationship with second daughter' or 'bathroom is on list for home modification - shower hose and bath board are temporary arrangement'.

Using the Action Plan for referrals

- The Action Plan (ONI Page 4 of 4) is used to describe a referral pathway for service users who need further assessment or for those with complex problems. The purpose is to keep track of how progress is going and whether any variation needs to be made to the plan of care.
- The columns capture more detail on: what information the service user has consented to share, codes for how the referral is being made, what transport is to be used, and what feedback is required.
- The 'feedback required' column is intended to prompt the timely sharing of information between important participants in the service user's care.

- The feedback column is of most relevance when this form is received by another service provider and they can determine if the original referring service provider, the service provider completing the profiles or the service user's caregivers or GP require feedback.
- It is often the case that more than one option for feedback will be recommended.
- By recording the actual date that the referral is made, the service provider making the referral can keep track of waiting times, and this may help determine whether additional follow-up action is required.

Developing care plans and service coordination plans

- When the ONI has been completed, there may be enough information for some agencies to develop a care plan; especially in cases where the service user's needs are adequately described without referrals for comprehensive assessments. In those instances a service specific plan of care is the next step. A care plan template is not provided in this manual as most services will have their own formats for such plans already in use.
- A service coordination plan is only useful where multiple agencies are involved and after the service user's needs have been fully assessed. In a service coordination plan, several goals of care might be included, each with their own care plans at the level of different agencies.

6 Appendices

Appendix 1: ONI tool templates

Appendix 2: ONI supplementary templates (Templates which can be used with the ONI)

- Appendix 2A: ONI service provider feedback form
- Appendix 2B: ONI fax cover sheet
- Appendix 2C: ONI request form
- Appendix 2D: CSTDA NMDS

Appendix 3: Working with people from Aboriginal and Torres Strait Islander backgrounds

Appendix 4: Working with people from Culturally and Linguistically Diverse backgrounds (CALDB)

Appendix 5: Specialist cultural/linguistic assessment tool

Appendix 6: Understanding dementia

Appendix 7: Working with people who are homeless or at risk of being homeless

Appendix 1: ONI tool templates

QUEENSLAND ONGOING NEEDS IDENTIFICATION

CORE ONI

Contact Information

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Title Other

Family Name:

Given Names:

Preferred Name/s:

Sex Male Female

Date of birth *dd/mm/yyyy*

Not estimated Estimated

Contact details

Usual Address

(number & street)

(locality & postcode)

Contact Address (if different from usual address)

(number & street)

(locality & postcode)

Contact phone number's

	Tick preferred number:	Can leave message? Y or N
Home:		
Work:		
Mobile:		

Fax:

Email address:

Who the agency can contact if necessary
(eg, case manager, next of kin, carer, guardian, enduring power of attorney, friend, emergency contact)

Person 1 Name

Contact details

(number & street)

(locality & postcode)

Phone:

Relationship to client

Person 2 Name

Contact details

(number & street)

(locality & postcode)

Phone:

Relationship to client

General Practitioner (if no GP, write N/A)

Name

Contact details

(number & street)

(locality & postcode)

Phone:

Fax:

Email:

Comments (incl. directions or other relevant contact issues)

Details of person completing this page

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

DO NOT WRITE IN THIS BINDING MARGIN

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

CORE ONI

Service Entry Data Set

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, record 99

Source of Referral
Record: **(1)** Self.
(2) Family, significant other, friend.
(3) GP/medical practitioner – community based.
(4) Aged Care Assessment Team.
(5) Community nursing or health service
(6) Hospital
(7) Psychiatric/mental health service or facility.
(8) Extended care/rehabilitation facility
(9) Palliative care facility/hospice
(10) Residential aged care facility.
(11) Aboriginal health service
(12) Other medical/health service
(13) Other community-based service.
(14) Law enforcement agency
(15) Other:.....
(99) Not stated / inadequately described.

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

Source of Referral Contact Details (if not GP)

Country of Birth
Record: **(1)** Australia **(2)** Other

If other, specify

Indigenous status:
(1) *Aboriginal* but not Torres Strait Islander origin
(2) *Torres Strait Islander* but not Aboriginal origin
(3) *Both* Aboriginal and Torres Strait Islander origin
(4) *Neither* Aboriginal nor Torres Strait Islander origin
(9) Not stated or inadequately described

Do you ever need help to communicate
(to understand or be understood by others):
(1) *No*
(2) *Yes, sometimes*
(3) *Yes, always*

Main Language Spoken at Home
Record: **(1)** English **(2)** Other

If other, specify:

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

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

Government Pensioner/Benefit Status
Record: **(1)** Aged Pension
(2) Veterans' Affairs Pension (complete DVA Card Status below)
(3) Disability Support Pension
(4) Carer Payment (pension)
(5) Unemployment related benefits
(6) Other government pension or benefit. If so, specify:

(7) No government pension or benefit

Pension/Benefit Card Number

Medicare Number

Health Care Card Number

DVA Card Status
Record:
(1) Yes - gold card
(2) Yes - white card
(3) Other DVA card:.....
(4) No DVA card

DVA Card Number

Insurance Status
Tick all that apply:
(1) None
(2) Private health insurance – basic cover only
(3) Private health insurance – including auxiliary cover for private dental and allied health services
(4) Motor vehicle accident insurance
(5) Workers' compensation
(6) Other 3rd party
(7) Ambulance fund
(99) Irrelevant or information not known

Health Insurer Name and Card Number

Details of person completing this page

Name Designation Agency

Sign Date Contact Number

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This information has been updated? Sign:

Name: Date:

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QLD ONI - CORE ONI

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QUEENSLAND ONGOING NEEDS IDENTIFICATION **CORE ONI** **Reason(s) the Consumer is Seeking Services** Facility:	(Affix client identification label here) URN: Family Name: Given Names: Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Alerts (including any relevant comments on risk or urgency)

ONI Priority Rating: Record rating here if relevant profiles have been completed to indicate relative priority for service

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

	Description of other issues as identified by the consumer or in the Ongoing Needs Identification process	
1		
2		
3		
4		
5		

ACTION REQUIRED: Code

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

Current services

Record services used in the last three months or on a recurring basis. If more than 8 services used, append an additional page

Service	**Record contact details or other information as appropriate**

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

Details of person completing this page

Name | Designation | Agency

Sign | Date | Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

CORE ONI
Action Plan

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Is this person HACC eligible? ☐ Yes ☐ No ☐ Don't know

Is this person eligible for disability services? ☐ Yes ☐ No ☐ Don't know

Is this person eligible for other support services (eg, DVA, NRCP)? ☐ Yes ☐ No *If yes, specify*:

Functional Profile is completed and attached? ☐ Yes ☐ No **Alternately, summarise Functional Profile below:**

Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Total score

After completing the relevant optional profiles, finalise the Action Plan below.

Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required. If more than 7 actions are required, append an additional sheet.

To be referred to (use codes below):

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

Agency/health professional: if you will be continuing to see the client, include yourself in the list of agencies/professionals for referral
For: Record purpose of referral
Consumer Consent: Record **(1)** Yes, consumer consents to referral and to sharing of information **(2)** Yes, consumer consents to referral but not to sharing of information **(3)** No, consumer has not consented to this referral

Referral method: Record **(1)** this form faxed to agency **(2)** letter (copy on file) **(3)** electronic **(4)** verbal request – face to face or phone call **(5)** other (incl. refer to self)
Transport Method: Record **(1)** Staff travel – service is delivered in home **(2)** Staff travel – client too unwell to travel **(3)** Staff travel – client has no transport **(4)** Client travel – own car **(5)** client travel – family/friends **(6)** Client travel – public transport or taxi **(7)** Client travel – walk **(8)** Community transport **(9)** Ambulance **(10)** Hitchhike **(11)** None
Feedback required: Record **(1)** to initial referral agency **(2)** to GP **(3)** to agency completing ONI **(4)** to carer/ guardian **(5)** other
Date: Record date referral actually made. If no referral actually made, leave blank
Review Date: Record date when action should be reviewed. If no need for review, leave blank

I have discussed the proposed referral/s and use/s of their personal information with the consumer/carer. I am satisfied that the consumer/carer understands the proposed uses and disclosures of the information that has been provided, and has provided their informed consent to these. Y N

Details of person completing this page

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

FUNCTIONAL PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If consumer does not answer, record 9

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

Item	Question	Score	Record score
1	**Can you do housework...**		
	Without help (can clean floors etc)?	2	
	With some help (can do light housework but need help with heavy housework?	1	
	Or are you completely unable to do housework?	0	
2	**Can you get to places out of walking distance...**		
	Without help (can drive your own car, or travel alone on buses or taxis)?	2	
	With some help (need someone to help you or go with you when travelling)?	1	
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	
3	**Can you go out shopping for groceries or clothes (assuming you have transportation)...**		
	Without help (taking care of all shopping needs yourself)?	2	
	With some help (need someone to go with you on all shopping trips)?	1	
	Or are you completely unable to do any shopping?	0	
4	**Can you take your own medicine...**		
	Without help (in the right doses at the right time?	2	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	1	
	Or are you completely unable to take your own medicines)?	0	
5	**Can you handle your own money...**		
	Without help (write cheques, pay bills etc)?	2	
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	1	
	Or are you completely unable to handle money?	0	

Do not ask the following 2 questions if the client scored 2 on all of the above 5 items (ie, can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.

6	**Can you walk...**		
	Without help (except for a cane or similar)?	2	
	With some help from a person?	1	
	Or are you completely unable to walk?	0	
7	**Can you take a bath or shower...**		
	Without help?	2	
	With some help (eg, need help getting into or out of the bath)?	1	
	Or are you completely unable to bathe yourself?	0	

NOTES:
- If unanswered, score 9.
- Rate what the person is **currently capable** of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 1).
- In rating an item that is irrelevant (for example, the person has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
- Item 6 (walking). Clients who are in a wheelchair should be rated as (1) if they are independent including corners etc or (0) if they are not wheelchair independent.

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

QUEENSLAND ONGOING NEEDS IDENTIFICATION

FUNCTIONAL PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If consumer does not answer, record 9

Questions for you to complete

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

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

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

Recommended functional assessments based on this Functional Profile *(tick all that are recommended)*

☐ **Domestic**

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

☐ **Self-care**

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

☐ **Cognition**

Refer for a cognitive assessment if:

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

☐ **Behaviour**

Refer for a behavioural assessment if:

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

Aids and equipment currently used *(tick all that apply)*

☐ Self-care Aids ☐ Medical Care Aids

☐ Support and Mobility Aids ☐ Car Modifications

☐ Communication Aids ☐ Aids for Reading

☐ Other (list):

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

QUEENSLAND ONGOING NEEDS IDENTIFICATION

LIVING ARRANGEMENTS PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, record 99

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

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

Accommodation Setting
Record: **(1)** Private residence – owned/purchasing **(2)** Private residence – private rental **(3)** Private residence – public rental **(4)** Independent living unit within a retirement village **(5)** Boarding house/private hotel **(6)** Short term crisis, emergency or transitional accommodation facility **(7)** Supported accommodation or supported living facility **(8)** Institutional setting **(9)** Public place/temporary shelter **(10)** Private residence rented from Aboriginal Community **(11)** Other

Comments on accommodation

Consider accommodation status above if home modifications are required

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

Comments on employment

Financial and legal profile

Mental Health Act status
Record **(1)** Involuntary **(2)** Forensic Order **(3)** N/A

Decision-making responsibility
Record: **(1)** Self **(2)** Significant Informal Assistance **(3)** Enduring Power of Attorney **(4)** Advance Health Directive **(5)** Formal Administrator or Guardian

Is the person capable of making their own decisions?

Yes No Not Sure

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

Financial decisions
Record: **(1)** Self **(2)** Significant Informal Assistance **(3)** Enduring Power of Attorney **(4)** Parent or Guardian **(5)** Formal Financial Administrator or Manager

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

Yes No Not Sure

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

Comments on legal and financial issues. Consider all legal issues including current legal orders (eg, AVO)

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

LAP Page 1 of 1

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QLD ONI - LIVING ARRANGEMENTS PROFILE

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

CARER PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, record 99

Carer Availability

(1) Has a Carer

(2) Has no Carer

(3) Not Applicable – no Carer required

(98) Not Applicable – paid Carer

Need for a Carer:

(1) The consumer cannot be left on their own at any time (whether by day or night)

(2) The consumer can only be left on their own for some, but not all, of the time (whether by day or night)

(3) Nil, no Carer required

CARER DETAILS

Family name:

Given names:

Date of birth:

☐ Not estimated ☐ Estimated

Country of birth:

Carer Residency Status

(1) Yes – Co-resident Carer

(2) No – Non-resident Carer

(3) Not Applicable – the consumer has no Carer

(98) Not Applicable – paid Carer

Relationship of Carer to Care Recipient

(1) Spouse/partner

(2) Parent

(3) Son or daughter

(4) Son-in-law or Daughter-in-law

(5) Other relative

(6) Friend/neighbour

Sex:

(1) Male

(2) Female

Language spoken at home:

☐ English (1201)

☐ Other *(specify)*:

Indigenous status:

(1) *Aboriginal* but not Torres Strait Islander origin

(2) *Torres Strait Islander* but not Aboriginal origin

(3) *Both* Aboriginal and Torres Strait Islander origin

(4) *Neither* Aboriginal nor Torres Strait Islander origin

(9) Not stated or inadequately described

Carer for more than one person:

(1) Yes

(2) No

Carer Support

Does Carer have someone to help them?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

Does Carer receive a Carer Payment or Allowance?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

Has Carer been given information about available support services?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

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

☐ Yes ☐ No ☐ Not sure ☐ No Carer

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

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

CP Page 1 of 2

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CARER PROFILE

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

CARER PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, record 99

Current threats to carer arrangements Tick all that apply

- ☐ **(1)** Carer – emotional stress & strain
- ☐ **(2)** Carer – acute physical exhaustion/ illness
- ☐ **(3)** Carer – slow physical health deterioration
- ☐ **(4)** Carer – factors unrelated to care situation
- ☐ **(5)** Consumer – increasing needs
- ☐ **(6)** Consumer – other factors

Comments (if applicable):

Carer Issue/s	Consider completing on Carer:
If carer requires HACC or HACC-like services	Functional and Living Arrangements Profiles
Health – consider the carer's overall health, age-related problems, disabilities, use of medicines	Health Conditions Profile
Psychosocial – consider the carer's mental health and emotional wellbeing, personal and social supports, family and personal relationships	Psychosocial Profile
Functional status and activities of daily living – consider the carer's overall health, age related problems, disabilities	Functional Profile
Health behaviours – consider the carer's living arrangements, housing, work, financial, legal	Health Behaviours Profile
Determinants of health - consider the carer's living arrangements, housing, work, financial, legal	Living Arrangements Profile

Are carer arrangements sustainable without additional services or support? ☐

Consider carer role, client needs, and current threats to carer arrangements when scoring

(1) No, arrangements have already broken down

(2) No, carer arrangements likely to break down within weeks

(3) No, carer arrangements likely to break down within months

(4) Yes, carer arrangements are sustainable without additional support

(5) Don't know

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CARER PROFILE

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

HEALTH CONDITIONS PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Overall health ☐ N/A

In general, would you say your health is?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

☐ None ☐ Very Mild ☐ Moderate ☐ Severe ☐ Very Severe

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

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

Vision and Hearing

Is your eyesight for reading (with your glasses)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ N/A

Is your long distance eyesight (with your glasses)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ N/A

Hearing is your hearing (with your hearing aid)?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ N/A

Oral health ☐ N/A

Problems with teeth, gums, dentures, including eligibility to access services?

☐ Yes ☐ No

Comments:

If yes, consider referral, Functional Profile and Health Behaviours Profile

Speech/Swallowing ☐ N/A

Problems with speech &/or swallowing?

☐ Yes ☐ No

Comments:

If yes, consider referral, Functional Profile and Health Behaviours Profile

Falls ☐ N/A

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

☐ Yes ☐ No

If yes, record number of falls: .....

Comments:

Consider both Functional Profile and need for referral if the consumer has any problems with vision, hearing or falls.

Feet ☐ N/A

Problems with one or both feet? ☐ Yes ☐ No

Comments:

Vaccinations: ☐ N/A

	Influenza	Pneumococcus	Tetanus	Other:
Date:				

Driving ☐ N/A

Drives a motor vehicle? ☐ Yes ☐ No

Fit to drive? *(Refer AustRoads Guidelines)* ☐ Yes ☐ No

Comments:

Continence ☐ N/A

How frequently is urine leakage experienced?

☐ **(0)** Never
☐ **(1)** Less than once a month
☐ **(2)** 1 to several times a month
☐ **(3)** 1 to several times a week
☐ **(4)** Every day and / or night

What amount of urine is lost each time?

☐ **(1)** A few drops
☐ **(2)** A little
☐ **(3)** More

Record score of frequency: Record points for amount Severity Index

X =

How frequently is faecal incontinence experienced (leak, have accidents or lose control with stool)?

☐ **(0)** Never
☐ **(1)** Rarely (less than once in the past four weeks)
☐ **(2)** Sometimes (less than once a week, but more than once in the past four weeks)
☐ **(3)** Often or Usually (less than once a day but more than once a week)
☐ **(4)** Always (more than once a day)

Comments:

Height and weight ☐ N/A

Weight: ..... kg Height ..... m

BMI: .....

BP/Pulses ☐ N/A

Systolic BP: ..... mm/Hg Diastolic BP: ..... mm/Hg

Pulse Regular Irregular Pulse rate: .....

Consider check for postural hypotension? ☐ Yes ☐ No

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - HEALTH CONDITIONS PROFILE

v2.00 - 01/2006
www.health.qld.gov.au/hacc

QUEENSLAND ONGOING NEEDS IDENTIFICATION

HEALTH CONDITIONS PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

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

Condition	Condition
1	5
2	6
3	7
4	8

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

Diagnosis	Diagnosis
1	5
2	6
3	7
4	8

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

1	7	13
2	8	14
3	9	15
4	10	16
5	11	17
6	12	18

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

Webster Pack or similar used for medicine? Yes No
Review of medications recommended? Yes No

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

HC Page 2 of 2

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - HEALTH CONDITIONS PROFILE

v2.00 - 01/2006
www.health.qld.gov.au/hacc

QUEENSLAND ONGOING
NEEDS IDENTIFICATION

PSYCHOSOCIAL PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

Mental health and well being
In the past 4 weeks about how often did you feel...

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

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

Total K-10 Score:

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

Have you had any difficulty sleeping? Yes No

Comments:

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

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

Yes, as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little
No, not at all

Consider referral & Functional Profile

Comment on personal and social support, including opportunities

Family and personal relationships
Does this person generally make and/or keep up friendships?
(1) Friendships made or kept well
(2) Friendships made or kept up with slight difficulty
(3) Friendships made or kept up with considerable difficulty
(4) No friendships made or none kept up

Does this person generally have problems (eg, friction, avoidance) interacting/living with others?
(1) No obvious problem
(2) Slight problems
(3) Moderate problems
(4) Extreme problems

Comments

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

Yes No Not sure

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

PP Page 1 of 1

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - PSYCHOSOCIAL PROFILE

v2.00 - 01/2006
www.health.qld.gov.au/hacc

QUEENSLAND ONGOING NEEDS IDENTIFICATION

HEALTH BEHAVIOURS PROFILE

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Regular health checks

Yes No

If yes, record last date or year

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

Smoking

Never smoked
Has quit smoking
Currently smokes

If quit, record when
Consider referral if currently a smoker

Alcohol

How often do you have a drink containing alcohol?

Never
Less then monthly
Monthly
Once a week
2-4 times per week
5+ per week

If never, proceed to next section

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

(Refer to ONI manual for definition of a standard drink)

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

Never
Monthly
Once a week
2-4 times per week
5+ per week

Consider referral if alcohol consumption is an issue

Malnutrition

Use the total score below to decide whether action is required.

			Score
1. Have you lost weight recently without trying? *Notes: 'recently' means last 6 months. If consumer unsure, ask if clothes are looser etc*	Yes No Unsure **If yes, complete 1a*	0* 0 2	
1a. If yes, how much weight have you lost? (in kilograms)	1-5 6-10 11-15 >15 Unsure	1 2 3 4 2	
2. Have you been eating poorly because of decreased appetite? *Note: decreased appetite means eating less than ¾ of usual food intake. "eating poorly' may be due to problems with swallowing and chewing. If so, score yes.*	Yes No	1 0	
Total score			

Total score of 2 or more: consumer at risk of malnutrition. Consider referral to GP or dietitian.

Hydration

Do you regularly drink at least 8 cups of fluid every day?

(A) Yes (B) No

If answer to question above is (B), have you recently decreased your fluid intake?

(A) No (B) Yes

If answer is (B) to either of the above, consider referral to GP or health professional.

Weight

Underweight
Average
Overweight

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

Physical activity

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

Yes No

Consider referral if 'no'.

Physical fitness

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

Very heavy (for example) run, fast pace; carry a heavy load upstairs or uphill (25 lbs., 10 kg)
Heavy (eg) jog, slow pace; climb stairs or a hill at moderate pace
Moderate (eg) walk, medium pace; carry a heavy load level ground (25) lbs., 10kg)
Light (eg) walk, medium pace; carry a light load on level ground (10 lbs., 5 kg)
Very light (eg) walk, slow pace; wash dishes

Consider both Functional Profile and need for referral if response is 'light' or 'very light'.

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

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

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QUEENSLAND ONGOING
NEEDS IDENTIFICATION

ONI PRIORITY RATING TOOL

Facility:

(Affix client identification label here)

URN:

Family Name:

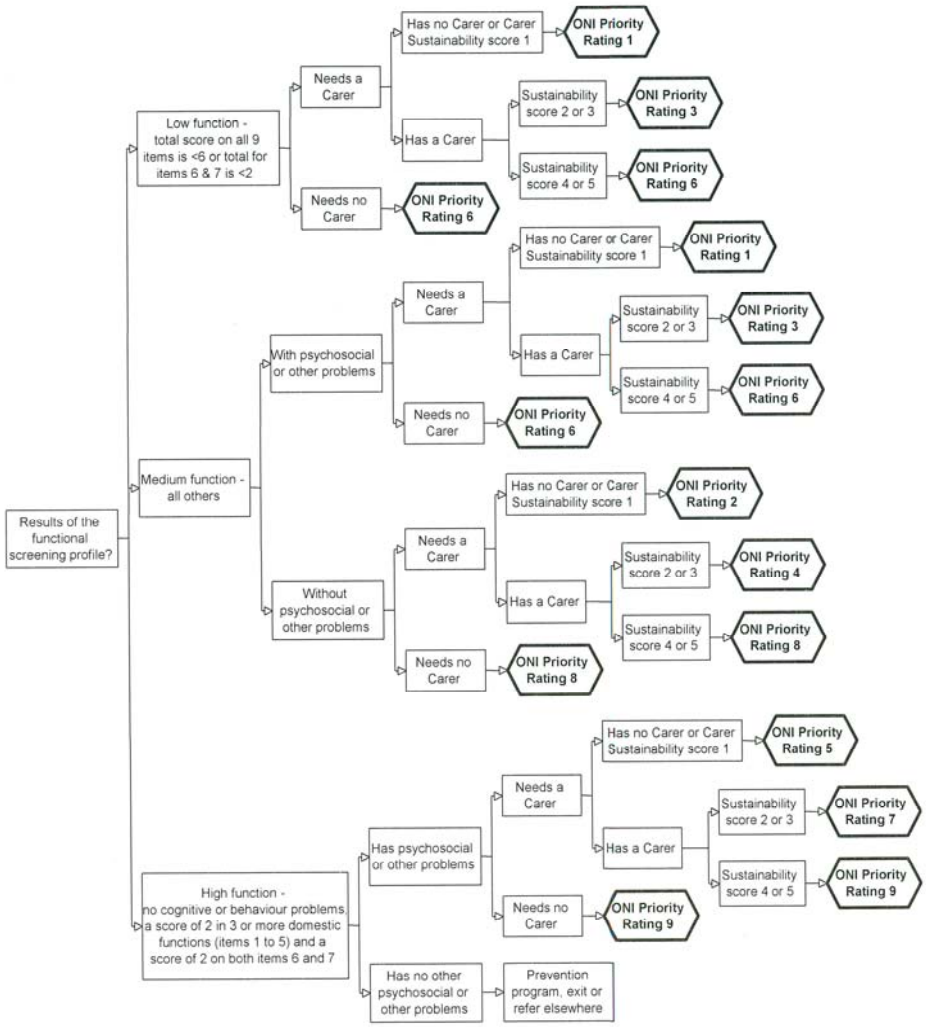
Given Names:

Date of Birth: Sex: M F

ONI Priority Rating: To be completed following screening process to indicate relative priority for service

Option 1: Decision Making Flow Chart

An alternate way to identify the ONI Priority Rating is shown on page 2 of this profile. Complete either page 1 or page 2, not both. Work through this tool, using either the flow chart below or the matrix over the page. If using the flow chart, circle the relevant box at each step. Definitions of psychosocial and other problems are on page 2. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3.



Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

OPR Page 1 of 2

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QLD ONI - ONI PRIORITY RATING TOOL

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QUEENSLAND ONGOING NEEDS IDENTIFICATION

ONI PRIORITY RATING TOOL

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

ONI priority rating: To be completed following screening process to indicate relative priority for service

Option 2: Decision Making Matrix

This is an alternate way to identify the ONI Priority Rating shown in more detail on page 1 on this profile. Complete either page 1 or page 2, not both.

Definitions of psychosocial and other problems are below. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3

RISK (all rated in Carer Profile)	**NEED**			
	Low function Total score on all 9 items is <6 or total for items 6 & 7 is <2	**Medium function** (not Low or High Function) **with significant psychosocial or other problems** (see below)	**Medium function** (not Low or High Function) **with no significant psychosocial or other problems** (see below)	**High function but psychosocial or other problems**. High function – no cognitive or behaviour problems, a score of 2 on 3 or more domestic functions (items 1 to 5) and a score of 2 on both items 6 and 7
Needs a carer but has no carer or carer arrangements have already broken down Need for Carer Status item – score 1 or 2. Carer Availability item – score 2 **OR** Carer Sustainability item – score 1	1	1	2	5
Carer arrangements exist but are unsustainable without additional resources (likely to break down in weeks to months) Need for Carer Status item – score 1 or 2. Carer Sustainability item – score 2 or 3	3	3	4	7
Carer arrangements suitable and sustainable Carer Sustainability item – score 4 or 5 **OR** **Carer not required** Need for Carer Status item – score 3 or 4	6	6	8	9

Psychosocial problems (all in Psychosocial Profile)
K10 score of 30 or more **AND/OR**
No personal and social support **AND/OR**
Significant family and personal relationships problems (score of 4 on both items)

Other problems
Consumer mistrusts health and community service providers (Psychosocial Profile) **AND**
Does not cooperate with health services (Health Conditions Profile) **OR**
Significant behavioural problems (Functional Profile) **OR**
Significant cognitive problems (diagnosis of dementia in Health Conditions Profile or cognitive problems (Functional Profile) **OR**
Decision-making problems (Living Arrangements Profile)

Note: If the relevant profile is not completed, rate that the person has no problems. For example, if no Carer Profile is completed, rate the consumer as having no carer risks.

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

QUEENSLAND ONGOING NEEDS IDENTIFICATION

HACC MDS SUPPLEMENTARY ITEMS

Facility:

(Affix client identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: M F

If question is irrelevant or information not known, record 99

Complete only if the Living Arrangements and/or Carer Profile not completed. Otherwise, leave blank.

Living arrangements
(1) Lives alone
(2) Lives with family
(3) Lives with others

Accommodation Setting
(1) Private residence – owned/purchasing
(2) Private residence – private rental
(3) Private residence – public rental
(4) Independent living unit within a retirement village
(5) Boarding house/private hotel
(6) Short term crisis, emergency or transitional accommodation facility
(7) Supported accommodation or supported living facility
(8) Institutional setting
(9) Public place/temporary shelter
(10) Private residence rented from Aboriginal Community
(11) Other

Carer availability
(1) Has a carer
(2) Has no Carer
(3) Not Applicable – no Carer required
(98) Not Applicable – paid Carer

Carer Residency Status
(1) Yes – Co-resident Carer
(2) No – Non-resident Carer
(3) Not Applicable – the consumer has no Carer
(98) Not Applicable – paid Carer

Relationship of Carer to Care Recipient
(1) Spouse/partner
(2) Parent
(3) Son or daughter
(4) Son-in-law or Daughter-in-law
(5) Other relative
(6) Friend/neighbour

CARER DETAILS

Family name:

Given names:

Date of birth:

☐ Not estimated ☐ Estimated

Country of birth:

Sex:
(1) Male
(2) Female

Language spoken at home:
☐ English (1201)
☐ Other *(specify)*:

Indigenous status:
(1) *Aboriginal* but not Torres Strait Islander origin
(2) *Torres Strait Islander* but not Aboriginal origin
(3) *Both* Aboriginal and Torres Strait Islander origin
(4) *Neither* Aboriginal nor Torres Strait Islander origin
(9) Not stated or inadequately described

Carer for more than one person:
(1) Yes
(2) No

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name Designation Agency

Sign Date Contact Number

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign:

Name: Date:

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QLD ONI - HACC MDS SUPPLEMENTARY ITEMS

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Appendix 2: ONI supplementary templates

(Templates which can be used with the ONI)

Appendix 2A: ONI service provider feedback form

QUEENSLAND ONGOING NEEDS IDENTIFICATION Facility:	(Affix client identification label here) URN: Family Name: Given Names: Date of Birth: Sex: M F

ONI Service Provider Feedback Form

Client Surname:	
Given Names:	
Date of Birth:	
Address:	
	Phone:
To:	Fax:
Agency:	
From:	
Agency:	Phone:

A. Outcome of Referral:

1. Able to provide service

Type of service:
Commencement Date:
Frequency:

2. Unable to provide service

- ☐ Consumer ineligible for service
- ☐ Referred elsewhere
- ☐ Advice / information provided. No further action required.
- ☐ Consumer declines further referral or service
- ☐ Consumer issues resolved. No further action required
- ☐ Service not available
- ☐ Requested service not accessible (eg: due to long waiting time, inaccessible location)

Unable to provide service because:

B. Services Ceased

Type of service:
Cessation Date:
Reason:

Details of person completing this page

Name	Designation	Agency
Sign	Date	Contact Number

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Appendix 2B: ONI fax cover sheet

QUEENSLAND ONGOING NEEDS IDENTIFICATION

Facility:

ONI Fax Cover Sheet

TO:		**FROM:**	
FAX NO:		**PHONE:**	
TOTAL PAGES:		**FAX:**	

Service being requested:

HACC Eligible ☐ Yes ☐ No **Priority Rating:**

Please indicate which ONI Tools have been completed and those that are being sent at this transmission

Tool	Completed	Sent	Tool	Completed	Sent
Core ONI	☐	☐	Carer Profile	☐	☐
Functional Profile	☐	☐	Health Conditions Profile	☐	☐
ONI HACC MDS Supplementary Page	☐	☐	Psychosocial Profile	☐	☐
Living Arrangements Profile	☐	☐	Health Behaviours Profile	☐	☐

Other Information Attached

Tool	Completed	Sent
ONI Priority Rating Tool	☐	☐
Other Tools (eg Tier 2, service specific info)	☐	☐
Consent Form	☐	☐
Other: (please specify)	☐	☐

Indicate the HACC brochure/s provided to the consumer: ☐ HACC Services Brochure

☐ Carer Brochure ☐ Client Rights and Responsibilities Booklet ☐ None

HACC Agencies are required as per HACC National Standards to advise clients on at least an annual basis about Rights and Responsibilities, the complaints and disputes process, available advocacy services and other available services in their region.

Recommended external case conference ☐ Yes ☐ No

Please send feedback to

Name Designation/Agency

Sign: Date: Contact Number:

DO NOT WRITE IN THIS BINDING MARGIN

v2.10 - 08/2008
www.health.qld.gov.au/hacc

Appendix 2C: ONI request form

QUEENSLAND ONGOING NEEDS IDENTIFICATION Facility:	(Affix client identification label here) URN: Family Name: Given Names: Date of Birth: Sex: M F

ONI Request Form

Note: If faxed, this Form must be covered with a Fax Cover Sheet to protect the privacy of the client.

Our agency has received a request for a service for the following person.

Name: DOB:

Address:

This client has indicated that your Agency is currently providing a service for this person:

In order to reduce duplication of screening/assessment for this person, a copy of the Ongoing Needs Identification (ONI) is requested, to be forwarded to the nominated contact person within our agency as a matter of **URGENCY**.

In addition to the **Core ONI**, the following information in the following Profiles is requested, where completed.

Functional Profile	Health Conditions Profile
HACC MDS Supplementary Items	Psychosocial Profile
Living Arrangements Profile	Health Behaviours Profile
Carer Profile	ONI Priority Rating Tool

Comments:

The client has given verbal consent for this information to be shared with our Service and has been informed; that this information will assist in the planning, coordination and delivery of community services to the consumer, that information received may be used for program reporting and / or research purposes in relation to de-identified personal information (eg. The HACC Minimum Data Set), and that information received may be used to evaluate the effectiveness of the delivery of community services. If this request cannot be actioned within 1 working day of receipt please contact us so that alternative arrangements can be made.

Name Designation/Agency

Sign Date Contact Number

DO NOT WRITE IN THIS BINDING MARGIN

v2.00 - 12/2005
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Appendix 2D: CSTDA NMDS

CSTDA NMDS

(This contains CSTDA NMDS data elements not included in ONI)

Name

Date of Birth

URN

or affix label here

Carer arrangements (informal)

The following questions are asking about the presence of an **informal carer** who provides support to the service user (ie these questions are **not about paid carers)**

Does the service user have an **informal carer**, such as a family member friend or neighbour, **who provides care and assistance** on a regular and sustained basis?

'Regular' and 'sustained' in this instance means that care or assistance has been ongoing, or likely to be ongoing for at least six months

Yes ☐ 1 > Go to next question No ☐ 2 Skip next 2 questions

Does the carer assist the service user in the area(s) of **self-care, mobility** or **communication**?

The following 2 questions relate to the informal carer mentioned above

Yes ☐ 1 No ☐ 2

What is the **age group** of the **carer**?

When asking the service user about the age of their carer it is considered more appropriate to ask about broad age groups rather than actual age

Less than 15 years	☐ 1	45 – 64 years	☐ 4
15 – 24 years	☐ 2	64 years and over	☐ 5
25 – 44 years	☐ 3		

Only complete this question if the service user is aged under 16 years

If aged under 16 years: do the service user's parents or guardians receive the **Carer Allowance (child)**?

Yes ☐ 1 No ☐ 2 Not known ☐ 3

This question is not asking about Carer Payment even though some parents of children aged less than 16 years receive it I addition to Carer Allowance (child)

Only complete this question if the service user is aged 15 years or more

If aged 15 years or more: what is the service user's **labour force status**?

Employed ☐ 1 Unemployed ☐ 2 Not in the labour force ☐ 3

Only complete this question if the service user is aged 16 years or more

If aged 16 years or more: What is the service user's **main source of income**?

Disability Support Pension	☐ 1	Other income	☐ 5
Other pension or benefit	☐ 2	Nil income	☐ 6
Paid employment	☐ 3	Not known	☐ 7
Compensation payments	☐ 4		

This item refers to the source by which a person derives most (equal to or greater than 50%) of his/her income. If the person has multiple sources of income and none are equal to or greater than 50%, the one which contributes the largest percentage should be counted.

For service users of all ages

Is the service user currently receiving **individualised funding** under the CSTDA?

Yes ☐ 1 No ☐ 2 Not known ☐ 3

Details of Screening Officer

Name _____ Designation/Agency _____

Sign _____ Date _____ Contact number _____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Appendix 3: Working with Aboriginal and Torres Strait Islander people

An essential skill in the provision of culturally appropriate services, cultural awareness requires an understanding of how a person's culture may inform their values and behaviour.

Cultural awareness recognises that we are all shaped by our cultural background, which influences how we interpret the world around us, perceive ourselves and relate to other people. Service workers don't need to be an expert in every culture to be culturally aware; rather, cultural awareness helps them to explore cultural issues with service users more sensitively.

Information about specific cultural practices will help to increase a service workers cultural knowledge by providing them with an overview of cultural characteristics and issues. However, it is always important to identify individual needs and preferences and remember that no individual can be reduced to a set of cultural norms.

Within any culture, peoples' values and behaviour can vary enormously. Differences may occur due socio-economic background, level of education, remote, rural or urban residence, identification with cultural and religious background, and different life experiences.

It is impossible to know all the differences that might exist across diverse cultural groups. However, it is possible to approach service delivery with the understanding that different and complex cultural conventions exist. For example, seek out information on different customs to improve your understanding and ability to adapt to whatever cultural codes you may encounter, and to avoid inaccurately attributing negative characteristics to a particular group or person.

It is important all staff and managers are provided with ongoing development opportunities to enhance their knowledge of culturally inclusive practices and their responsibility in implementing culturally appropriate services[1].

Improving your cultural awareness and understanding of cultural influences:

Service workers need to be aware of their own cultural influences.

1. Be aware of:
    - judging other people's behaviour and values according to the standards of their own culture.
    - making assumptions about cultural influences and applying generalisations to individuals.

2. Understand:
    - the behaviour and beliefs of people within cultures can vary considerably.
    - not all people identify with their cultural or religious background.
    - the importance of appropriate communication.

3. Increase your knowledge of different cultural practices and issues through cultural background information sessions and/or resources and cultural awareness training[1].

[1] http://www.culturaldiversity.com.au/practice-guides/cultural-awareness

Points to consider ***before* visiting and assessing an Aboriginal or Torres Strait Islander person**

Managers/Coordinators should:

- Ensure assessors are informed and accommodating of the service user's environment and beliefs. Assessors should be carefully screened for cultural awareness before visiting an Aboriginal, Torres Strait Islander and/or Australian South Sea Islander service user to ensure they are sensitive to the service user's cultural background, living arrangements and communication needs.
- Reiterate with the assessor/s the need to maintain confidentiality – i.e. don't reveal details of your visit to the service user or any details of the service user assessments to extended family or friends without the service user's consent. This is extremely important in small, regional and remote communities.
- Be flexible about the time it may take to complete an assessment. There may be an expectation that assessors generally undertake four or five assessments per day. However, when assessing Aboriginal and Torres Strait Islander people it may only be possible for one or two assessments to be completed in a day. This can be due to travel distances and language barriers, particularly in remote and regional areas of Queensland.
- Ensure assessors participate in initial cultural awareness training prior to visiting service users in remote or regional communities.
- There are a number of cultural awareness training programs available including the nationally accredited unit *'HLTHIR404B - Work effectively with Aboriginal and/or Torres Strait Islander people'.* This is a unit of competency from the Certificate III in Home and Community Care and the Certificate III in Aged Care.
- Ensure assessors have an understanding of the cultural differences between Aboriginal, and Torres Strait Islander culture. Each culture is different.
- Ensure assessors obtain permission from a relevant elder or community member before they enter a remote or discrete Aboriginal or Torres Strait Islander community.
- Consult with local staff prior to the visit and organise joint visits with local workers when possible as English may not be the service user's first language.
- An introduction by a local staff member should assist to build trust with the service user. Many local staff in remote areas originate from the community they work in and have local knowledge of the service user's history, family, cultural and language requirements.
- Ensure assessors organise face-to-face assessments when possible, rather than over the phone assessments. Extensive consultation with Aboriginal and Torres Strait Islander service providers identified:
    - The service user prefers to see the assessors face (and body language).
    - Not all service users in remote Aboriginal and Torres Strait Islander communities have telephones, and if they do, they may not be functioning all of the time due to line outages.
    - English may not be the service user's first language.
- Ensure assessors are responsive to culturally appropriate interaction between genders (men's and women's business) when enquiring about personal affairs and health conditions. For example, it may be more appropriate to have male-to-male or female-to-female dialogue when asking personal questions.

- Ensure assessors are informed of the cultural protocols of individual communities. For example:
    - Assessors may not be welcomed into a community when there has been a death in the community due to cultural protocols.
    - Assessors will need to be sensitive to the individual community dynamics, including kinship ties, and positive and negative interactions between family groups to avoid creating conflict with service users.
    - Ensure assessors are conscious of the use of subtle body language by the service user. For example, the service user may show signs of discomfort with certain questions and you may need to approach the question in a different manner.
- Most importantly reiterate to assessors they should be accommodating of people's differences, living arrangements and lifestyles and respect the service user's cultural practices.

Points to consider during the assessment of an Aboriginal or Torres Strait Islander service user:

The assessor should:

- Ask the service user how they would like to be addressed. Don't assume you may use the term aunty or uncle or the service user's first name because someone else does so.
- Build rapport with the service user and understand it may take 2 to 3 visits before trust can be established and the real needs of the service user can be identified. If the service user is not familiar with the assessor then shallow responses may be given.
- Recognise that the service user may want to identify your family connections or background before they feel comfortable providing you with personal information.
- Avoid conducting an assessment with a laptop and/or a tick and flick form. Obtain information through conversation where possible. Asking a series of questions may give the service user a sense of being interrogated. It was identified that a conversation shows respect for the elder.
- The ONI tool should be used as a guide to the conversation.
- Use narratives where possible – give examples or a story about the question.
- Be sensitive; try not to ask direct questions, except for obvious questions i.e. name and date of birth. Be extremely sensitive when addressing continence, hygiene and psychosocial issues. For example, it may be more appropriate to have male-to-male or female-to-female dialogue when asking personal questions.
- Be aware that silence may not imply that the service user understands the question; silence may also not indicate agreement to what the assessor may be suggesting.
- Ask open questions to avoid yes/no answers and understand that 'yes' doesn't always mean 'yes' – the service user may believe that they are required to give you the answer that you want, and will say yes just to please you.
- Avoid building unrealistic expectations as the local service provider may be unable to provide all service types required by the service user.

Points to consider after visiting and assessing an Aboriginal, Torres Strait Islander service user:

- As a courtesy, assessors should check-in with the local service coordinator before departing the community (i.e. assessors not employed by the local service providers).

Core ONI

- When completing the *'interpreter required'* section, keep in mind although the service user may be able to carry out a simple conversation in English, they may not be able to comprehend questions of a complex nature or express themselves clearly enough to participate in the assessment process.
- Ensure that assistance is sought from an appropriate interpreter – family members may not always be the most appropriate interpreters. For example, the service user may not want some family members to be privy to the information gathered in the ONI assessment.
- As people often lose their ability to communicate in a second language in times of stress, illness, and/or cognitive impairment you should consider the need for an interpreter for obtaining consent, providing information and conducting the assessment process, and subsequent reviews.
- If a service user does not require an interpreter for day-to-day services but does for complex communication situations then this should be rated as needing an interpreter.

Functional profile

- Functional ability (performing tasks of day-to-day living) is not affected by language and cultural barriers. However, a language barrier may determine there is a need for additional assistance during assessment — for example, an interpreter service.
- Barriers are taken into account in other profiles such as the living arrangements, carer and psychosocial profiles. In the action plan you can recommend a referral to a culturally specific service. **Use the alerts box if significant barriers exist, and capture any specific issues on the relevant profiles.**
- Family roles and relationships may impact on a service user's ability to function and perform tasks in certain areas. This should be considered when assessing people from all cultural backgrounds, and functional ability should be assessed on the service user's indentified capacity to undertake tasks.
- Lack of ability to function in certain areas because of psychological conditions such as post traumatic stress disorder and depression should be considered the same as other mental health conditions which may vary in intensity i.e. you should rate the service user's functional capability when they were at their worst in the previous month.
- Memory and behaviour problems may be difficult to determine when assessing a service user from an Aboriginal or Torres Strait Islander background or when using an interpreter to assist with your assessment. You should clarify with the interpreter that you have assessed the situation or issue correctly.

Carer profile

- It is important to understand the family roles and relationships and how the service user's decline in functional ability may significantly impact on the family unit. If a spouse, children or other relatives appear to be carers, but are not performing the necessary tasks then they should not be considered as the service user's carer. If family members are prepared to perform some tasks but refuse to perform other necessary tasks, then the carer relationship should be considered unsustainable without extra assistance.
- When assessing service users from all cultural backgrounds carer availability and sustainability should be considered based on the service user's identified capacity to perform the task.

Psychosocial profile

- Service users may not initially identify issues of isolation, indicate family members are not always available, or if there is family conflict, as they do not wish defame or shame their family.
- This is often information that is received over time.
- In some cultures there is no word for depression and it is shameful to talk about ‘mental health’ but is ok to talk about feeling sad.

This guide was compiled using information obtained through consultations conducted throughout Queensland with Aboriginal and Torres Strait Islander service providers between April and October 2011. These consultations where conducted by Ms Lauriann Trevy, HACC Service Development Officer, Mackay. In addition, information and recommendations from the reference group established to oversee the development of this guide have been included in this guide.

Appendix 4: Working with people from culturally and linguistically diverse (CALD) backgrounds

An essential skill in the provision of culturally appropriate services, cultural awareness requires an understanding of how a person's culture may inform their values, behaviour, beliefs and basic assumptions.

Cultural awareness recognises that we are all shaped by our cultural background, which influences how we interpret the world around us, perceive ourselves and relate to other people. You don't need to be an expert in every culture to be culturally aware; rather, cultural awareness helps you to explore cultural issues with service users more sensitively.

Information about specific cultural practices will help to increase a person's cultural knowledge by providing an overview of cultural characteristics and issues. However, it is always important to identify individual needs and preferences and remember that no individual can be reduced to a set of cultural norms.

Within any culture, peoples' values, behaviour and beliefs can vary enormously. Differences may occur due to time of arrival in Australia, length of settlement, socio-economic background, level of education, rural or urban residence, identification with cultural and religious background, and different life experiences - including the experience of migration.

It is impossible to know all the differences that might exist across diverse cultural groups. However, it is possible to approach service delivery with the understanding that different and complex cultural conventions exist. People involved in service delivery to people from a culturally and linguistically diverse (CALD) backgrounds need to seek out information on different customs to improve their understanding and ability to adapt to whatever cultural codes they may encounter, and to avoid inaccurately attributing negative characteristics to a particular group or person[2].

It is important that all staff and managers are provided with ongoing development opportunities to enhance their knowledge of culturally inclusive practices and their responsibility in implementing culturally appropriate services. There are a number of cultural awareness training programs available including the nationally accredited unit *'HLTHIR403B - Work effectively with culturally diverse clients and co-workers'*. This is a unit of competency within the Certificate III in Home and Community Care and the Certificate III in Aged Care.

Improving cultural awareness and understanding of cultural influences:

Service workers need to;

- Be aware of:
  - their own cultural influences
  - judging other people's behaviour and values according to the standards of your own culture
  - making assumptions about cultural influences and applying generalisations to individuals.
- have an understanding of:
  - the behaviour and values of people within each culture can vary considerably
  - the extent to which people adopt practices of their new country and retain those from their cultural background can vary within communities, even within families.
  - not all people identify with their cultural or religious background.

[2] http://www.culturaldiversity.com.au/practice-guides/cultural-awareness 24 Feb. 12

- culture itself is a fluid entity, undergoing transformations as a result of globalisation, migration and dispersion from original homelands.
- the importance of appropriate communication[3].

- Increase their knowledge of different cultural practices and issues through cultural background information sessions and/or resources and cultural awareness training.

Reference: http://www.culturaldiversity.com.au

Guidelines for completing an assessment on CALD people:

- Arrange a face-to-face assessment. It is difficult to assess a CALD person in a non face-to-face model even when an interpreter is used. Non-verbal cues are often a key aspect of an assessment when communicating with people where English is their second language.
- Determine if is appropriate to have an interpreter present for the assessment.
- Use accredited interpreters to translate all documents where an informed consent is required.
- Where written information about services and procedures is provided ensure that it is available in the service user's preferred language.
- Ensure service users and their carers have access to internal and external complaint mechanisms and quality improvement systems in their preferred language. Offer a variety of ways to provide feedback — for example, written comment, interviews and group discussion.
- Avoid the use of closed questions.
- Minimise the use of jargon and slang.
- Seek feedback from the service user to determine their level of understanding in relation to the questions you are asking or the information you are providing.
- Use appropriate gestures, sign language or picture cards to assist communication where possible.
- Be aware of service users who politely agree with everything you say; this is may be an indication that they do not understand.
- Be aware although some service users may be functionally independent i.e. able to perform tasks of everyday living they may be in need of social supports. For example, service users may have no social support network or avenues for socialisation.
- Cultural needs such as requiring specific types of food may also pose additional burdens due to availability and accessibility to appropriate food outlets.

Core ONI

- When completing the *'interpreter required'* section, keep in mind although the service user may be able to carry out a simple conversation in English, they may not be able to comprehend questions of a complex nature or express themselves clearly enough to participate in the assessment process.

[3] http://www.culturaldiversity.com.au/practice-guides/cultural-awareness 24 Feb. 12

- As people often lose their ability to communicate in a second language in times of stress, illness, and/or cognitive impairment you should consider the need for an interpreter for obtaining consent, providing information and conducting the assessment process, and subsequent reviews.
- If a service user does not require an interpreter for day-to-day services but does for complex communication situations this should be rated as needing an interpreter.

Functional profile

- Functional ability (performing tasks of day-to-day living) is not affected by language and cultural barriers. However, a language barrier may determine there is a need for additional assistance during assessment — for example, an interpreter service.
- Barriers are taken into account in other profiles such as the living arrangements, carer and psychosocial profiles. In the action plan you can recommend a referral to a culturally specific service.

  Use the alerts box if significant barriers exist, and capture any specific issues on the relevant profiles.
- Family roles and relationships may impact on a service user's ability to function and perform tasks in certain areas — for example, the traditional family supporter may find him or herself responsible for tasks around the house that were previously the responsibility of others. This should be considered when assessing people from all cultural backgrounds. Functional ability should be assessed on the service user's identified capacity to take on the new roles and tasks.
- It is important to recognise in some cultures the emotional well-being of a person is related to the provision of care by loved ones, and this is given greater value than independence and autonomy. In some cultures dependency is seen as an entitlement and an expression of love and support from family. For others, independence and autonomy are highly valued. This may affect the way in which people engage in and respond to assessment and services that focus on the promotion of functional independence.
- Lack of ability to function in certain areas because of psychological conditions such as post-traumatic stress disorder and depression should be considered the same as other mental health conditions. Rate the service user's functional capability when they were at their worst in the previous month.
- What may appear as agitated behaviour to some may be considered normal behaviour within that person's cultural context. This needs to be considered on an individual basis when completing the profile and should be validated by someone who knows the service user when possible.
- Memory and behaviour problems may be difficult to determine when assessing a service user from a CALD background or when using an interpreter to assist with your assessment. It is important to clarify with the interpreter that the service user's situation or issue has been assessed correctly.

Carer profile

- It is important to understand the family roles and relationships and how a service user's decline in their functional ability may have significantly impact on the family unit. If a spouse, children or other relatives appear to be carers, but are not performing the necessary tasks then they should not be considered as the service user's carer. If family members are be prepared to perform some tasks but refuse to perform other necessary tasks, then the carer relationship should be considered unsustainable without the provision of extra assistance.

- When assessing service users from all cultural backgrounds carer availability and sustainability should be considered based on the service user's identified capacity to perform the task.

Psychosocial profile

- Service users may not initially identify issues of isolation, or that family members are not always available, or that there is family conflict. This information is often discovered over time when rapport with the service user is developed.
- In some cultures there is no word for depression and it is shameful to talk about 'mental health' however in these situations it may be acceptable to talk about 'feeling sad' rather than depressed.

Tools:

Specialist cultural/linguistic assessment tool (refer to Appendix 5)

The specialist cultural/linguistic assessment tool is designed to assist the assessor to gather a more comprehensive understanding of the service user's social and cultural background and determine how this may impact on their assessment outcomes and service delivery needs.

The tool has been designed for use with people from CALD backgrounds. It was collaboratively developed and trialled by a working group consisting of representatives of Diversicare, Greek Welfare Association, Co-As-It, Cathay Club and the Islamic Home and Community Care Service.

Resources:

E-training: http://www.communitydoor.org.au/etraining

Interpreter services: http://switc.org.au/

Appendix 5: Specialist cultural/linguistic assessment tool

Cultural/Language Assessment
(This contains extra cultural and linguistic information not included in ONI)

Name

Date of Birth

URN

1. Year of arrival in Australia?

2. Citizenship status of consumer?

Australian citizen	☐
Australian resident	☐
Non-resident of Australia	☐

3. What were the reasons for the consumer's move to Australia?
Eg migration for work/family reasons; refugee etc.

4. What is language ability of the consumer?

Primary/Secondary Language (Tick all appropriate boxes)

Fluent in primary language	☐
Fluent in other languages (other than English)	☐
Had fluency in primary language but now losing this ability	☐

English (Tick appropriate box)

Speaks English Very Well (Fluent)	☐
Spoke English Very Well but is now losing this ability	☐
Speaks English Well (Conversational)	☐
Does Not Speak English Well (Limited English ability only)	☐
Does Not Speak English At All	☐

Literacy in Primary Language (Tick appropriate box)

Literate in primary language	☐
Had literacy in primary language but now losing this	☐
No literacy in primary language	☐

Literacy in English (Tick appropriate box)

Literate in English	☐
Had literacy in English but now losing this	☐
No literacy in English	☐

5. How would you characterise the consumer's non-verbal communication style? eg hand gestures, emotive, reserved etc

6. Marital status
M ☐ S ☐ W ☐ Sep ☐ D ☐ De F ☐

7. Religion

8. Employment/trade/professional history

In country of origin:
In Australia:

9. Specific dietary needs
eg kosher, halal, 'hot/cold' foods, other needs that may affect ability to access meal services etc.

10. Specific cultural needs
eg ethnic affiliation, gender needs, level of 'traditionalism' of consumer, family roles, who makes decisions about care etc.

11. Social Isolation (Adapted from UCLA Loneliness Scale Version 3, Russell, 1996)
Introduction to client: *Below is a set of statements made by other people who have shared their experiences with us. Please indicate the extent to which each of the statements applies to your situation.*

Statement	Yes	Perhaps	No
There is always someone I can talk to about my day to day problems			
I miss having a really close friend			
I experience a general sense of emptiness			
There are plenty of people I can lean on when I have problems			
I miss the pleasure of the company of others			
I find my circle of friends and acquaintances too limited			
There are many people I trust completely			
There are enough people I feel close to			
I miss having people around			
I often feel rejected			
I can call on my friends whenever I need them			

Details of Assessing Officer
Name _____ Designation/Agency _____

Sign _____ Date _____ Contact number _____

If information ***needs updating, indicate below and record updated information on a new Cultural/Language Assessment***

This information has been updated Date: _____
Name: _____ Sign: _____

Appendix 6: Understanding dementia

Dementia is the term used to describe the symptoms of a large group of illnesses which cause a progressive decline in a person's functioning. It is a broad term used to describe a loss of memory, intellect, rationality, social skills and what would be considered normal emotional reactions.

Most people with dementia are older, but it is important to remember that most older people do not get dementia. It is not a normal part of ageing. Dementia can happen to anybody, but it is more common after the age of 65 years. People in their 40s and 50s can also have dementia.

There are many different forms of dementia and each has its own causes. Some of the most common forms of dementia are:

- Alzheimer's disease
- vascular dementia
- Parkinson's disease
- dementia with Lewy bodies
- fronto temporal lobar degeneration (FTLD)
- Huntington's disease
- alcohol-related dementia (Korsakoff's syndrome)
- Creutzfeldt-Jacob disease.[4]

The early signs of dementia are very subtle and vague and may not be immediately obvious. Some common symptoms may include:

- progressive and frequent memory loss
- confusion
- personality change
- apathy and withdrawal
- loss of ability to perform everyday tasks.

Sometimes people fail to recognise that these symptoms indicate that something is wrong. They may mistakenly assume that such behaviour is a normal part of the ageing process. Or symptoms may develop gradually and go unnoticed for a long time. Sometimes people may refuse to act even when they know something is wrong.

The early signs of dementia are very subtle and vague, and may not be immediately obvious. Early symptoms may also vary a great deal. Usually though, people first seem to notice that there is a problem with memory, particularly in remembering recent events.

Early warning signs may include:

1. **Memory loss that affects day-to-day function**

   It's normal to occasionally forget appointments or a friend's phone number and remember them later. A person with dementia may forget things more often or not remember them at all.

2. **Difficulty performing familiar tasks**

   People can get distracted from time to time and they may forget to serve part of the meal. A person with dementia may have trouble with all the steps involved in preparing a meal.

[4] http://www.fightdementia.org.au/common/files/NAT/20050700_Nat_HS_1.1WhatIsDementia(1).pdf 24 Feb. 12

3. **Confusion about time and place**

   It's normal to forget the day of the week – for a moment. A person with dementia may have difficulty finding their way to a familiar place, or feel confused about where they are.

4. **Problems with language**

   Everyone has trouble finding the right word sometimes, but a person with dementia may forget simple words or substitute inappropriate words, making sentences difficult to understand.

5. **Problems with abstract thinking**

   Balancing a cheque book can be difficult for anyone, but a person with dementia may have trouble knowing what the numbers mean.

6. **Poor or decreased judgement**

   A person with dementia may have difficulty judging distance or direction when driving a car.

7. **Problems misplacing things**

   Anyone can temporarily misplace a wallet or keys. A person with dementia may put things in inappropriate places.

8. **Changes in personality or behaviour**

   Everyone becomes sad or moody from time to time. Someone with dementia can exhibit rapid mood swings for no apparent reason. They can become confused, suspicious or withdrawn.

9. **A loss of initiative**

   It's normal to tire of some activities. However dementia may cause a person to lose interest in previously enjoyed activities[5].

Alzheimer's Australia offers support, information, education and counselling.

For further information contact the National Dementia Helpline on 1800 100 500 or visit www.alzheimers.org.au

[5] http://www.fightdementia.org.au/common/files/NAT/20050700_Nat_HS_1.2DiagnosingDementia.pdf 24 Feb. 12

Appendix 7: Working with people who are homeless or at risk of being homeless

In assessing people who are homeless or at risk of being homeless, have an understanding of how being homeless impacts on people's overall health and quality of life. A person's living arrangements may impact on them physically, socially and emotionally and influence their behaviour, beliefs and interactions with service providers.

Key pathways into homelessness include:

- housing affordability stress
- family breakdown
- poor life transitions
- untreated mental health and
- substance abuse disorders.

Approach service delivery with the understanding that different and complex situations may occur in peoples' lives. Seek information to improve your understanding, and ability to work with people from a diverse range of circumstances.

Ongoing development opportunities will enhance knowledge of homelessness and responsibilities in implementing appropriate services. There are a number of training programs available that are nationally accredited including the Homeless Support Skill Set with the following units of competency:

- CHCCH301B Work effectively in social housing
- CHCCH427A Work effectively with people experiencing or at risk of homelessness
- CHCCS504A Provide services to people with complex needs

Be aware that:

- homelessness can affect anyone at any stage of life
- homelessness crosses all gender, age, cultural and educational backgrounds
- specialist and generic services and supports can assist
- your own values influence your response to people's circumstances, behaviour and values.

Understand:

- the effects of social exclusion and marginalisation
- the role of social housing
- how being homeless may influence a person's behaviour and interactions with service providers
- risk factors for homelessness (mental illness, substance abuse, problem gambling, limited life skills and poor financial literacy).

Guidelines for completing an ONI with people who are homeless:

- arrange a face-to-face assessment
- build trust and confidence and be aware it may take several visits to get to the core issues
- meet at the service user's location rather than at the service centre or in the privacy of an office, if it is considered safe to do so

- be aware blue uniforms can unnerve a homeless person as this may indicate to them that the service worker is with the police and that they may be in trouble
- homeless people may be hesitant to provide their personal information. Often their personal information is the only thing they own so they may be hesitant to give information away
- avoid use of closed questions
- provide written information about services and procedures for ease of reading and carrying on their person
- offer a variety of ways to make a complaint and provide feedback
- seek feedback to determine the person's level of understanding in relation to the questions being asked or the information being provided
- be aware some people may be functionally independent but in need of social supports,

Core ONI

- Collect information in a sensitive manner. Homeless people may be hesitant to provide their personal information due to their circumstances.
- As people may lose their ability to communicate in difficult circumstances, provide written information about user rights and the available services.
- Ensure core data is captured. At times important data can be missed i.e. by indentifying the service user's home as the name of a park, rather than recording a post code or only recording the age provided and not the date of birth.
- If a service user does not require an interpreter for day-to-day services but does for complex communication situations, this should be rated as needing an interpreter or an advocate.

Functional profile

- Functional ability may or may not be affected by being homelessness. However, language, speech or mental health barriers may determine there is a need for additional assistance during assessment — for example, an interpreter or advocate service.
- Barriers are taken into account in other profiles such as the living arrangements, carer and psychosocial profiles. In the action plan you can recommend a referral to a housing or homelessness support service. Use the alerts box if significant barriers exist, and capture specific issues on the relevant profiles.
- In terms of goal setting – the service user may say what the service worker wants to hear in the outset and then several visits later may open up about their true goals.
- Lack of ability to function in certain areas because of psychological conditions should be considered the same as other mental health conditions. Rate the service user's functional capability when they were at their worst in the previous month.
- Memory and behaviour problems may be difficult to determine when assessing a service user from a homelessness background.

Psychosocial profile

- Service users may not initially identify issues of isolation, or that family members are not available, or that there is family conflict. This information is often discovered over time when rapport with the service user is developed.
- People who are homeless may have a variety of complex needs in terms of the breadth of multiple needs that are inter-related or connected and/or depth of need (for instance profound, serious, severe or intense).

- One need may override, compound or even mask another need, making it difficult to isolate specific needs and address them in order of priority.
- Dual diagnosis is most commonly used to describe people who have a diagnosed mental health issues, associated health issues in addition to substance misuse issues.
- Complexity of need may make it difficult for people to maintain a secure housing tenancy.

Resources:

- Parity, Council to Homeless People - http://www.chp.org.au/parity
- Opening Doors Queensland Strategy for Reducing Homelessness 2011-14 http://www.communities.qld.gov.au/housing/community-and-homelessness-programs/homelessness-programs/reducing-homelessness-in-queensland/opening-doors-queensland-strategy-for-reducing-homelessness-2011-14