Health & Wellbeing Assessment

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| **Assessment Details** | | | |
| Date of Assessment: |  | Assessor Name: | Jon Morrell |

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| **Client Details** | | | | |
| Client Surname: | | Coxall | | |
| Client First Name: | | Alexandria | | |
| Preferred Name/Other Name/Known as: | |  | | |
| Date of Birth (dd/mm/yyyy): | | 1944-03-25 | | |
| Address 1: | 2 Timperly Rd | | | |
| Address 2: |  | | | |
| Suburb: | South Bunbury | | State: | WA |
| Postcode: | 6230 | | Ph (Home): |  |
| Ph (Mobile): | 0434926424 | | Ph (Work): |  |

*Note: For Indigenous clients, date of birth/age may be estimated.*

Document Objectives

* Commence the development of rapport and building a relationship with the client;
* Review client needs as identified by the nurse/mobile advisor; and
* Establish ongoing services and support the client requires.

NOTE: Before completing this assessment, please first review the Initial Assessment conducted by the Nurse/Mobile Advisor, and/or interdisciplinary assessments.

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| **Client Background** | |
| Who am I? (Tell me about yourself, summary of life history/story) | |
| Alex is married to Neville. Alex and Neville originate from Victoria, Australia. Alex had a total of eight years education. She used  to work as a dressmaker. Currently they are residing in a house in Bunbury. Financially  they are stable. They have four daughters and one of them, Helen, lives locally. Katie (Bunbury), Leanne (Eaton), Jane (Albany).  Alex is fully supported by her husband Neville who has health issues of his own. Daughter Helen is also local and supports as able. | |
| What is important to me? | |
| My family.  To be able to continue living in my own home.  To be socially and physically active to maintain my health and well being.  For my husband and family to have some help with caring for me.  My husband and daughters are supportive and provide a lot of support for me to live at home. Helen and Katie live in Bunbury and are very supportive. | |
| What are my likes/dislikes? Including hobbies, interests and passions. | |
| Likes | Dislikes |
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| **Overall Health & Wellbeing** | |
| General physical health. ie Levels in independence | |
| Cognitive decline with confusion and STML, Pain, reduced mobility and range of motion. Falls risk.  Dementia in Alzheimer's disease, Back problems-dorsopathies (includes scoliosis, sciatica), Ruptured artery - 4 x stents, Angina, Disorders of the thyroid gland, Osteoarthritis, Falls, Malaise & fatigue (includes general physical deteri lethargy andargy and tiredness) | |
| **Referral to SCC Clinical Team required?** | Yes  No |

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| **Communication** |
| Vision impaired (glasses)  Wears reading glasses,Wears distance glasses  Alex wears glasses for reading and long distance.  Cognitive impairment. Supported by husband and family with healthcare information and appointments. |

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| **Social Support** |
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| Social support needs identified: |
| Alexandria requires support to engage in social activities. |
| Interventions agreed with client/carer: |
| Alex attends day respite on Fridays at the Maarli Center which will continue under her CHSP arrangements.  Southern Plus support workers will provide extra companionship/social interaction during support services. |

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| **Cognition & Behaviour** | | |
| Please tick if not applicable | | |
| **Follow up of cognitive/dementia supplement form required?** | | Yes  No |
| Comments | Cognition has declined significantly associated with Dementia. ...Unable to complete multi step tasks. Requires supervision, redirection and prompting. ACAT | |

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| **Psychology** |
| **De Jong Gierveld 6-Item Loneliness Scale** |
|  |
| **Abbreviated Mental Test Score** |
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| Psychology needs: identified |
| Alex's cognition has declined significantly associated with Dementia. She is unable to complete multi step tasks. Requires supervision, redirection and prompting with most activities. |
| Interventions agreed with client/carer. |
| Alexandrias carers and support workers will assist Alexandria to identify potential issues that are causing anxiety or agitation using the CAUSEd anacronym, take appropriate actions and report outcomes.  • Communication issues  • Activity (is it appropriate and available)  • Unwell/Unmet needs  • Story (consider what we know about Alexandria that may be a clue)  • Environment (what environmental factors are contributing to their feelings of anxiety)  • dementia.  As per previous entry.  Wellness Partner will arrange for further cognitive assessment as required. |

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| **Self Care at Home: Assisted Daily Living** |
| **Activities which client always needs assistance with:**  Dressing/undressing,Meal preparation  **Activities which client needs occasional/partial assistance with:**  Toileting: use of aids, clothing, cleaning, washing hands,Grooming: shaving, hair, makeup...,Putting on glasses and/or hearing aids  **Activities which client is independent with:** |
| Grab rail, non-slip mat, and drop down bench in place.  Requires full Functional assessment. |

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| **Domestic Assistance** | | | | |
| Relevant to client? | Yes No *If No, please proceed to* [*next section*](#_Meal_Preparation)*.* | | | |
| **Assistance Required** | | **Independent** | **Assisted** | **Dependent** |

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| Domestic assistance needs identified: |
| Self care deficit related to household cleaning secondary to chronic pain, reduced activity tolerance (cardiac) and dementia. |
| Interventions agreed with client/carer: |
| • Southern Plus support workers will provide assistance with cleaning weekly/fortnightly for 1.5 hours.  • Cleaning tasks will include:  Vacuum/sweep and mop floors weekly or fortnightly depending on need (consult with Neville), clean bathroom and toilet, wipe/dust surfaces (light dusting), strip and remake bed. The DA service will be a combination service whereby the support worker will take the time to involve Alex in completing tasks as she is able to tolerate and is meaningful for her. It will also be adjacent to services to provide personal care and general social and physical support (may include assisting with exercise as per physio program or walking in the garden.)  • Support workers will assist with other household tasks as as requested by Alexandria as time permits and utilise any spare time to identify other jobs that need doing (empty/put out bins, tidy clean the fridge/microwave/dusting surfaces/skirting/window sills etc.) |

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| **Meal Preparation** |
| Would benefit from Meal Preparation in the home to ensure health and nutrition with good eating habits. Also provided information with regard to private home delivered meal options. ACAT  Eats independently  No weight loss in last six months (0)  Alex has been eating three quarters or more of usual intake and no loss of appetite (0)  0 - 1 Low risk of malnutrition - is eating well with no recent weight lossAlex has upper denture and partial lower denture. She manages her own oral hygiene independently ACAT |
| Would benefit from Meal Preparation in the home to ensure health and nutrition with good eating habits. Also provided information with regard to private home delivered meal options. ACAT  Requires assistance at all times when out in the community. Utilizes wheelchair when out in the community. |
| Interventions agreed with client/carer: |
| Southern Plus will facilitate the provision of prepared and home delivered meals through Light and Easy. |

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| **Carers & Respite** | | | | | | |
| Does the client have a carer? | | | Yes No *If No, please proceed to* [*next section.*](#_Finances_1) | | | |
| Does client’s carer currently work? | | | Yes  No | | | |
| Is carer registered with Centrelink? | | | Yes  No | | | |
| Is the client’s carer experiencing any stress? | | | Yes  No | | | |
| Emergency Care/Support. What do you have in place if the carer were unable to look after the client? | | | | | | |
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| Is carer interested in accessing any of the below for themselves or the care recipient? | | | | | | |
| In home respite (SCC) | | Yes  No | | Breakfast Club (SCC BND) | | Yes  No |
| Centre based day centre (SCC) | | Yes  No | | Overnight respite (SCC) | | Yes  No |
| Recreation based (Carers WA) | | Yes  No | | Carer Retreats (Carers WA) | | Yes  No |
| Residential respite (Client must have ACAT approval) | | | | | | Yes  No |
| Retaining meaningful activities through the period of caring for someone is important for the carer’s physical, psychological, social health and wellbeing. | | | | | | |
| Has carer’s social/leisure activities decreased since becoming a carer? | Yes – would like to re-engage in these activities  Yes – but would NOT like to re-engage in these activities  No | | | | | |
| Carer/respite needs identified: | | | | | | |
| Carer duress with his own health issues... | | | | | | |
| Interventions agreed with client/carer: | | | | | | |
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| **Referral to SCC Respite** required? | | | | | Yes  Yes, completed  No  *If No, please proceed to* [*next section*](#_Domestic_Assistance_1) | |

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| **Finance** |
| Husband Neville manages finances |

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| **Cultural / Religious Beliefs and Preferences** | | | | |
| Does the client have any cultural beliefs which may impact services? | | | Yes No  *If No, please proceed to* [*next section.*](#_Other_Needs_2) | |
| Religion: |  | Ethnicity: | |  |
| Language: | English  Other | | | |
| If Other, please specify: |  | | | |
| Do you have cultural/religious beliefs/practices which SCC need to be aware of? Eg Acknowledging a religious or cultural day such as Christmas Day, Ramadan, staff gender (eg female only), removal of shoes before entering client’s house | | | | Yes  No |
| If Yes, please specify: |  | | | |

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| **Other Needs** | | | |
| **Does the client require any assistance with the following areas:** | **Yes** | **No** | **Assessment/Referral Required?** |
| Oxygen follow up |  |  | Silver Chain (via GP) |
| Financial planning |  |  | Financial Planner |
| Transport |  |  |  |
| Socialisation |  |  |  |
| Pastoral support |  |  | Pastoral Care |
| Grief management |  |  |  |
| End of life planning |  |  | Pastoral Care  End of Life Assessment  Clinical (eg Palliative) |
| Does client have a spouse/partner at the same residence? |  |  |  |
| If Yes, does client wish to still reside with their spouse/partner if they (or spouse/partner) were to move into Residential Care? |  |  |  |
| Other needs identified: | | | |
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| Interventions agreed with client/carer: | | | |
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| **Client Goals** | | | | |
| **What are we trying to achieve?** | | | | |
| **Timeframe** | **Goal** | | | **Case Manager Actions** |
| Long term  Short term | 1 |  | |  |
| Long term  Short term | 2 |  | |  |
| Long term  Short term | 3 |  | |  |
| Who is going to monitor the progress? | | | Client  Carer  Family/Friend  Coordinator  Other | |
| If Other, please specify: | | | | |
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| **Consumer Directed Care & Case Management** | | | | |
| Client level of involvement in the CDC budget and case management | | | None  Low  Medium  High | |
|  | | | | |
| SCC/Case Manager level of involvement in budgeting and case management | | | | |
|  | Work in partnership with client to develop a goal orientated support plan |  | | Work with support staff to ensure quality of service delivery is maintained and SCC will provide appropriate training as provided |
|  | Working with schedulers to maintain appropriate services times to continue to meet client’s need |  | | Manage budgets, provide invoices, monthly budget statements and report to Department of Health and Ageing. |

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| **Access to the Home for Support Workers** | | | | | | | |
| Relevant to client? | Yes No *If No, please proceed to* [*next section.*](#_Revised_Client_Schedule) | | | | | | |
| Preferred point of entry |  | | | | | | |
| Is there a spare key? | Yes  No | | Is there a key safe in place? | | | | Yes  No |
| If Yes, what is the number and location: |  | | If No, would the client/carer like SCC to provide a key safe? | | | | Yes  No |
| SCC staff have permission to access the spare key for the below purpose: | | | | | | | |
| To be used only in case of emergency (ie client not answering door or phone) | | | | To be used to gain entry into home for all care service visits | | | |
| Other  *If Other, please specify* | |  | | | | | |
| **Emergency Procedure** | | | | | | | |
| What would you like us to do if no one answers the door for a scheduled visit? | | | | | | | |
| Call house phone | Contact family/friend | | | | Phone number |  | |
| Other If Other, please specify |  | | | | | | |
| **Note:** *Also advise client of SCC procedure of contacting the Case Manager to check the access code* | | | | | | | |

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| **Participants Involved in Care Plan Development** | | | |
| Does client’s family have any specific requests? eg Frequency of care plan reviews | | | Yes  No  N/A |
| If Yes, please describe | | | |
|  | | | |
| This Care Plan has been discussed and agreed to with: | | | |
| Client | Name(s): |  | |
| Representative/Carer | Name(s): |  | |
| ***COPY TO BE ATTACHED TO AGREEMENT*** | | | |

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| **Assessments Required: Summary** | | | | | | | |
| Please note which of the below assessments were conducted during the Health & Wellbeing Assessment. | | | | | | | |
|  | **Yes** | **No** | **N/A** |  | **Yes** | **No** | **N/A** |
| Functional Assessment and ADL Preferences |  |  |  | End of Life Assessment |  |  |  |

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| **Referrals Required: Summary** | | | | | | | |
|  | **Yes** | **No** | **N/A** |  | **Yes** | **No** | **N/A** |
| SCC Clinical Team |  |  |  | Occupational Therapist |  |  |  |
| Client’s GP |  |  |  | SCC Dementia team |  |  |  |
| SCC Mental Health team |  |  |  | Clinical Psychologist |  |  |  |
| Financial Planner |  |  |  | Pastoral Care |  |  |  |
| Silver Chain (via GP) |  |  |  | Respite |  |  |  |
| Other If Other, please specify |  |  |  |  | | | |

| **Health & Wellbeing Assessment Checklist: Information to be Provided** | | | | |
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| **Information to be discussed with client** | **Completed?** | | | **Comment**  **(if not explained please provide reason)** |
| **Yes** | **No** | **N/A** |
| Review/validation of client goals and needs identified at Initial Assessment and interdisciplinary assessments |  |  |  |  |
| Next steps (eg commence long term services, regular Case reviews) |  |  |  |  |
| Client to receive copy of care plan in Home Care File |  |  |  |  |
| Provide copy of budget to client and reinforce fees and charges |  |  |  |  |

| **Health & Wellbeing Assessment Checklist: Documents for Completion** | | | | |
| --- | --- | --- | --- | --- |
| **Documentation to be completed** | **Completed?** | | | **Comments** |
| **Yes** | **No** | **N/A** |
| Updated Care Plan (recorded in cdmNet Planning tab) |  |  |  |  |
| Update Procura: care plan and budget |  |  |  |  |
| Update Procura: enter updated service plan and care activities |  |  |  |  |

| **Revised Client Schedule** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| **Morning** |  |  |  |  |  |  |  |
| **Midday** |  |  |  |  |  |  |  |
| **Evening** |  |  |  |  |  |  |  |