FOI 27-3598 - Document 3

5.3.2. Referring for urgent services and linking support at triage

Triage delegates are responsible for determining whether individuals require referrals under the Alternative Entry Pathway. This allows clients to access services prior to undergoing an assessment.

The triage section of the IAT includes a question about an older person's need for urgent service provision; *Does the client require urgent service provision (direct to service)?* This is a mandatory question and requires a *Yes* or *No* answer and details must be added to a free text box. This question is used to determine the need for urgent services via the Alternative Entry pathway. Information on issuing referrals under the Alternative Entry Pathway is included in Chapter 3.

Even if the urgent services are only required for a short period, the older person will still be required to undergo an assessment.

The triage delegate may also identify and recommend linking supports for the older person following triage, or for consideration by the assessor at assessment.

5.3.3. Triage for clients who have been referred through a support plan review

In submitting a request for a reassessment following a SPR, the assessor will be able to update the triage section of the Assessor Portal and should enter as much information as they can while conversing with the client at the end of the SPR.

The triage delegate should consider the information entered in the triage section of the Assessor Portal by the assessor, and if satisfied can complete the triage questions in the Assessor Portal, without needing to speak with the client, given this occurred at the SPR stage. An assessment can then be scheduled for the client at a time that aligns with their priority setting.

Where this occurs, consent to complete triage questions must be sought by the assessor when the assessor is speaking with the client (or their registered supporter and/or appointed decision maker) at the SPR stage.

If a conversation with the client has not occurred at the SPR stage, the triage delegate should speak with the client to confirm a significant change has occurred, drawing on the triage questions to inform response. If the triage delegate is satisfied a significant change has occurred, they should complete the triage questions and recommend a reassessment.

5.3.4. Conducting triage for the End-of-Life Pathway

The End-of-Life Pathway is available to participants already accessing Support at Home as well as older people who are not currently accessing services through the Support at Home program.

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FOI 27-3598 - Document 3

A participant can access one episode of the End-of-Life Pathway through the Support at Home program. An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- a medical practitioner or nurse practitioner provides an estimated life expectancy of 3 months or less, and
- a score of 40 or less on the Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator)

Older people who are not currently accessing Support at Home, who would like to access the End-of-Life Pathway, can be referred for a high-priority aged care assessment.

The End-of-Life Pathway Form must be completed and validated before End-of-Life Pathway can be approved. The form captures specific medical information related to the participant's medical condition and evidence of end-of-life. An appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner) will complete the form.

The assessment referral will follow the same process as it does for all assessments and will be assigned by a Team Leader for triage.

All triage questions will be *optional* for the End-of-Life Pathway so there is flexibility in only asking questions that are appropriate to the individual. Questions that would be insensitive to ask during triage can be skipped.

The End-of-Life Pathway Form does not need to be submitted for the triage delegate to complete triage and assign the assessment to an assessor. If an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required (e.g. downloading the form and visiting their GP, non-GP specialist or nurse practitioner to have the form signed).

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 0.

For participants seeking access to the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation.

If a Triage Delegate identifies a submitted End-of-Life Pathway Form contains a mistake or missing information, triage should still be completed and the older person should be progressed to an assessment, while keeping the form as not validated. An older person should be informed the form contains missing or mistaken information and what they need to do for the form to be fixed. Once fixed, the form can be presented for validation at assessment.

The Triage Delegate can flag a referral as End-of-Life before or after (not during) triage by clicking the 'Flag as End of Life.'

To access the End-of-Life Pathway, existing Support at Home participants can request an urgent support plan review.

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FOI 27-3598 - Document 3

5.3.5. In-hospital triage and self-referrals

For hospital assessments, in the first instance an assessor, once obtaining the older person's consent, will complete the triage questionnaire using clinical records and information that is available, in liaison with the hospital discharge team. Note, if the older person is currently receiving aged care services the Function, General Health, and General Wellbeing and Safety sections of the triage questionnaire are optional. Following triage, the assessor may recommend a high or medium priority assessment.

Where an assessment is self-referred, and the assessor is with the older person, assessors will be able to conduct triage with the older person at the same time as the assessment. For assessors who are not Triage Delegates, triage must be conducted with triage delegate oversight.

5.3.6. Recording eligibility for an assessment for individuals aged 50-64

When determining whether an individual aged 50-64 years is eligible for an aged care needs assessment, triage delegates should clearly record their decision and the information they relied upon to come to that decision. This should be recorded in the free text box at the end of the triage section. For example, when finding someone aged between 50-64 is eligible for an assessment under the homeless/risk of homelessness provisions of the Act, the triage delegate should make specific reference to which criteria under the relevant definition applies to the individual who is seeking an assessment. Refer to section 5.3 of this Manual for the definition of homeless and risk of homelessness.

The free text box at the end of the triage section of the Assessor Portal should also be used by the triage delegate to record confirmation an individual aged under 65 has been informed of other services that may be available to meet their needs before electing to be provided funded aged care before the age of 65.

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> Note:
>
> Triage Delegates should review the 'client story' note in an older person's record to confirm if an eligible person aged 50-64 has been informed of other services that may meet their needs during screening.

5.3.7. Preparing an older person for their assessment

Triage delegates should outline to the older person what will happen at the assessment, discuss their availability for the assessment and then make the appointment. Where possible, the triage delegate should give the name of the assessor that will be undertaking the assessment.

Additionally, triage delegates should:

- Complete the Work, Health and Safety (WHS)/Home Safety Risk screen and check for alerts and notes in the referral information on the My Aged Care record. Ask relevant questions to identify work, health and safety concerns which could affect the assessment for example: "Are there any risks or hazards the Assessor needs to be aware of before attending the assessment in your home?" The team leader may

FOI 27-3598 - Document 3

already have knowledge of information that may be relevant to assessment services and assessor safety.

Note:
Special WHS requirements (such as the necessary presence of the older person's guide dog) at the assessment. Arrange other responses (such as the need for two assessors to attend the assessment due to safety concerns).

- Upload any additional older person information to the older person record (e.g., WHS screen) and use 'Notes' to record assessment booking details. Include if relevant, with older person's consent, sensitive information in sensitive notes and attachments.

- Check to see if there are cohabitating older people in the house who may also require an assessment and refer them to My Aged Care or include a note that they may be self-referred to their assessment organisation if circumstances meet the self-referral criteria and if appropriate.

5.3.8. Preparing for an assessment with an older Aboriginal and Torres Strait Islander person

Taking note of the community the older person belongs to, assessors can support culturally safe and appropriate assessment practices. This information may help ensure the referral is assigned to an assessor who is either from the same community or has a strong understanding of the local customs and cultural context. This alignment may enhance the delivery of culturally safe, trauma aware and healing informed assessments.

In preparation for the assessment, the assessor/triage delegate should collect as much relevant information as possible prior to the assessment. This helps to inform the process and reduces the need for the older person having to re-tell their story.

Where consent is obtained from the older person, this may include:

- information collected by the Elder Care Support workforce
- Information from GPs or the Aboriginal Torres Strait Islander health/medical services, including results from MBS 715 health check
- Information from other health professionals, where appropriate

Once triage is finalised and the assessment assigned to an assessor, the answers to triage questions cannot be altered by an assessor. Assessors and team leaders will be able to access historical triage information on an older person's record, which includes details such as the dates of previous triage, the organisation and individual who conducted it, and the outcomes of the triage.

Where possible, Aboriginal and Torres Strait Islander people should be matched with an assessor who is appropriate as per the local customs, protocols, kinship obligations and preferences of the older person. This may include the support of family members or advocates where appropriate.

Department of Health, Disability and Ageing website:

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Deaf Connect (free face-to-face sign-language and Remote Video Interpreting Service)

Fact sheet for Assessors on care finders

My Aged Care website: Support for Hearing and Vision Impairment;

Help from a care finder

5.4. Revoking eligibility during an assessment

An individual's eligibility to undergo an assessment is determined by a triage delegate based on the information available to them when triage is conducted. The Act provides specific circumstances where an eligibility decision may be revoked on the initiative of the System Governor, including during the application process the individual gave information or documents which were false or misleading, omitted any matter or things that without would make the document false or misleading. This may include situations where key facts presented were inaccurate or misleading, resulting in the eligibility decision being granted erroneously. In such cases, it is the departmental delegate's responsibility to assess the evidence, and if warranted, initiate the revocation process to maintain the integrity of the aged care system.

If an assessor or assessment delegate has concerns about the information or documents provided by an older person and/or their registered supporter(s) or appointed decision makers, they should contact their assessment organisation's operational manager, who will make contact with the relevant area of the Department to resolve.

For further information on revocations on the initiative of the System Governor and individual, please refer to Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints.

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5.5. Assessment settings

5.5.1. Usual accommodation setting

An initial assessment should be face-to-face in the older person's usual accommodation setting. This will assist with the environmental, physical, and social components of the assessment by observing the older person's level of independence, functioning, and existing support arrangements in familiar surroundings. Due to the nature of transition care services, some assessments will occur in the hospital setting.

However, if this is not possible, assessments for Aboriginal and Torres Strait Islander people should be undertaken at a setting that makes the older person feel safe, at ease and comfortable.

Assessing an older person who is not in their usual accommodation setting

When assessing an older person who is residing in a residential aged care or hospital setting for services to support their transition to residing in the community, the assessor can still complete a 'true' assessment based on their best efforts to understand and assess against the person's functional needs in the community setting they intend to reside in not the setting where the assessment is being carried out. in these

FOI 27-3598 - Document 3

circumstances, it may be necessary for assessors to seek information about the older person's home environment from the older person's care and support team to make an as accurate assessment as possible of their functional needs.

5.5.2. Telehealth

It is best practice for assessments to be conducted face-to-face. Assessment organisations are strongly encouraged to ensure assessments are face-to-face wherever possible. Where face-to-face contact between the assessor and older person is not possible (e.g., when assessing an older person in a remote area or the older person is inaccessible due to exceptional circumstances such as a seasonal weather event), a telehealth assessment may be undertaken. Where a telehealth assessment is proposed by the assessor, it is important that they explain to the client the rationale of using that assessment setting and any implications this may have such as timing, the potential need for other people to be involved before, during and/or after the assessment and logistical considerations such as organising video call capabilities.

The assessor must make additional efforts to ensure the quality of assessment is not compromised when conducting a telehealth assessment and that assessment decisions remain evidence based.

Another suitably qualified person (such as a local health worker) and/or the older person's agent, registered supporter or appointed decision maker may attend the assessment with the older person to assist the assessment process.

If a local health worker or provider is involved, and with consent from the older person, the assessor may, work with these individuals prior to an assessment to attain relevant information that can help inform the assessment process.

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth to assess eligibility for the End-of-Life Pathway, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 6.3.1.

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5.5.3. Remote setting

Assessors should use the remote assessment indicator in the My Aged Care assessor portal to indicate if an assessment has been or will be conducted in a remote area. This indicator can be checked before starting an assessment, when uploading from the Aged Care Assessor App or on finalisation of an older person's Support Plan.

The Department uses the Modified Monash Model (MMM) as the classification system to define geographical remoteness. The remote assessment flag should only be selected where a face-to-face assessment is undertaken in a remote (MM6) or very remote (MM7) area. You can check the MMM classification by entering their address in the department's Health Workforce Locator.



My Aged Care – Assessor Portal User Guide 6 – Completing an assessment

FOI 27-3598 - Document 3

5.5.4. Hospital setting

Assessments in a hospital setting are typically conducted by a clinical assessor.

For those older people in hospital requiring an assessment, they should be assessed in the same way as those assessed at home, utilising the IAT to ensure a nationally consistent approach to assessment of aged care needs, including consideration of the home environment and social issues. An older person needs to be in a stable condition for a hospital-based assessment to take place (unless a rapidly deteriorating condition makes this impossible). Being medically stable ensures that the care needs of the older person outside of the hospital can be accurately assessed and the most appropriate care services recommended.

In hospital assessments, the assessor must ensure that a carer or other advocate is advised of the assessment in all circumstances and should be present during an assessment where possible.

Approvals for all types of care can be made following an assessment in a hospital environment (e.g. an assessor can recommend for Assessment Delegate to approve CHSP). There should be no presumption that older people will progress from hospital to residential care, as they may be able to return to their previous living arrangements. This is especially appropriate following an acute incident where the individual may benefit from a reassessment in the home environment after the acute phase.

Assessors need to be aware that for an older person to be approved for TCP, the assessment must be conducted while the person is in hospital. Assessors should also consider arranging an assessment for Support at Home or CHSP when the older person is discharged from a hospital and returns to their usual accommodation setting. This allows a more accurate picture of care needs in the home setting and ensures the older person's current needs and goals are being assessed.

Assessors should be aware that a person being assessed in a hospital setting cannot be approved for the Restorative Care Pathway or a period of reablement.

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5.6. Commencing the Assessment

> Note
>
> Only appropriately qualified and certified assessment staff can hold assessor roles and undertake assessments. There are different credentials for clinical and non-clinical assessors. Please refer to training requirements for assessment teams in Chapter 2 and Aged care assessment workforce minimum qualification requirements in APPENDIX F – Aged care assessment workforce minimum qualifications.

Assessors are required to do the following prior to attending the assessment:

- After the referral has been assigned to the assessor, the assessor must review all information in the older person's record.
- With the older person's consent, consider the collection of information on the older person's situation and medical conditions diagnosed by suitably qualified medical personnel that may be required prior to the assessment. Contact the referrer or health professional if indicated prior to the assessment.
- Note and manage WHS risks.

FOI 27-3598 - Document 3

- Note the timeliness measure for completion of the assessment process.
- Determine whether a culturally appropriate support person, interpreter, care finder, elder care support worker or advocate (through OPAN for example) needs to be included in the assessment.
- Gather any anticipated forms or resources, including providing copies of relevant My Aged Care booklets and/or brochures depending on the type of assessment to be conducted.
- Review *Best practice tools and tips for conducting the assessment* in this manual for guidance on how to achieve a conversational, respectful, and empathetic approach during the assessment. This will allow the assessor to develop rapport with the older person and their support network.
- Download the assessment if using Aged Care Assessor App.
- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, assessors can do this by using the assessor portal to find the client, then view their support network (if any supporter relationships have been registered). Refer to Chapter 3 for information on how registered supporters must engage with the older people they support, and how they might be involved in an assessment.
- Check the authority of any active, appointed decision makers of the older person, if they have made themselves known to the assessor or My Aged Care. Appointed decision makers are not required to register as supporters to exercise their legal authority under a Commonwealth, state or territory arrangement. However, this is encouraged to streamline authentication and information sharing to support older people. Assessors can engage with active, appointed decision makers before, or without them, formally registering as supporters, provided the assessor is satisfied they are acting within their authority recognised under the Act. To do so, assessors should seek legal documentation that shows the person is an active, appointed decision-maker for the older person and that their decision-making authority is relevant to the assessment. Medical evidence about the older person may also be required to show that the decision maker's authority is active.
- Review notes entered at triage including referrals, attached documents and previous support plans if applicable, to help familiarise yourself with the older person and their needs and limit the need for the older person to repeat their story.
- Connect with the local Aboriginal and Torres Strait Islander community with their knowledge of local services and culture.
- It is recognised that building rapport and trust with older Aboriginal and Torres Strait Islander clients may require multiple contact attempts, particularly for individuals who have experienced trauma or institutionalisation. Assessment organisations should make all reasonable efforts to engage with the client in a respectful and culturally safe manner with their advocate if they have identified they are in contact with one.
- Assessment organisations are encouraged to consider culturally safe engagement strategies, such as involving trusted agents like Elder Care Support workers or other appropriate advocates as well as arranging face to face contact where possible.

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5.6.1. Confirming an older person's preference prior to the assessment

As it is a phased rollout, Aboriginal and Torres Strait Islander people who are booked with a Single Assessment System organisation need to have the choice to transfer their assessment to an Aboriginal and Torres Strait Islander assessment organisation if one commences in their area.

FOI 27-3598 - Document 3

Preferences for an Aboriginal and Torres Strait Islander assessment organisation should be uncovered during the assessor's pre-assessment planning. This allows the assessor time to contact the client, discuss their preference and organise transferring the client prior to the assessment commencing.

- If the preference is identified at the start of the assessment, the assessor may wish to explain to the client that making a referral to an Aboriginal and Torres Strait Islander assessment organisation may cause a delay with them receiving their current assessment or an Aboriginal and Torres Strait Islander assessment organisation is not yet available in their region. Subject to the client's agreement, the general recommendation would be that the assessor with the booking continues with the assessment as planned. However, if the client still does not wish to proceed with the assessment, the assessment will need to be cancelled.
- The client's condition needs to be taken into consideration, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.
- A conversation with the client prior to the assessment is recommended to ensure that they have choice and control and the ability to make decisions regarding their care.
- If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation; and they understand the timing impacts; then the assessor can ensure a warm referral. The assessor may contact an Aboriginal and Torres Strait Islander assessment organisation and where suitable the organisation may self refer the client.
- A rejection reason 'client prefers a FNAO' is available in the My Aged Care Assessor Portal. An older Aboriginal and Torres Strait Islander person should not be rejected based on a client's preference unless it is a last resort. A transfer prior to the assessment is preferable to a rejection.
- If the referral is cancelled by the assessor at the point of assessment, this may slow down the process for the client which is not the desired outcome.

The above process also applies to support plan reviews, and subsequent new assessments.

At the time of the assessment, the assessor must:

- Be clear to the older person who you are and the organisation you are from and outline your role as an assessor on behalf of My Aged Care.
- Wear the My Aged Care badge or ID according to assessor branding protocols and style guide.
- Inform the older person of the assessment process and potential outcomes
- Conduct a wallet check:
    - explain to the older person why you need to do this
    - sight two valid identity documents
    - if the wallet check has been attempted but the older person is unable to produce two valid identity documents or has indicated they will provide documents at a later point, enter this information as a note in the older person record as evidence of attempting the wallet check
    - record the results on the older person's record.
- Confirm that the older person understands the role of the assessor and the assessment process and obtain the older person's (or, as appropriate, the active, appointed decision maker's consent, whether or not they are a registered

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FOI 27-3598 - Document 3

supporter) before commencing the assessment. Explain to the older person that the assessment has now commenced as they have provided consent, and
- Confirm the identity of other people supporting the older person at the assessment, including the status of registered supporter and agent relationships
- Submit requests to register supporters/agents as required and when practical, ensure any supporting documentation is uploaded, including legal documentation and medical evidence if required.
- If the assessor is an Enrolled Nurse conducting a comprehensive assessment, they must be under direct or indirect Registered Nurse supervision within the same organisation.

Note:
The older person can withdraw their consent at any time. In this case the assessment is discontinued.

5.6.2. Wallet check

A wallet check assists to verify the older person's identity and reduce the risk of duplicate records. Whoever has the first face-to-face contact with the older person following the creation of the older person's record (e.g., an assessor or service provider) is expected to sight two types of valid older person identification and record this information on the older person record. The My Aged Care assessor portal provides a list of types of identification that can be used for the wallet check.

The wallet check only needs to occur once. If a reassessment is being conducted for an older person who has previously had a wallet check it is best practice for the assessor to check the older person's identification and confirm their details have not changed. Where possible assessors should use the wallet check as an opportunity to confirm an individual's age provided at screening or triage matches the age on their identification. If there are concerns that an individual does not meet the age eligibility requirement or one of the exceptions to undergo an assessment based on identification cited during a wallet check, the department should be contacted.

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Note:
The wallet check can be conducted at any stage of the registration or assessment process and through the Aged Care Assessor App.

5.6.3. Registering a supporter

Registered supporters help older people to make and communicate their own decisions about aged care. A registered supporter can request and receive information about an older person's aged care, help them to understand information and make their own decisions, and let people like My Aged Care and aged care providers know what the older person's decisions are.

During an assessment, an older person and/or their prospective supporter can request to register a supporter relationship by:

FOI 27-3598 - Document 3

- completing the Registration of a Supporter form. The assessor can upload the form and any associated documentation to the client's record. **Note:** a registration form may also be generated following the completion of the online registration form through the My Aged Care website. This will look different to the Registration of a Supporter form but should have all the same information. Assessors should treat it the same as the Registration of a Supporter form.
- submitting a registration request online with the assessor via the assessor portal or app, including uploading any associated documentation. If necessary, the Aged Care Assessor App camera can take a photo of document/s to upload as an attachment as long as the document photographs are clear and readable.

A completed registration form and any associated documentation can be uploaded to the client's record. The prospective supporter can also mail a copy of the documents to My Aged Care , and the assessor can write a note in the older person's record of this undertaking (see APPENDIX B – Contact details.)

> Note:
>
> Updated consent scripting and declarations for the registration of a supporter must be used by assessors if they are assisting an older person or prospective supporter through the registration process. These will be available on the Assessor Portal or App, and the printed Registration of a Supporter form.

Assessors must not use scripting or forms previously used for the appointment of regular or authorised representatives, as these are not relevant to the registered supporter role.

It is important to note that while assessors can collect and submit the required information, they may not be able to confirm or approve the registration of a supporter relationship, depending on the circumstances. For example, some applications must be escalated to the departmental team responsible for supporters to consider before a decision to register can be made. This includes applications:

- where the prospective supporter has declared a conflict of interest
- where there is anything to suggest the prospective supporter cannot comply with the duties of a supporter (e.g., the prospective supporter is currently suspended or had a previous registered supporter relationship cancelled), or
- where the prospective supporter wishes to rely on their authority as an appointed decision maker recognised under the Act and must provide additional documentation like legal and medical evidence. These documents must be submitted to, and validated by, the departmental delegate responsible for supporters.

The My Aged Care website includes information on the various ways a person can request to register, or become, a supporter.

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My Aged Care - Registering a Supporter

My Aged Care - Registered Supporter Resources.

If, in submitting a request to register a supporter who wishes to rely on their authority as an appointed decision maker recognised under the Act for the older person, proof of legal

FOI 27-3598 - Document 3

decision-making authority cannot be obtained, advise the pending registered supporter to provide the required proof, including any legal or medical documentation to the delegate team responsible for registered supporters. This team will process the documents and if validated, register the relationship.

5.7. Undertaking an assessment using the Integrated Assessment Tool

The assessment starts with getting the older person's consent. Consent from the older person, or their active, appointed decision maker recognised under the Act is recorded on the IAT. The IAT is an assessment tool that has been designed to support skilled assessors to assess a client's aged care needs. It comprises questions across social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

The IAT is divided into thirteen sections. Some sections of the IAT contain nested questions to tailor assessments, only diving deeper into areas where needed. This means that some question sets or validated tools in the IAT will only display to the assessor if certain answers are selected to the question directly proceeding it. The IAT integrates eleven validated tools directly into the assessment process, enhancing the depth and clinical relevance of the assessment.

Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Each assessment organisation is responsible for providing their assessment staff with training on how to use these Validated Assessment Tools. General information about each tool is provided in assessor induction training but additional training provided by the assessment organisation is recommended to make sure each assessor understands the results from each validated tool.

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The IAT includes decision support rules to assist assessors to make recommendations for the type of support an older person requires based on the older person's responses to relevant questions.

In completing the IAT, the assessment information should include:

- evidence that the assessor has explored the older person's own supports and/or non-funded services (e.g., state and local government programs, private services) as options to help maintain their independence.
- evidence that the assessor has explored, observed and understands the older person's needs, concerns, strengths and goals to justify the assessor's recommendations for all aged care services.
- evidence of supporting an older person's communication or support person needs.
- a completed 'Support Considerations' section to demonstrate an understanding of what is important for the older person in regard to how support is provided, such as the below list (note some of these may be sensitive topics):
    - any cultural and/or religious values and beliefs
    - gender identity or sexual orientation/sexuality or experience of discrimination
    - history of childhood experiences
    - life experiences including traumatic events and associated triggers

FOI 27-3598 - Document 3

- other relevant information relating to parole conditions or other information that should be sensitively discussed with the older person when developing the Support Plan and that providers should be aware of.

The IAT User Guide provides assessors with further advice about each question in the IAT and possible answers. Assessors must refer to the IAT User Guide to ensure accuracy in the use of the IAT and in the delivery of high-quality assessments.



All mandatory questions must be completed, and it is best practice that the older person's concerns and goals are added before finalising the IAT. From 29 June 2026, there will be a prompt to remind assessors to add client's goals to the support plan before finalising the IAT to ensure an accurate assessment of a client's care needs. This is completed by navigating between the IAT and the support plan. This change is intended to improve the accuracy of a client's care needs, as information captured under concerns and goals can help inform a system prompt indicating whether a client may be suitable for Restorative Care. Assessors have the option to either accept or reject this prompt. If no client goals are required, assessors can still tick the check box in the prompt without navigating to the support plan and proceed to finalise the IAT.

The assessor then selects 'Finalise IAT' before moving to the support plan. This is so the ongoing home support Classification Algorithm can generate an ongoing home support classification level (IAT Outcome in the system), which may be a Support at Home classification or CHSP. A classification level recommendation must be made for people who choose to access services through the MPSP or NATISFACP.

If the IAT has not been finalised, the IAT Outcome and classification will not be displayed. The assessor will not be able to recommend the person for funded aged care services.

Aboriginal and Torres Strait Islander assessment organisations will be required to use the IAT to conduct assessments and must do so in a way that is culturally safe for the region or older person. Assessors may conduct the assessment without a device. In such cases, the assessor should upload the information into the IAT when the assessment is completed. Assessors may also be able to make inferences from the yarn to complete the IAT.

Use the validated culturally appropriate assessment tools as needed (see the IAT User Guide for more information).

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FOI 27-3598 - Document 3

Note:

For End-of-Life Pathway assessments, only mandatory questions that are required to run the IAT Outcome and generate a classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

Important:

Under Support at Home, the care management supplement may apply to a registered provider in respect of an individual who is a care leaver. If applicable, the care management supplement will be credited to the provider's care management account.

To identify these individuals during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.

Assessors who have identified individuals who are care leavers during the assessment should select the diversity field 'a person separated from your parents or children by forced adoption or removal'.

This will ensure Services Australia is able to identify these individuals from the assessment and apply a care management supplement to their provider's care management account. Refer to the Support at Home Program Manual for more information on care management supplements.

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IAT User Guide

5.7.1. Clinical attendance

All sections of the IAT will be visible to both clinical and non-clinical assessors.

Where an assessment is initiated as a home support assessment by a non-clinical assessor and questions are triggered that require clinical judgement (referred to as clinical questions), the non-clinical assessor must arrange for the attendance of a clinical assessor to be involved in asking the clinical questions in the IAT. This process is known as clinical attendance and is supported by an assessment organisation's Clinical Governance Framework (see Appendix C for guidance) and standard operating procedures. This process helps to make it easier for an older person to have their needs fully assessed without delaying their assessment or having to be transferred between assessors. The clinical attendance process is outlined in detail below.

Clinical attendance in practice

When a non-clinical assessor triggers clinical questions in the IAT, a warning message in the My Aged Care Assessor Portal or Aged Care Assessor App will prompt the assessor to complete the section in accordance with their organisation's clinical governance

FOI 27-3598 - Document 3

framework. If the assessor is using the IAT offline form, the clinical questions are colour coded in light pink.

Where clinical questions are triggered, the assessor must seek clinical attendance to ask the clinical questions (listed at Appendix D). Clinical attendance will need to be sought from a staff member who is assigned a clinical assessor role in the My Aged Care Assessor Portal. The ways in which clinical attendance can occur are detailed in the Table below and presented as tiers. Tier 1 is considered best practice; it is expected that an assessment organisation will adopt Tier 1 clinical attendance in the majority of cases.

> Note:
>
> Enrolled Nurses (EN) who hold the clinical assessor role cannot provide clinical attendance to non-clinical assessors. This is considered outside an EN's scope of practice.

For case studies of how clinical attendance will work in practice please see Appendix D.

Table 20. Clinical attendance procedure

Tier 1	A clinical assessor who holds a clinical assessor role in the My Aged Care Assessor Portal is available by video or phone call at the time the assessment is taking place to be involved in asking the clinical questions with the non-clinical assessor to the older person being assessed. A video call is preferable. The assessor can receive a call back when a clinical assessor becomes available. The assessment should continue while waiting for the callback. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of any other clinical questions (see appendix D) and ensure that these questions are answered with a clinical assessor in attendance. There may be situations where it is not appropriate for the assessor to continue with the assessment, even with virtual, clinical attendance. This will be determined using the following criteria: • It is not physically or psychologically safe for the older person to continue the assessment, • It is not physically or psychologically safe for the assessor to continue the assessment, • The older person's condition requires a clinical assessor to undertake an end-to-end assessment

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	Where it is considered inappropriate to continue, the assessment will end and a team leader will reassign the incomplete assessment to a clinical assessor to undertake.
Tier 2	There may be circumstances where real-time clinical attendance is not possible. If a clinical assessor cannot be contacted at the time the assessment is taking place, the assessor will complete the questions that do not require clinical judgement. All other clinical questions are noted and cannot be asked. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of the clinical questions prompted (see appendix D) and ensure that these questions are answered with a clinical assessor in attendance. The assessment will end once the assessor has completed the non-clinical questions in the IAT (noting the IAT itself will remain incomplete). The assessor will need to speak with a clinical assessor in their organisation about the assessment and the clinical questions. If it is appropriate for the clinical questions to be asked by a clinical assessor over the phone, arrangements will be made with the older person and relevant support people for this to take place. It is preferable the original, non-clinical assessor is also on the call. If the clinical components are completed over the phone by a clinical assessor, the assessment does not need to be reassigned to this assessor. It may be determined that the assessment should be reassigned to a clinical assessor to complete the assessment, either in person or over the phone. This may be required because: • multiple clinical questions are triggered in the IAT, • the needs of the older person are best assessed in person to ensure a high-quality assessment. Where an in-person assessment with a clinical assessor is required, a team leader will reassign the assessment to a clinical assessor.

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FOI 27-3598 - Document 3

If the clinical process is initiated the assessor must:

- ensure the older person understands that there are questions in the assessment tool that need to be asked with a clinically qualified assessor so that they can apply clinical knowledge and judgment to ensure that the older person's needs are assessed in full and with their safety and wellbeing in mind. This should occur before the clinical assessor is contacted.
- include the older person in the initial discussion when the clinical assessor is being briefed on the older person's situation. The older person and/or their support person should be given the opportunity to describe their circumstances if they feel comfortable to do so.
- ensure the camera is on at both ends so that older person can see the clinical assessor if the clinical assessor is called in on a video enabled device.
- ensure the call is on speaker phone so that the older person and clinical assessor can speak directly to one another, if the clinical assessor is called on a phone without video functionality.
- explain to the older person that a follow-up phone call will be necessary to complete their assessment, if real-time clinical attendance is not possible.

If a follow-up call is necessary:

- the original non-clinical assessor should be present on the phone call to ensure there is continuity of contact with the original assessor.
- it is important that the non-clinical assessor keeps the older person, their primary contact and/or support person up to date on when the follow up phone call will take place.

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FOI 27-3598 - Document 3

5.7.2. Tools and techniques for assessing an older person's needs

The table below details best practice tools and techniques for undertaking aged care needs assessments.

Table 21. Aged care needs assessment best practice tools and techniques

Use the Aged Care Assessment Quality Framework	• Use the four quality goals, personal, effective, connected and safe in your assessment practice.
Use a conversational approach when interacting with the older person	• Confirm with the older person that they are comfortable with digital devices being used during their assessment, ensuring that the older person understands why and how the information recorded is used during the assessment. • Use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes. Ensure your conversation is undertaken in a manner that is respectful, non-judgmental, and non-confrontational. • Know when and how to best use closed, open, direct, and indirect questioning. • Use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements. • Use active listening skills. • Make eye contact to help engage the older person in the assessment process, unless it is culturally inappropriate to do so. For example, some Aboriginal and Torres Strait Islander people may consider direct eye contacts disrespectful or uncomfortable, but others may be more comfortable with Western norms of communication. If using a computer at the older person's home, ensure you are not focused on just the computer. • Gauge the older person's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly. For Aboriginal and Torres Strait Islander clients • Observe the local cultures and customs when conducting the assessment. • Start with a social yarn to build rapport and trust. Share stories or other topics of common interest. • Take a whole-of-person approach to the discussion – understanding what motivates a person and contributes to their wellbeing – spiritual, emotional, and physical. • Explain to the older person and any support people present that if they feel uncomfortable during the assessment at any time, the assessment will be paused and rescheduled to ensure their wellbeing. Allow for

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FOI 27-3598 - Document 3

	multiple visits, if required, to build trust and develop a relationship between the assessor and the older person • Welcome the presence of the older person's family member or advocate to be part of the meetings • Take a less formal, yarning approach to aged care assessment.
Use appropriate language when speaking with the older person	• Use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs. • Use language that is positive and not dismissive. If necessary, potentially sensitive topics (such as lack of service availability or older person fees) can be introduced at the appropriate place during the assessment process after the older person's areas of concern and goals have been identified, and when support options are being explored in the Support Plan stage. • Use language that focuses on the older person's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence. • Take the time to explain what will happen • Use informal and the local language where possible and avoid jargon • Adjust language as needed to ensure sensitivity towards End-of-Life Pathway participants (for example, focusing on more immediate needs rather than longer-term goals). • Reflect the conversation back to the older person to ensure you have understood what was said and agreed on.
Interpreters or support person	• where the older person prefers to communicate in a language other than English or has indicated in their record that a support person is required, an interpreter or support person must attend the assessment (either in-person or via phone).
Supporting people with dementia and other cognitive impairments	• Use simplified language where appropriate. • Repeat questions and information where needed • Be attuned to non-verbal signs that the person may need further information to help them understand. • Consider body language, including facial expressions and posture. • Consider the assessment environment, particularly background noise or activities competing for attention • Seek discrete responses to questions (e.g. 'Yes' or 'No,' or choices between two options) rather than multiple options. • Provide ample time for a person to respond to questions.

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Using Validated Assessment Tools	Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Clinical assessors should use their clinical judgement to determine if it is appropriate to use other Validated Assessment Tools. If other assessment tools are used, the assessor should make a note of this in their assessment summary. The assessor should record assessment tool outcomes and recommendations based on these outcomes within the Assessment Summary. The assessor should also make sure that the older person and their support people understand the outcome of any assessment tools used.
Observing functional activities	Where possible, assessors must observe the older person's activities to gain insight beyond information that is conveyed just verbally by the older person, a registered supporter or anyone else who supports the older person. Therefore, collect information through additional means: • ask the older person to ***show you*** how tasks are completed in the home and ***observe*** the older person undertaking those tasks (this is an 'active' assessment) and • advise the older person ***what*** you have observed/seen during the task.

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5.7.3. Aboriginal and Torres Strait Islander assessments

To support timely access to services, assessors are encouraged to use their professional judgement to determine when an assessment can be completed in one session or, be split over a few sessions without disadvantaging the client from receiving timely services.

By starting the assessment with a yarn, the assessor should be able to gauge whether it is appropriate to proceed with completing the assessment during the session.

Where an assessment cannot be finalised during the initial session and additional sittings are required, the assessors should complete the initial yarn and schedule a follow up assessment. The subsequent sessions should be conducted as soon as practicable, as service referrals cannot proceed until the assessment is completed and the Support Plan has been approved by the assessment delegate.

While the assessment remains open, the assessment organisation should maintain regular check ins with the client to ensure their circumstances have not changed. This ongoing engagement helps ensure the assessment remains accurate and responsive to the older person's needs.

FOI 27-3598 - Document 3

Factors to consider in determining whether to complete the assessment on the first visit include:

- **Support from Elder Care Support worker**: Has an Elder Care Support worker facilitated the older person's entry into the aged care system, explained the assessment process, and help built trust in engaging with aged care?
- **Client Engagement and Readiness:** Are the client's body language and verbal cues non-responsive, suggesting they need more time to become familiar with the concept of aged care assessments?
- **Availability of Information:** Has sufficient information been collected from various sources to allow the assessment to be undertaken in one sitting?
- **Supportive Environment:** Are family and/or community members present and helping to create a safe and non-stressful environment for the assessment?

5.7.4. Aboriginal and Torres Strait Islander assessment organisations delivering home support assessments

Aboriginal and Torres Strait Islander assessment organisations participating in the pilot are expanding their expertise to deliver comprehensive assessments. If a non-clinical assessor triggers clinical questions within the IAT and the organisation does not yet have clinical assessors or full capability to provide comprehensive assessments including if the IAT Outcome generates a Support at Home Classification level, the following action must be taken to ensure continuity of care and uphold a client centred experience:

- Clearly explain next steps
- If the assessment is not finalised, and a cancellation is necessary, the assessor will only be able to refer the client for urgent aged care services through the alternative entry pathway (see Chapter 3 for further detail),
- To preserve valuable information, the assessor should print the information from the "client's assessment history" tab before cancellation and upload the document to the client's record.
- Facilitate a supported referral by contacting another organisation with capacity for comprehensive assessment.
- Provide information on interim supports and assist with connections where possible.
- Maintain engagement with client and their support network and, where appropriate, include an Elder Care Support worker, to ensure continuity of care throughout the process.

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5.7.5. Recording assessment information

Assessors should make sure all important assessment information is recorded before leaving the assessment. The assessment information in the IAT should be transparent, objective, accurate, complete and in plain language.

Before an assessment is finalised, assessors should perform a quality check on the assessment information, expanding on information and assessment evidence where required. Accurate recording of assessment information prevents unnecessary follow-up

FOI 27-3598 - Document 3

queries and makes it more easily readable and usable for people who need to access it in the future. Once the IAT is finalised, it will become read-only and cannot be edited.

The accurate recording of assessment information (see the Aged Care Assessment Quality Framework):

- lays the foundation for creating the Support Plan for the older person and is reflective of what the older person said, was observed doing, and/or reported by carers/support persons
- minimises duplication between the assessment and Support Plan
- provides sufficient evidence for assessment delegate decision
- is required for audit purposes
- helps to inform an older person's provision of care and highlights important information or risks about the older person's situation that needs to be managed by the care provider or other parties
- puts the older person at the centre of the Support Plan

Depending on the risk and issues highlighted in the assessment, the assessor must decide where to record the information in the older person's record, e.g., in the IAT, the Support Plan, in Notes, as attachments or as sensitive notes or sensitive attachments.

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. All documents must be in PDF format and finalised in the My Aged Care Assessor Portal. The department is unable to access documents submitted to the Assessor Portal unless they have been finalised. The assessment documentation must include:

- Consent
- IAT and Validated Assessment Tools (VATs)
- Additional Evidence
- Support Plan and Recommendations
- Notice of Decision letter
- Referral Information

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The assessment should contain comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals.

Recording sensitive information

If the older person shares (or the assessor is in receipt of) sensitive information, with the older person's consent this can be recorded by adding a sensitive note and/or a sensitive attachment on the older person's record. This information will not display to providers or to older persons viewing their information through the My Aged Care Online Account and will be visible only to assessors and contact centre/ACSO staff.

Sensitive notes should be used to record information that is of importance. This may include information about:

- financial issues
- safety concerns
- health issues
- legal situations
- past experiences of trauma

FOI 27-3598 - Document 3

For example, a sensitive note could be used to record a personal safety issue such as conflict between family members causing the older person to be anxious.

> Note:
>
> Assessors must follow their reporting obligation specified in relevant legislation and protocols in their state or territory where they identify an older person is at risk of elder abuse.

Sensitive notes and attachments are not visible through the My Aged Care Service and Support portal. Instead, a message will display on the older person's record stating "the older person has a sensitive note/attachment on their record."

Given the assessor may be best placed to discuss the sensitive issues with the provider/s, the provider could contact the assessment organisation for enquiries on notes and/or attachments. The provider may also contact the assessor directly if they have a question concerning sensitive attachments. Sensitive information may be disclosed to the provider if it is relevant to their particular service. For example, where it is recorded that an older person has a sensitive health issue, an assessor may be contacted by a garden maintenance provider and the assessor may consider it inappropriate to disclose the information; whereas if the assessor is contacted by a personal care provider, the assessor may have a duty of care to disclose the information as it has implications for the service being delivered.

Where an existing older person currently receiving services has received a reassessment, and has disclosed new information that is categorised and recorded as a 'sensitive' note (that may impact the safety and welfare of the older person, staff or other older people), the assessor should contact the provider/s to make them aware of the sensitive information and enable them to make a risk-determination of how best to support the older person for the safe delivery of services (see section 12.12.4 Older people who are in prison).

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Sensitive user flag

The My Aged Care system also enables an older person or registered supporter to be flagged as a 'sensitive user' if the older person or registered supporter requests to limit access to their information, AND the older person or registered supporter:

- works for My Aged Care or the department
- has a conflict of interest with My Aged Care staff, or
- has provided reasonable justification to support that their identity and contact information is to be protected.

An older person or their registered supporter may request that the older person or the registered supporter is made a 'sensitive user' through the My Aged Care contact centre. The request will be assessed and if appropriate the older person or registered supporter's record will be flagged as a 'sensitive user' record.

The details of a 'sensitive user' will remain available to assessors and service providers who are working with the older person. Older people or registered supporters who are flagged as a 'sensitive user' will need to disclose this status to the contact centre at the time of their interaction, as the information is restricted and will require a team leader to access and edit the record.

My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the older person record

5.7.6. Urgent service provision in the IAT

The IAT includes a question about an older person's need for urgent service provision, "Does the client require urgent service provision?" This a mandatory question and requires a Yes or No answer. The response to this question is one of multiple factors used by the system to calculate a priority category for the person for the Support at Home Priority System. Other information is also used to calculate a priority category. An older person's priority for ongoing funding is based on their personal circumstances and characteristics.

An older person can be determined to need urgent service provision if the older person:

- is considered at urgent and immediate risk in terms of their personal safety; and/or
- is at immediate risk of admission into residential care; and/or
- is unable to be safely discharged from hospital without timely access to in-home care; and/or
- has a carer, and the carer arrangements are unsustainable, or the carer is at crisis point.

The guide below has been developed to help assessors determine whether an older person requires urgent service provision.

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Table 22. Urgent service provision guide

	Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
Criteria for determining urgency	Indicators that a carer arrangement is unsustainable: • Carer in crisis • Carer may have a dual caring role. • Carer's employment is being jeopardised by their caring duties • Carer may be returning to full time employment. • The level of care required by the older person is increasingly more complex and the primary carer is unable to provide the level of assistance required. • Recent changes in the older people' family, cultural, housing or	Some indicators of a person being at urgent and immediate risk with respect to their personal safety may include, but are not limited to: • Neglect of basic needs i.e., unable to access or prepare food resulting in malnutrition, weight loss or dehydration • Inadequate personal hygiene such as severe neglect of personal care leading to serious hygiene issues, infections or injuries. • Repeated hospital admissions due to frequent falls with sustained injuries. • Failure to administer necessary medications/treatments and/or attend medical appointments. For example, medication mishaps with potential for adverse outcomes.	There is an immediate risk of the older person entering Residential Care due to: • carer in crisis and/or inability of carer to offer required support; or • Lack of access to services to meet the older persons' needs and fairly mitigate immediacy of risk to personal safety • If the older person had access to these services (as	The older person cannot be safely discharged from hospital without significant risk, where: • A lack of access to services in the home would create significant risk of re-admission to hospital; and • If the older person had access to these services (as soon as possible following hospital discharge), their care needs could be managed at home. Note: As there will still be a wait time for the older

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FOI 27-3598 - Document 3

Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
social situation resulting in trauma, or feeling unsafe (including culturally unsafe) The carer in crisis is no longer able to provide care due to: • A change in the carer's personal circumstance i.e. death/significant decline in carers own health status • An inability to sustain their caring role due to a lack of assistance being received i.e. the older person has significant needs and no (or minimal) support is being provided. **NOTE**: Carer in crisis is different to caregiver stress. Caregiver stress is a condition of exhaustion, anger, or guilt that results from unrelieved	• Severe cognitive impairments with behavioural and psychological symptoms impacting client safety (e.g. wandering) • Person is unable to safely navigate their home and community due to insufficient aids, equipment and/or home modifications. • Recent changes in the older person's family, cultural, housing or social situation resulting in trauma, or feeling unsafe (including culturally unsafe)	soon as possible), they could be managed at home.	person's Support at Home funding to become available, a comprehensive assessment should be performed as soon as possible to support continuity of care and to not delay discharge.

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FOI 27-3598 - Document 3

	Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
	caring for a chronically ill dependent. The stress can vary depending on the individual and generally does not prohibit the carer from providing care. Caregiver stress can be reduced by accessing respite care.			

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FOI 27-3598 - Document 3

FOI 27-3598 - Document 3

Concerns, goals and recommendations

It is important to identify the goals the older person wants to achieve that are associated with the areas of concern that the older person wishes to address. The goals note the older person's strengths and abilities, the domain the goal(s) relate to, their area of difficulty and level of motivation to achieve the goal. The recommendations represent the agreed strategies and support to achieve goals. It is recommended that goals are added under 'Client concerns and goals' on the *Goals & recommendations* tab before accepting or overriding the IAT Outcome.

After recording observations under all relevant domains and categories in the IAT and prior to finalising the IAT (noting that once the IAT is finalised, answers in the IAT become read-only) the assessor supports the older person to identify the goals they would like to achieve to help address their areas of concern.

The goals should reflect the older person's current strengths, abilities, and areas of difficulty, along with the relevant domain and their level of motivation to achieve each goal. Recommendations must outline the agreed strategies and supports to help achieve these goals. Historical content from previous Support Plans should not be carried over unless it is clearly identified as historical or dated appropriately. Including outdated information can lead to confusion and reduce clarity. All content must focus on the older person's present needs and circumstances.

Assessors must:

- Draft and include at least one Concern and Goal linked to any recommended services. If no services are recommended or no change to services is required, a Concern and Goal does not need to be included.
- Draft Concerns and Goals that are clear, actionable, realistic and written from the older person's perspective (e.g., I find showering to be painful (concern). I would like to learn ways to have a shower without pain and reduce my pain rating from moderate (6/10) to mild to (3/10) (goal)).
- The older person's Concerns, Goals and recommendations will become clear as the assessor conducts the assessment and records their observations within the IAT. The assessor must ensure that the older person's Concerns and Goals reflect their needs as detailed in the IAT (e.g., Physical and Medical domains of the IAT provide details of the Mr Arnolds functional limitations with showering and the pain he is experiencing).
- Consider whether the older person will benefit from a short-term reablement intervention to maximise their independence, choice and quality of life, and the older person's capability, motivation, and strengths to contribute to their goals. Reablement can be provided by the assessor or by CHSP providers, with assessor review to determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Consider whether the goals identified suggest suitability for Restorative Care Pathway (RCP) such as improving function, learning, reablement, or other goals which support delaying the need for higher level or ongoing services. This consideration should include whether a person has the motivation and capacity to actively participate in RCP including attending frequent allied health interventions (over more passive interventions). The need for a multi-disciplinary allied health and/or nursing approach to care must also be required before recommending RCP. Consideration of long-term needs should also be given before approving RCP as it will impact their position on the Support at Home prioritisation system.
- Consider the overall volume of RCP recommendations being made and any guidance or operational advice regarding system pressures or delays in accessing RCP. If timely access to RCP may be uncertain, assessors may wish to discuss alternative supports with the older person.

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FOI 27-3598 - Document 3

- Consider, throughout the assessment, whether the older person will benefit from assistive technology and home modifications funding to support functional needs and safety at home in areas such as:
    - managing body functions
    - self-care
    - mobility
    - domestic life
    - communication and information management

5.7.7. Classification algorithm

About the classification algorithm

The ongoing home support classification algorithm (classification algorithm) is a set of business rules used to assign individuals an ongoing home support classification level. The outcome of the algorithm that is known as the IAT Outcome in the assessment workflow.

The classification algorithm was introduced on the commencement of the Support at Home program and *Aged Care Act 2024.* It is designed to place people with similar clinical care needs in a classification level for ongoing home support, which confers a funding amount. This intends to:

- **Achieve consistency –** so that decisions are not influenced by individual discretion or subjective judgment.
- **Ensure equity –** so that everyone is treated fairly.
- **Build confidence –** so older people and their families can trust that the system is transparent and reliable.

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The classification algorithm was carefully developed over time and built on data from over 22,000 assessments conducted in 2023 through the IAT live trial. Before it was implemented, the algorithm was refined using more than 200,000 assessments completed in 2024-25. This process was undertaken to ensure it would achieve the best outcomes for older people, deliver on the policy intent of the Support at Home program and support the responsible use of taxpayer funds.

How the classification algorithm works

The classification algorithm uses data that an assessor enters into the IAT during an assessment across a number of domains in the tool. The algorithm uses this data to evaluate an older person's clinical characteristics and assigns a classification level (or funding level) for ongoing home support (i.e., CHSP or Support at Home). The classification algorithm ingests the information entered by the assessor about an older person's functional ability, the extent to which their needs are being met, and other compounding factors that introduce additional complexity for an older person compared to others with similar functional ability and needs met.

For a given set of clinical characteristics, the classification algorithm will always generate the same classification level. The rules or criteria that must be met for each ongoing home support classification level are defined in section 81-10 of the *Aged Care Rules 2025* (the Rules). The Rules are prescriptive and do not allow for an ongoing home support classification to be approved that is different to the rules it describes and which the algorithm relies on. Therefore, overriding the classification algorithm outcome to a different ongoing

FOI 27-3598 - Document 3

home support classification level (e.g., CHSP to SaH class 1-8; ineligible for CHSP/SaH to CHSP or SaH class 1-8; SaH class 1-8 to a different SaH class 1-8) is unlawful.

The accuracy of the IAT Outcome relies on information that has been entered into the IAT during the assessment. Assessors continue to play a critical role in achieving high quality assessment outcomes by using their strong communication and interpersonal skills to complete the IAT during the assessment, and their clinical judgement when undertaking comprehensive assessments.

Accepting the IAT Outcome

If an assessor intends to recommend ongoing home support for an older person through Support at Home or CHSP, the system generated IAT Outcome must be accepted by the assessor. For example, where the IAT Outcome recommends an ongoing SaH class 5, the assessor will accept this IAT Outcome to recommend ongoing SaH class 5.

Note: Under the *Aged Care Rules 2025,* if the individual is a Disability Support for Older Australians (DSOA) Program client and they receive an IAT Outcome recommending an ongoing SaH class, the assessor is permitted to override the algorithm and select the CHSP classification, if that is preferred by the individual

Accepting a SaH package outcome will result in a DSOA client having their DSOA funding capped on an ongoing basis. Should a DSOA client access a SaH package, this will result in the DSOA client being exited from the DSOA Program. Assessors should ensure that DSOA clients considering accessing a SaH package are fully informed of the impact of the assessment on their DSOA funding *before* finalising the client's assessment.

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If the IAT Outcome results in 'ineligible for CHSP/SaH,' the person is not eligible to receive CHSP or ongoing SaH. An assessor must not override the IAT Outcome to recommend an ongoing home support classification level. If by considering the eligibility criteria in the *Aged Care Act 2024* for residential care, the assessor wants to recommend residential care, it is appropriate to accept the ineligibility outcome and recommend residential care.

Important:

To support the IAT Outcome recommending a level of care which appropriately addresses an individual's care needs, assessors should ensure all inputs into the IAT are accurate before it is finalised. From 29 June 2026, the IAT amendment process will allow Assessment Delegates to return a finalised IAT to assessors to correct errors and resubmit it. This process can only be used once per assessment.

FOI 27-3598 - Document 3

Overriding the IAT Outcome

Important:

There is functionality in the assessor workflow that allows for actions that must not be taken by assessors as these actions do not align with the *Aged Care Rules 2025 (the Rules),* deeming them unlawful. This includes:

• the IAT Outcome must not be overridden to recommend a different ongoing home support classification (e.g., Ineligible for CHSP/SaH to CHSP or SaH 1-8; CHSP to SaH 1-8; SaH 1-8 to CHSP; SaH 5 to SaH 6). In line with section 81-10 of the Rules, the criteria for each classification are prescriptive and do not allow for the recommendation of an ongoing classification different to the IAT Outcome.

• a CHSP classification can be overridden to recommend Restorative Care Pathway (RCP) during a comprehensive assessment. In line with section 81-15 of the Rules, RCP cannot be recommended for approval when a Support at Home classification has not been generated by the IAT Outcome.

It is important that assessors do not take these actions and delegates do not approve recommendations when these actions have occurred.

It is necessary to override the system-generated IAT Outcome to recommend the:

- SaH Restorative Care Pathway,
- SaH End-of-Life Pathway,
- Transition Care Program (TCP) without ongoing in-home services,
- Permanent Residential Care without ongoing in-home services,
- Residential Respite care without ongoing in-home services.

Note: In order to recommend residential care (permanent or short-term) without ongoing in-home services, assessors will need to override the IAT Outcome of CHSP or Support at Home to 'ineligible for ongoing SaH/CHSP.' Assessors can then recommend these care types in the support plan. Assessors may also approve an ongoing home support classification alongside residential care and select 'not seeking services' to avoid a reassessment being required for older person if they choose to return home.

An older person can be recommended and approved for CHSP or Support at Home services at the same time as TCP, provided the IAT Outcome generates an ongoing home support outcome. For example, Support at Home services can only be recommended if the IAT Outcome generates a SaH 1-8 classification level and interim CHSP services may also be recommended. If the IAT Outcome results in a CHSP classification, only CHSP services can be recommended.

If it is not appropriate to recommend ongoing home support services at the same time as TCP for people new to the aged care system, the IAT Outcome can be overridden to 'ineligible for CHSP/SaH' and then the transition care option can be chosen under 'Add a Care type for Delegate Decision' button. The system will not allow CHSP services to be recommended concurrently with TCP if the IAT Outcome has been overridden with 'Ineligible for CHSP/SaH.'

For transitioned HCP, SaH clients and CHSP clients who are assessed for TCP, the IAT Outcome will need to be accepted, and TCP added as a care type. These

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FOI 27-3598 - Document 3

services can continue to be accessed while accessing TCP, as long as the services are not duplicative. See Chapter 6 for further information.

Once the override button is selected, a screen will display where an assessor can perform these actions. If an assessor overrides the IAT Outcome, they will be required to:

- select a reason for overriding the IAT Outcome, and
- provide a descriptive reason for overriding.

Tips for assessors when explaining the IAT Outcome and recommended classification level for ongoing home support to older people and their supporters.

- I have put the information you/<older person's name> have/has given me during your/their assessment into the assessment tool and the system has generated an outcome for your/their <eligibility for CHSP/level of funding for Support of Home> OR <ineligibility for ongoing home support services>.
- The system uses a set of rules which rely on information that you/they have told me during your/their assessment which include:
    - Your/their functional ability to undertake daily tasks e.g. walking, eating, bathing, toileting, managing their finances, cooking, and shopping, and
    - the extent to which your/their needs are currently being met, and
    - other factors that may introduce additional complexity for you/them such as sensory concerns, medical conditions and co-morbidities (i.e., the simultaneous presence of two or more diseases or medical conditions), carer availability, mental health, continence, and vision impairment.
- Your/their level of funding for ongoing home care services has been determined using this set of rules.
- This helps to ensure consistency in how funding is assigned and means that your/their funding level will be the same as other people who have similar needs and clinical characteristics.
- I have included services in your support plan that will help to meet your goals and needs. Once approved and your funding is assigned to you, you can work with a provider to determine the services you will receive and how often within your funding level.

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Note: While these tips aim to provide assessors with clear and accurate advice about how to describe IAT Outcomes for ongoing home support when talking to older people and their supporters, we encourage all Assessment Organisations to work with their assessors on scripts and strategies they can use to support them to have these conversations using a person centred, educative and positive approach.

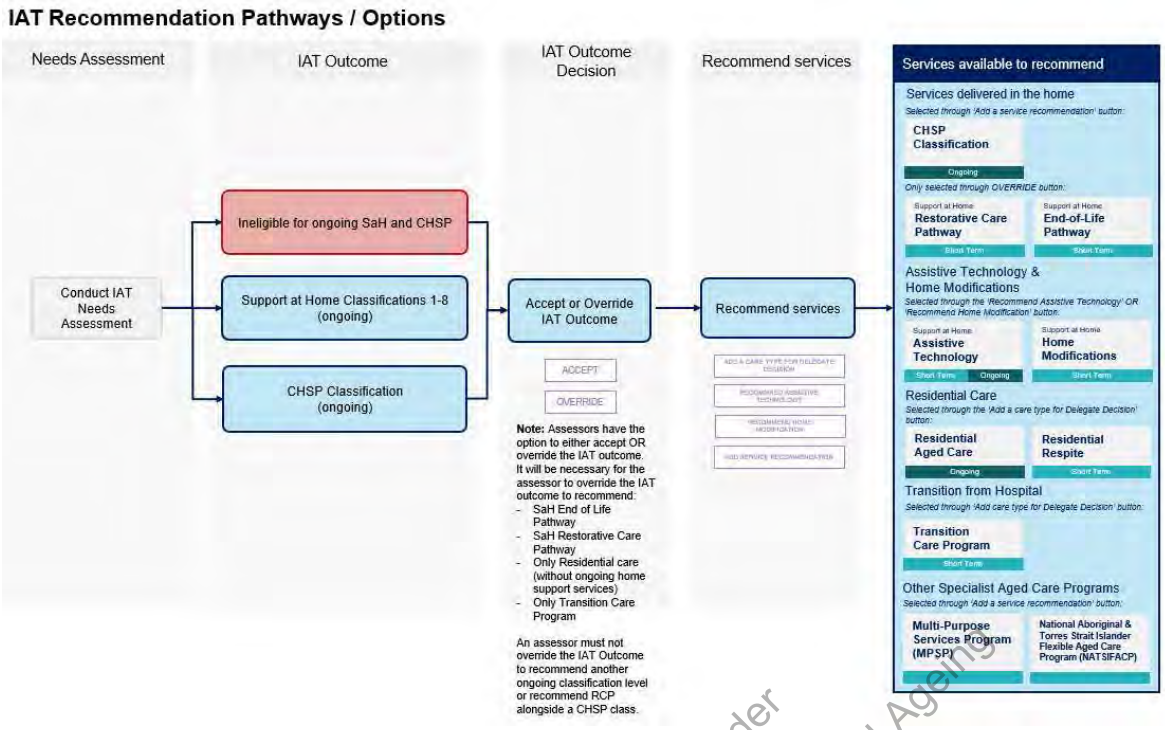


Figure 4 - IAT recommendation pathways and outcomes

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5.8. Converting a home support assessment to a comprehensive assessment

If an assessment is triaged as a home support assessment and the IAT Outcome generates a Support at Home classification, and/or the assessor wants to recommend residential care (permanent or short-term), the assessment will need to be converted to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal.

> Note: Enrolled Nurses (EN) who hold the clinical assessor role may provide supervision to non-clinical assessors if a home support assessment is converted to recommend Support at Home and no clinical questions have been triggered in the IAT. ENs must ensure that they continue to act within their scope of practice.

In the expanded view of the *Goals and Recommendations* tab, the assessor will have the option to convert to a comprehensive assessment if the current assessment type is Home Support. An assessor will only be allowed to convert to comprehensive assessment from a home support assessment.

In assessments where services under the Support at Home program and/or residential care are recommended, but clinical questions are not triggered in the IAT during the assessment, a non-clinical assessor will need to seek the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal. The supervising assessor will need to be nominated before the assessment can be converted.

If a clinical assessor has already provided clinical attendance during the assessment and nominated as the supervising assessor, the details saved when the IAT was finalised will display as read-only.

FOI 27-3598 - Document 3

When the assessment is finalised, a system notification 'Notification of Supervised Assessment' will be sent out to the outlet associated with the nominated supervising assessor. This notification will be visible on the Assessor Portal as per existing notifications functionality.

The supervision required to convert a home support assessment to a comprehensive assessment is not the same as the clinical attendance process outlined in Section 5.7. Rather, it is a conversation between assessors to ensure the support plan reflects the needs of the older person and the appropriate care recommendations are included for delegate approval. There is no requirement for the assessment to be undertaken again by the clinical assessor.

5.9. Developing a high-quality support plan

The Support Plan is a plain language summary of the older person's situation, strengths, goals, aged care needs and recommendations, based on information obtained during the completion of the IAT.

The Support Plan sections include:

- Assessment summary
- Concerns and goals
- Service recommendations

The role of an assessor, when developing the Support Plan with an older person, is to consider IAT findings and the older person's needs holistically to recommend support most appropriate to their needs and circumstances.

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> Note:
>
> The Support Plan functionality in the system accommodates the Support at Home classes and associated service recommendations and AT-HM scheme.
>
> Once finalised, the Support Plan is sent to the older person, and their registered supporter/s and/or appointed decision maker/s as applicable (via post and/or email), as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan; therefore, accuracy and clarity is essential.
>
> Referral codes are included in the Support Plan for the majority of services approved however there are several nuances about where they will appear depending on the program or pathway. For further detail on how referral codes will be communicated to clients and providers, see section 9.4 Referral and support for service access

FOI 27-3598 - Document 3

5.9.1. Assessment summary

The assessment summary section of the Support Plan is a succinct overview of the assessment that appears on the Support Plan for the older person.

When completing the assessment summary, the My Aged Care system allows the assessor to pre-populate a summary of the older person's functional ability, support considerations and complexity indicators that were identified during the assessment and recorded in the IAT. The pre-populated information will be displayed in the ISBAR format, which is the required template for recording information in the assessment summary.

Assessors must use a standard template (see ISBAR approach below) to complete the assessment summary to ensure information is recorded in a consistent manner across assessment types. It is simple to adopt and helps make information easier to read while better supporting the delegation process and assisting the service provider to develop the care plan.

The assessment summary must:

- Be written in a succinct manner (using the ISBAR approach), focusing on relevant/essential information.
- Be presented in a structured way that makes the information easy to interpret.
- Be understandable to anyone without prior knowledge. Limit spelling and grammatical errors and avoid acronyms, abbreviations, jargon, and unnecessary headings.
- Provide a holistic and complete summary of the older person's assessment at that time.
- Be relevant. Only include information that is relevant to the older person's current situation. This may mean updating previous information.

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Assessors must also:

- Use the 'pre-populate' function in the Assessor Portal to enable the ISBAR template to tailor the pre-populated assessment information in consultation with the older person. Ensure the Assessment summary is not limited to pre-populated information but includes a holistic, comprehensive view of the older person as per information collected from the assessment.
- Avoid simple dot point form. Information should be re-written in a sentence format that is succinct, objective, supports the client's needs, readable to the older person and justifies funding for My Aged Care services. See template in the Table 23 below.
- Review and edit information populated from the assessment – such as functional needs, health conditions, support considerations, and complexity indicators. For a SPR or reassessment, the assessor (in updating previous information) may need to remove content that is no longer current to remain within the 5000 character system limit. All past versions of the Support Plan are retained as a record of any deleted content. Each Support Plan must reflect the older person's current needs and circumstances. Historical content needs to be clearly identified or removed to ensure clarity of current needs.
- If clinical attendance occurred during the assessment process, the assessor must make a note of this in the Support Plan.
- Enrolled Nurses (EN) who complete a comprehensive assessment must include a statement in the support plan that the assessment has been conducted under direct or indirect RN supervision within the same organisation

FOI 27-3598 - Document 3

> Note
>
> Learner assessors must be supervised by an experienced certified assessor through their learning pathway. The Support Plans developed by learners, before their appraisal activity 2 is marked complete, must include a statement that the assessment was conducted under supervision and include the supervisor's name.

All support plans within the assessment summary must be written using the ISBAR approach. It is expected assessors use the ISBAR format as a guide on how information is structured in the assessment summary with clear headings and subheadings where required. This ensures readability for not only the older person, but for their carers, service providers or future assessors, providing a holistic view of the assessment and older person.

> Note to Aboriginal and Torres Strait Islander Assessment organisations:
>
> Assessors should be mindful that the Support Plan should be written in a way that can be understood by the older person and their support network. If needed, the assessor may follow up with the older person to explain the Support Plan to the older Aboriginal and/or Torres Strait Islander person.

Table 23. Assessment summary template using the ISBAR approach

ISBAR topic	Assessment information
Introduction	• Older person's name and age • Reason for assessment, including referral details (who made the referral and why, if appropriate) • Assessment details – type (home support or comprehensive), date, location, mode, attendees, assessor name • Whether the assessor is an EN requiring direct/indirect supervision from an RN.
Situation	• Key health conditions that impact functional limitations and need for an aged care assessment • Medical issues (clinical assessors to include diagnosis status) *

Background	• Living arrangements*
	• Diversity considerations supporting the Statement of Rights and Principles
	• Current social situation and social history*
	• Current support
	  ○ Carer profile (including details of Power of Attorney in place)
	  ○ Other informal supports*
	  ○ Current and previous services including aged care, mental health, disability, palliative care

Assessment	• Assessment observations (include carer involvement/carer strain) under the relevant domains: Function • Medical and medications

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ISBAR topic	Assessment information
	• Physical and personal health and frailty • Social • Cognition • Behaviour • Psychological • Home and personal safety • Financial or legal • Support considerations • Whether clinical attendance was sought by a non-clinical assessor • Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.

Recommendations	• Previous approvals
	• Current recommendations*
	  ○ Reason for the recommendation (the older person benefit from X)
	  ○ Comments to support recommended interim services
	  ○ Comments relating to the urgency of service
	  ○ Who is to action the recommendation – older person, assessor
	  ○ Recommendations associated with the carer and/or affected support person/s
	  ○ Recommendations must be justified by a clear link to assessment outcomes and support the older person's goals and concerns.
	• Referrals*
	  ○ Status of referral (e.g., referral made with consent, older person declined referral)
	  ○ Who is responsible for contacting services
	  ○ Time-limited/end date or review date, or a rationale for ongoing services.
	• Contact details (if not older person) *
	• Who has been sent a copy of the Support Plan, including whether it has been linked to the older person's My Health Record*

*Indicates items that are not pre-populated

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Further guidance on **the information that should be included under each heading is below:**

Introduction section: Sets the scene for the assessment. This section should include the client's name and age, the type of assessment being conducted, the reason for assessment, support persons present such as carers/registered support persons/translation services, the date of when the assessment took place, whether the assessment was conducted face-to-face or via telehealth or telephone, the name of the assessor including supervising assessors (including registered nurses if assessor is an enrolled nurse).

Situation section: Ensure this section outlines the primary reasoning for the referral for aged care reason including any linkages to functional, social, psychosocial and environmental factors. This section should include an older persons' medical history with specific reference to the primary health condition(s) that impact their activities of daily living and/or social situation. Include any recent hospitalisations or access to ongoing medical intervention. This should link to any medical services the older person is currently receiving including any specific specialists, doctors or other medical professionals they are currently seeing (e.g. GP)

Background section: Include information that pertains to the older person's current social situation and any social history with details on living arrangements, work and/or social engagements. This includes caring arrangements (formal or informal) that are in place for the older person and what specific supports they are currently providing to the older person. This should also outline any carer stress or carer sustainability issues pertaining to the older person. Assessors should outline any aged care services (past and present) or other government or state-based services that are being accessed at the time of the assessment.

Assessment section: Include all relevant sections of the assessment and highlight any complexity indicators. Record detailed observations against the domains and use language such as 'the older person experiences X and has difficulty with Y, they would benefit from Z.' It should include all validated assessment tools and its scores that were used in the 'assessment' section along with an explanation of what the score indicates. This should include reference to completion of the DEMMI modified tool if respite is recommended – see section 6.10.1Recommending residential respite care for more information. The assessor should exercise clinical judgement on whether specific scores should be excluded (e.g. sensitivity content for the older person)

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Recommendation section: Include all new recommendations/continuation of existing approvals, status of service referrals, time limited/ongoing/interim supports, who is responsible for actioning next steps, older persons' contact details and whether clinical attendance was required. Ensure that recommendations can be justified clearly through the Assessment Summary ISBAR format. Ensure that the information provided here can be linked to the older persons' service recommendations and approvals under the Goals and Concerns. It is best practice to revisit the recommendations section of the Assessment Summary following recording the older person's Concerns and Goals and prior to finalising the IAT.

FOI 27-3598 - Document 3

5.10. Wellness and reablement approach

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that, even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community.

By focusing on capacity-building and restoring or maintaining function, wellness and reablement approaches directly contribute to the wellbeing outcomes described in the Act and the strengthened Aged Care Quality Standards. These support older people to live safely, independently, and with a sustained sense of meaning and connection in their own homes and communities.

5.10.1. Delivering reablement

The provision of wellness and reablement approaches should be embedded in the assessment and support planning processes. Wellness and reablement underpins all assessment and service provision, drawing on the wellness philosophy to inform a way of working with people. Wellness and reablement are inclusive approaches that involve assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals irrespective of age, capacity, diagnosis or setting[3]. Additionally, these approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks, as well as reducing risks affecting the ability to live safely at home. They avoid 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves (or with less assistance), and to increase satisfaction with any gains made.

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Reablement approaches involve time-limited services for a period of up to 12 weeks and always include a specific goal. Time-limited support aims to address a specific barrier to independence and to support the older person getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, to achieve their goals.

It should be noted that wellness and reablement approaches should be adopted by all assessors, including clinical assessors. For clinical assessors who are undertaking a comprehensive assessment, the option is also available to recommend an older person to receive a reablement service under CHSP if it is appropriate to do so.

A wellness and reablement approach to assessment means where possible, assessors undertake a 'show me' (active) assessment in which older people demonstrate how they undertake certain tasks to better understand their limitations and identify risks. This is distinct from the traditional "tell me" approach used by assessors.

Understanding what a good day looks like for an older person and how it relates to their individual goals and outcomes is important to determine short-term support needs during an assessment. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement is usually delivered within a 12-week period

[3] Metzelthin, S.F., Rostgaard, T., Parsons, M., & Burton, E. (2020). Development of an internationally accepted definition of reablement: a Delphi study. *Ageing and Society, 42*, 703 - 718.

FOI 27-3598 - Document 3

with the aim to wrap up and cease the services when the older person has met their goal or specific outcome.

Time-limited reablement under the CHSP that assessors may refer older persons for can include:

- Learning a new skill, or actively working to regain or maintain an existing skill modification to a person's home environment,
- Providing access to assistive technology to help live more independently and safely in the home.

For example, learning a new skill could require referral for support on how to prepare simple meals for themselves, rather than referring for meals delivery. Regaining or maintaining existing skills could require referral for Allied Health and Therapy Services to ensure the older person can continue to transfer around the home and reduce the risk of falls.

As part of the assessment process, the assessor will need to work with the older person to identify whether they would benefit from a reablement approach to home support services, based on their needs and goals.

If the older person agrees short-term reablement support is appropriate and/or beneficial to them, the assessor should include service solutions within the Support Plan to promote their independence. The assessor must record the reason for the reablement period within the Support Plan such as:

- rebuild confidence and independence in mobility
- rebuild confidence and independence in cognitive abilities, including for people living with dementia
- adaptation to functional limitation
- support the development/relearning of daily activities
- task simplification and energy conservation for managing housework
- promote social contact, community access and participation
- skills development in using public transport
- supporting independence through assessment for appropriate assistive technology
- training in the use of assistive technology
- supporting independence through assessment for home modifications ensuring safe living environments.

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The Support Plan may include recommendations to assist the older person to maintain and strengthen their capacity to continue to undertake daily activities and maintain social and community connections. Due to the nature of reablement supports, it is possible there will be several items in the Support Plan that need to be delivered in a coordinated way across a number of CHSP service types over a limited time period. In these circumstances, the assessor could refer an older person to a lead provider – the organisation or individual provider who will deliver the key services as identified in the Support Plan.

The assessor may also need to take on a coordination role to ensure that all services in the Support Plan are linked to a CHSP provider, and that they will all be delivered within the timeframe of the overall reablement service. For older people receiving reablement support, assessors must include review dates on the older person's Support Plan for the purposes of reviewing the older person's progress towards their goals and desired outcomes, requirement for ongoing services, or whether to adjust the services required.