

## **PROPOSED USE OF FORMS draft 1 (September 04)**

WHEN CHOOSING WHICH FORMS TO USE PLEASE CONSIDER:

### **THE DEPTH OF ASSESSMENT SHOULD BE IN PROPORTION TO THE NEEDS IDENTIFIED**

“ As the idea of a [FACE] ‘toolset’ implies, the underlying concept is to provide practitioners, service users and carers with a set of tools that may be used in different combinations to achieve the desired goal of accurate person-centred assessment proportionate to the need of the individual.” (from ‘Meeting the Standard. The FACE Overview Toolset’ Document Version 2.0 January 04, by Paul Clifford)

This means that the documents can be used in a flexible variety of orders, though the Background is the basic minimum.

#### **BACKGROUND (pp3)**

- **All clients** will require this initial paperwork done once, it should be sent with all referrals. It forms the basis of all our paperwork.

#### **REFERRAL FORM (pp2)**

- Eventually, to all services in Camden from all services in Camden (this needs agreement from steering group)
- At present the core teams of District Nurses, Social Services OTs and community teams and the REACH teams can receive a FACE referral form, but it should be accompanied by the Background form as minimum extra information.

## CONTACT ASSESSMENT (p4 of the Background)

- used for service users who require only a short episode of care, when the initial assessor's input is going to be minimal.

= Background + Contact + Referral

- long episode of uni-professional care

= Background + Contact+ Specialist

**note** – if this person then needed to be referred on, an Overview would be expected so it is good practice to complete an Overview for longer episodes of care generally

- urgent or rapid assessments when it is not known if Overview is required or appropriate *at that time*

= Background + Contact, then later  
either Overview + Goal Sheet/Summary,

- initial contact if the Overview is not appropriate *at that time*

= Background + Contact + Goal Sheet/Summary

## OVERVIEW (pp8)

This is the multi-professional domiciliary assessment to be done

- if the service user and/or the professional identifies a range of multi-professional needs/goals to be met.
- This assessment should be shared with other professionals involved in the client's life and *must* be accompanied by the Background – unless the service user has refused consent to information sharing. In that case, the client has to be told that other visiting professionals may need to fill in the same forms again.
- **NB if the Overview is done, the Contact sheet is not required.**
- If the Contact has already been done, the information should not be duplicated onto the Overview.

= Referral + Background (+ Contact if already done, otherwise not to be used)  
+ Overview + (possibly) summary/goal sheet

note – re: consent. Consent for information sharing can be obtained by the assessor or the client, whichever is deemed more appropriate. It does not need to be filled in the Overview if it is already on the Contact.

**SUMMARY/GOAL SHEET** (pp2)

This is a summary of goals set, met or to be resolved and can be a summary of the Overview assessment

In some cases the Overview may not be applicable to send as referral information even though it has been used for the client. For instance;

- if the needs identified have been met
- if sending the documentation is over-laborious at this stage
- if the professional being referred to is unlikely to require it for their assessment.

= Referral + Background and Contact + Summary/Goal sheet

At this stage these are the only SAP documents being used in Camden.

JT/ draft 1/ FACE documentation guidelines/ September 04