DARLINGTON BOROUGH COUNCIL ADULT SOCIAL SERVICES AND DARLINGTON PRIMARY CARE TRUST

SINGLE ASSESSMENT PROCESS
OVERVIEW ASSESSMENT GUIDANCE
APRIL 2005

What is the Overview Assessment Document?

The Overview Assessment is a person-centred form to record a broad assessment of the person's needs in the context of their whole life. With the appropriate consent, it may be shared across participating agencies in Darlington, to provide a range of health and social care.

The Overview Assessment records the detailed information about the person's current needs and any help that may be required to address those needs, that are relevant to the person at that point in time. An up to date Contact Assessment will have been completed prior to the overview, to provide basic demographics and an indication of the presenting needs.

Underlying principles: In general the Overview Assessment:

- Will only be needed for a person who has needs that cannot be satisfied using the Contact Assessment alone.
- Starts at the point where the person is, not necessarily at the start of the form.
- Is a conversation with the person, not, a stream of questioning. The form is not the assessment it is a method of recording a conversation in a meaningful structure.
- Is designed to be completed by one person, be it a Health or Social Care worker. However, in some circumstances it may be beneficial for a number of professionals to complete the assessment in partnership, e.g. if the person is in Hospital, Intermediate Care, or the community. In these instances a Care Co-ordinator will be responsible for co-ordinating the assessment.
- Has, several different sections. You only need to complete the relevant parts, not necessarily the form in its entirety.
- Belongs to the person, and the original document should remain the person's responsibility wherever possible. If the person is able and willing, they should hold the document, in the Person Held Record, and make it available to other health and social care professionals as needed.

The following agencies have agreed to use the Overview Assessment:

- Darlington Social Services
- Darlington Primary Care Trust
- Darlington Memorial Hospital, through the Discharge Management Team
- County Durham ad Darlington Priority Services NHS Trust, through the Integrated Mental Health Team.

Who does the Overview Assessment apply to?

The Single Assessment Process in Darlington will apply to people who:

- Live in the Borough of Darlington and
- Are registered with a Darlington PCT GP practice and
- Are aged 18+ with a Physical or Sensory Impairment and
- Older People, including those with a mental health need aged 65 plus.

Who Completes the Overview Assessment?

The Overview Assessment may be completed by, health or social care workers who have assessment responsibility where more in-depth needs or risks are evident.
See Appendix 1 for more information from the National Guidance.

Guidance Notes for completing the Overview Assessment

Page 1: Information relating to the person's name and ID should be transferred from the Contact Assessment, this should be recorded at the top of each page.

What help/support does the service user feel they need: The Overview Assessment starts from the person's own perspective. Information gathered here will help the person and the assessor to decide which domains and sub domains require further exploration.

Accountability Section: Depending on the individual circumstances there may be more than one professional involved in the assessment. It is therefore important that all professionals involved record their details in this section.

When completing any domain or sub-domain the following issues should be considered:

- In the Risks/Comments box please detail any intervention required.
- If qualified nurse/therapist supervision is required, give details/rationale.
- Comment upon the stability of the person's condition and any anticipated changes.
- Are the interventions stated likely to be long term? If yes, please give details.
- Has the person been screened for Continuing Health Care against the 'triggers'?
- Specify the number and level of carers required in the columns A, B, C, D.
  Key:
  A – Registered Nurse
  B – Formal Carer with Registered Nurse/Therapist Supervision
  C – Generic Support Worker/Home Carer
  D – Informal Carer

SAP National Guidance (see LAC (2002) 1, HSC 2002/1) outlined the minimum Domains and Sub Domains that should be part of the single assessment. The Darlington Overview Assessment has eleven domains, which are divided into a number of related sub domains. All of the domains have the following main structure:

- Main domain title, and sub-domain titles e.g. 1a, 1b, 2a, 2b etc.
- Section for Overview Assessment Date and Initial
- Section for Reassessment Date and Initial – it is important to record this date as the reassessment will not necessarily cover all of the domains completed at the initial Overview Assessment. This provides all professionals involved with details of the last assessment carried out in this area, and who completed it.
- Numbered section relating to the persons level of independence and if assistance is provided/needed what level e.g. see Key – A, B, C, D, above
- Comments box for additional information
- Risks box, to record any identified risks, including Health & Safety, observed and/or potential risks, to the service user or others.

In addition some domains and sub domains may included the following:

- Triggers – to indicate if a referral should be made for a Specialist Assessment or for the assessor to contact a Specialist Team/Professional for advise/information.
- Accredited Tools and Scales with guidance on when to refer for a more Specialist Assessment.
- Prompts to check against the Continuing Health Care Criteria.

It is important to remember that the triggers, tools and scales should be used to inform and support professional judgement, not replace it. For example if, after completing the relevant section and any tools or scales, the professional is still concerned about a particular issue they should always request further advise or refer on for a Specialist Assessment.

<u>Overview of Domains and Sub Domains</u>

Domain 1 – Personal Care includes the following sub domains:
1a – Eating & Drinking
1b – Personal Hygiene
1c – Dental and Oral Hygiene
1d – Dressing
1e – Bathing/Showering

Domain 2 – Health Disease Prevention includes the following sub domains:
2a – Smoking
2b – Drinking
2c – Exercise
2d – Blood Pressure
2e – Flu Jab
2f – Cancer Screening
2g – Nutrition Screening

Domain 3 – Physical Well Being includes the following sub domains:
3a – Breathing
3b – Pain

3c – Medication

1. I am able to collect my prescribed medicines or alternative arrangements are in place – covers access issues, consider:

    - Does the patient have problems accessing either a GP and/or a Pharmacy
    - Who orders repeat prescriptions for the patient
    - Who collects repeat prescriptions from the surgery and takes them to the Pharmacy
    - Who delivers medication to the patient
    - Does the patient ever run out of repeat medication
    - Does the medication all run out at the same time
    - How does the patient access ‘OTC’ medication if needed

2. I can take my medicines myself without any assistance – covers compliance issues, consider:

    - Do they understand how and when to take their medication
    - Do they understand the instructions
    - Got side effects from their medicines
    - Adjust the dose sometimes myself
    - Do people often have to remind you to take your medication
    - Have lost faith in my medication

3. I always take my medicines in the way that the doctor wants me to – covers clinical issues, consider:

    - Do you know what your medicines are for
    - Do you understand how and when to take your medicines
    - Do you get side effects from your medicines
    - The medicines do not give immediate benefit
    - My illness has got worse
    - I still get symptoms even when I take my medicines
    - I need to purchase additional medicines from the Pharmacy

4. I can easily get all my medicines out of their containers – covers day to day medicines management issues, consider:

    - Medical conditions such as arthritis, stroke or tremor
    - Lack of strength and or dexterity
    - Difficulty with blister packs
    - Poor eyesight
    - Can't open and close child resistant containers
    - Difficulty picking up tablets
    - Problems swallowing tablets
    - Difficulty pouring liquid medicine from a bottle
    - Are they able to administer eye or ear drops
    - Can they inject insulin
    - Can they read the labels on their medicines and understand the directions.

3d – Allergies
3e – Sleep Pattern
3f – Foot care
3g – Continence
3h – Skin Care
3i – Falls
3j – Handling constraints
3k – Client Handling Risk Assessment
3l – Access to property
3n – Transfers
3o – Moving items around the home
3p – Use of Stairs

Domain 4 – Mental Health includes the following sub domains:
4a – Behaviour
4b – Memory/Cognition
4c – Decision Making/Insight
4d – Mood
4e – Personal Relationships
4f – Geriatric Depression Scale
4g – Motivation
4h – Psychotic Symptoms

Domain 5 – Senses includes the following sub domains:
5a – Communication
5b – Hearing
5c – Sight
5d – Maintaining Safety

Domain 6 – Living Conditions/Domestic Care/Finance includes the following sub domain:
6a – Current Accommodation
6b – Provision of heating in accommodation

6c – Health and Safety Issues regarding the environment guidance notes:
Assessing service users needs and making decisions about the provision of appropriate services can have serious health and safety implications for the service users, care and service providers and other persons. The information recorded is used by those involved in the assessment process and in the provision of care to identify risks to the health and safety of service users and employees providing care to enable appropriate precautions to be adopted.

It is therefore essential that adequate consideration is given to health and safety implications when completing the Contact and Overview Assessment document and during decision making. It is important that health and safety risks are considered when completing all domains of the assessment. The main health and safety considerations include:

- Moving and handling needs
- Challenging behaviour
- Violence
- Cross infection and medication issues
- General life skills e.g. road safety, use of transport etc.

Also provided within the Overview Assessment document there is a specific domain for health and safety issues regarding the environment. This section should be used to record if there are any specific health and safety risks observed in the environment. These may include:

- Access & Egress
- Slips / Trips / Falls
- Concerns regarding electrical / gas safety
- Hygiene
- Fire
- Pets (dangerous dogs, birds and other animals, presence of fleas etc.)

It is important that adequate detail of information relating to all health and safety risks is transferred from the assessment form onto the care plan. This will ensure that the providers of service receive comprehensive information in relation to health and safety, enabling them to adequately plan for and provide an appropriate level of service.

Care providers will need to conduct specific service user risk assessments, in order that adequate health and safety arrangements can be made. It is therefore essential that co-operation and co-ordination between all parties be maintained to provide a safe and healthy service for all concerned.

6d – Care the Home
6e – Shopping
6f – Food Preparation
6g – Landry/Ironing
6h – Finance

Domain 7 – Community Involvement/Social Interaction includes the following sub domains:
7a – Cultural/Religious Needs
7b – Employment Part 1
7c – Employment Part 2
7c – Education
7d – Leisure
7e – Pedestrian Road Safety
7f – Use of Transport

Domain 8 – Vulnerable Adult: If any issues/concerns are identified relating to abuse, neglect, personal safety, or public safety, these should be pursued in line with Adult Protection policy and procedures.

Domain 9 – Other Needs: Use this section to record any issues that are not covered in the other Domains or Sub Domains.

Domain 10 – Informal Care Network: When completing the assessment you should include information relating to care provided by an informal carer e.g. family member, friend, neighbour.

Domain 11 – Joint Carer Assessment: A joint carers assessment should always be offered and the response recorded. Carers who provide a substantial amount of care should also be advised, that they can have a separate ‘carers’ assessment if they wish.

Consent to Share Information: It is essential to obtain the person’s consent before sharing any of the information contained in this form with other health and social care professionals.

The term ‘Consent’ means that the information recorded on this form may be stored on a computer and complies with the Data Protection Act, and may only be shared for the purpose of providing health and social care for the person identified in Part 1, with health or social care professionals who have a need to know the information in order to provide that care.

Consent provided by the person: In most instances the overview assessment will be completed by direct discussion with the person and they will be able to give consent. Most people are willing to share information if they understand that it is used responsibly with due concern for privacy and confidentiality. The assessor should:

- Ensure copy of SAP Leaflet A2a Agreement to Assessment, Sharing Information and Provision of Care is given to the person being assessed and obtain their signature on the A & B Consent Forms. This information should be recorded in the case notes and Copy B kept on the case file.

Consent provided by person's authorised representative: If the person is represented, by another e.g. next of kin or legal guardian, then that representative may provide consent on behalf of the person. Only the following are acceptable as Source of Authority:

- Power of Attorney
- Guardianship under the Mental Health Act
- Receivership

The assessor should record the representative's details, e.g. name, address, telephone number and source of authority and get them to sign the authorisation forms (Copy A & B) in the Leaflet A2a SAP Agreement to Assessment, Sharing Information and Provision of Care. This information should be recorded in the case notes and Copy B kept on the case file.

Person asked but not willing to give consent: If the person is capable of providing consent but chooses not to allow information to be shared:

- Indicate that the person has not given consent to share information and give reasons and date, clarify that the person has made this choice.
- No actions may be set using this form and it cannot be shared with other persons outside your organisation.
- Appropriate care should be provided using existing systems of care. If this appears to pose a serious risk to the person then, seek advice from your supervisor or Caldicott Guardian.

<u>SAP Summary of Need</u>
After completing the Overview Assessment all identified needs should be summarised on this form. Social Care staff will have to check any identified social care needs against Darlington SSD Fair Access to Care Services (FACS) matrix to determine eligibility – see separate guidance.

<u>SAP Summary Care Plan</u>
After summarising all the identified needs and checking eligibility of social care needs re FACS the assessor should agree with the service user, and family/carers if the service user is agreeable, what services are required. These should be recorded on the Summary Care Plan indicating: the need, the objective, the service provider, start and end dates. The Summary Care Plan does not provide detailed instructions on what is required these will be identified in 'professional' specific Care Plans e.g.

- District Nurses Core Care Plans relating to specific health needs
- Social Services Home Care Weekly Programme
- Intermediate Care Rehabilitation Plan
- Day Centres Programme of Activities

Person Held Records
The Contact and Overview Assessment, Summary of Need and Summary Care Plan will be held in the person's own home in a Person Held Records Folder, together with any 'professional' specific Care Plan and a Contact Sheet for professionals to record their visits and actions.

Request for Specialist Assessments
In line with government guidelines and in support of the Single Assessment Process, if a specialist assessment is requested as an outcome of the Overview Assessment, and provided the person has consented to share information, a copy of the Contact and Overview documentation should be sent to the specialist. This will provide them with valuable information relating to other areas which may impact on their area and will reduce duplication i.e. asking the person the same questions already covered in the previous assessments. After completing their specialist assessment the assessor should feedback the outcome and agreed actions/interventions/services to the professional who requested the assessment or Care Co-ordinator. This information can then be added to the Summary Care Plan.

Comprehensive Assessment
A comprehensive assessment is not another type of assessment. When all or most of the domains and sub domains have been completed and a number of specialist assessments undertaken this becomes a comprehensive assessment.

Role of the Care Co-ordinator
In complex cases where there are a number of different professionals/agencies involved a Care Co-ordinator should be agreed. The Care Co-ordinator could be e.g. a Care Manager, District Nurse, Occupational Therapist, Physiotherapist, Intermediate Care Assessor. The Care Co-ordinator is a practitioner who ensures that the care plan is effectively delivered through:

- Taking lead responsibility for ensuring effective communication between the various practitioners/agencies involved with users and carers.
- Prompting further assessment, care plan and service adjustments, and
- Ensuring monitoring and review activity takes place.

For further guidance see Appendix 1 re National Guidance.

Monitoring, Reviewing and Reassessments
Once the services/interventions agreed in the Summary Care Plan have been set up each agency is responsible for monitoring, reviewing and reassessing their service according to their departmental procedures. However, in support of the SAP principles, if a number of agencies are involved it would be good practice to try and co-ordinate the reviews into a joint process. Any changes as a result of monitoring, reviewing or reassessing the Care Package should be recorded in the Person Held Records and feedback to the agencies involved.

Recording and Storing Information
Information gathered through the Contact and Overview Assessment, Summary of Need and Summary Care Plan and subsequent Reviews and Reassessments will also be stored, in paper format and on IT systems where they exists, by each agency involved. The recording, storing, retaining and destruction of these personal records will be governed by individual agency regulations.

Please note, re Community Nursing/Therapy Services. If the person is being discharge off health services the Health Assessor will be responsible for photocopying the completed nursing/therapy records, filing according to PCT policy and returning the original record to the person for them to retain or destroy at their choice.

APPENDIX 1 – National Guidance DoH LAC (2002) 1, HSC 2002/1

Overview Assessment

Purpose

Professionals carry out an overview assessment if, in their judgement, the individual's needs are such that a more rounded assessment should be undertaken. At overview assessment, all or some of the domains of the single assessment process, such as 'personal care and physical well-being', 'senses' and 'mental health', are explored. The need for an overview assessment may be immediately apparent, and should be commenced once basic personal information has been collected. At other times a contact assessment may have been carried out. In some situations, a specialist assessment of a specific problem may have been undertaken first, with the overview assessment providing subsequent contextual assessment information.

All or some of the domains?

In considering whether to explore all the domains or just some of them, professionals will be guided by their judgement, taking into account service users' wishes and any indications of wider needs that are triggered at the contact assessment. For example, if it is established that a person is incontinent of urine, further assessment of mobility, medication and access to the toilet should usually be carried out. If family relationships have become bitter, professionals may explore the safety of the person and those close to them.

For some individuals there will be a strong likelihood that they may need intensive support or prolonged support (for example, a year or longer), including permanent admission to a care home, the receipt of intermediate care services or substantial care packages at home. In such cases, all the domains and many sub-domains should be explored, and specialist assessments carried out in a number of them. This equates to a comprehensive process.

Where an overview or comprehensive assessment is being carried out, professionals should discuss this with the person, and explain the benefits for assessing needs in the round and for taking a preventative approach. The professional may add that even if further needs are identified they may not be serious and may not call for further help.

Who undertakes overview assessment?

It is both possible and practical for all of the overview assessment to be completed by a single professional from either the NHS or social services. The domains of 'clinical background' and 'disease prevention' do not need specific health tests to be undertaken; rather, in the first instance, they require the assessing professional to check on past assessments. While it is not essential for overview assessments to be carried out by qualified professionals, local agencies should nevertheless have clear agreements as to who is competent to carry out the overview assessment. Staff training and development should be offered to ensure acceptable levels of professional competence.

Care Co-ordination
Where more than one professional is involved in the assessment of needs and subsequent care planning, they will need to liaise as appropriate. In some situations, typically where the needs are complex and require the input of several professionals and/or agencies, local agencies should consider nominating one professional a care co-ordinator for both the assessment and subsequent care planning. The care co-ordinator will act as the focus for communication for the different professionals and, most importantly, with the individual person. As the needs of many vulnerable people are multiple and long-term, specialist professionals who may only be involved in a case for a limited time may not be well placed to co-ordinate care. Often the role is best handled by community nurses or social workers, who tend to have a long-term role.

Agencies should agree local protocols for care co-ordination including who should do it, and what tasks are involved. Generally, where a person's needs are predominantly associated with their health, a nurse or other health worker should co-ordinate the assessment and care provision. Where social care needs are to the fore, a social worker or care manager might co-ordinate assessment activity and care. Where mobility and access needs predominate, occupational therapists or physiotherapists should assume care co-ordination. However, this is not a cast-iron rule, and agencies should be prepared to act flexibly in the best interests of service users, who may value continuity and familiarity above everything else.

This guidance emphasises that geriatricians and old age psychiatrist should play the leading or prominent role in comprehensive assessment. Local protocols for the actual practice of care co-ordination, should take account of this, and whichever professional acts, as the care co-ordinator in an individual case, should ensure they have ready access to the relevant geriatrician or old age psychiatrist and their team.

In addition, in deciding on care co-ordination in individual cases, councils should take account of their statutory duties with regard to assessment, and the flexibility provided by section 31 of the Health Act 1999 and Section 113 (1A) of the Local Government Act 1972.

Please note this guidance refers to 'older people'. In Darlington the SAP applies to older people and people 18 plus with a sensory or physical impairment. In recognition of this the term 'older people/person' has been changed to 'person'.