

# The Inner West Area Comprehensive Assessment Agreement

A guide for community care services  
and agencies providing comprehensive  
assessment

- Who to refer
- Where to refer
- How to refer

Inner West Area includes the following Local  
Government Areas:

Ashfield  
Burwood  
Canada Bay  
Canterbury  
Leichhardt  
Marrickville  
Strathfield

Review Date: June 2005

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# Agencies Party to this Agreement

<b>Agency</b>	<b>Auspice</b>	<b>Manager giving approval</b>
Canterbury Aged Care Assessment Team	Central Sydney Area Health	Dr John Cullen Clinical Director General, Geriatric and Rehabilitation Medicine Concord Hospital
Concord Aged Care Assessment Team	Central Sydney Area Health	Dr John Cullen Clinical Director General, Geriatric and Rehabilitation Medicine Concord Hospital
Glebe Aged Care Assessment Team	Central Sydney Area Health	Dr John Cullen Clinical Director General, Geriatric and Rehabilitation Medicine Concord Hospital
Community Support Team (Department of Ageing, Disability and Home Care)	Department of Ageing, Disability and Home Care	Lauren Murray Regional Director Metropolitan South West
Inner City Live at Home (community options)	Central Sydney Area Health	Dr John Cullen Clinical Director General, Geriatric and Rehabilitation Medicine Concord Hospital
Inner West Live at Home (community options)	Central Sydney Area Health	Dr John Cullen Clinical Director General, Geriatric and Rehabilitation Medicine Concord Hospital
Canterbury Community Options	Department of Ageing, Disability and Home Care	Lauren Murray Regional Director Metropolitan South West
Central Sydney Community Nursing	Central Sydney Area Health	Ivanka Komsanac Program Manager Central Sydney Community Nursing Service
Community Mental Health	Central Sydney Area Health	Sam Vasta Manager Ashfield, Canterbury, Marrickville David McMaster Manager Glebe Branch

# About Comprehensive Assessment in Community Care

While most people accessing community care will only need a single service or a few basic maintenance and support services, others require multiple services, case management, specially designed types and combinations of services or high levels of service provision in order to remain living with independence in the community. Without access to support of this nature, such people may be at risk of entering a more restrictive environment (such as a hospital or nursing home); be at risk of harm to themselves or others; or be at risk of losing their current care arrangements.

In order to appropriately identify the needs of such clients (and possible responses to that need) such people ideally should be referred for a 'comprehensive assessment'. It is estimated that one in six community care clients are appropriate for referral for a holistic or 'comprehensive assessment'.

Comprehensive assessment involves a holistic look the client's situation, needs, strengths, abilities and resources - not just their need for a specific service. Comprehensive assessment is a process rather than a one-off event. It may occur over time, it could involve just one assessor, or (depending on the client's situation) it could involve a number of key workers or services.

## Service Level Assessment and Comprehensive Assessment

Everyone accessing the community care system will have a **Service Level Assessment**. Service Level Assessment determines eligibility to basic support services and matches a SPECIFIC service to a person's needs.

**Comprehensive assessment, in contrast, is only for people who are at RISK of:**

- ✓ **Harm to themselves or others;**
- ✓ **Entering a more restrictive environment (such as hospital, nursing home, or even prison); or**
- ✓ **Losing current care arrangements.**

A comprehensive assessment may provide a person with access to 'higher' levels of support, packaged care, or case management. For example, for a person who is aged and has complex needs, a comprehensive assessment may determine eligibility to Community Aged Care Packages, or if a person's care needs require it, access to hostel or nursing home care. The outcome will depend of the specific needs of the person. A comprehensive assessment can assist a person and their carer / family to identify a person's strengths, resources and needs, and to provide information and possibly, a range of referrals into the community care system (including referrals across a range of funding programs).

## Services providing 'comprehensive' assessment in the Inner West

The following agencies have identified themselves as providing assessments in the Inner West Area that can be considered as comprehensive in nature:

- Canterbury Aged Care Assessment Team
- Concord Aged Care Assessment Team
- Glebe Aged Care Assessment Team
- Community Support Team (Department of Ageing, Disability and Home Care)
- Inner City Live at Home (community options)
- Inner West Live at Home (community options)
- Canterbury Community Options
- Central Sydney Community Nursing Service (5 branches)
- Community Mental Health (4 branches)

Contact details and areas of operation for these agencies follow on page 9 of this document.

## Eligibility Criteria must still be satisfied

Each agency has specific ELIGIBILITY criteria and geographical areas of operation. Before referring to one of these agencies you must check the eligibility criteria. In all instances, you must call the Intake Officer and discuss your intended referral.

NOTE: Apart from the Aged Care Assessment Teams (ACATs), these agencies are not purely assessment services, but are also service providers. However, in this Agreement, the *function* of assessment has been separated out from other services the agency may provide. As stated in the National Framework for Comprehensive Assessment, one way to conceptualise a comprehensive assessment is to see it as a process that belongs to the individual and not to the service system:

*'It is a service which assists the client to work through a process of identifying how they can best be effectively supported to live in the community'.<sup>1</sup>*

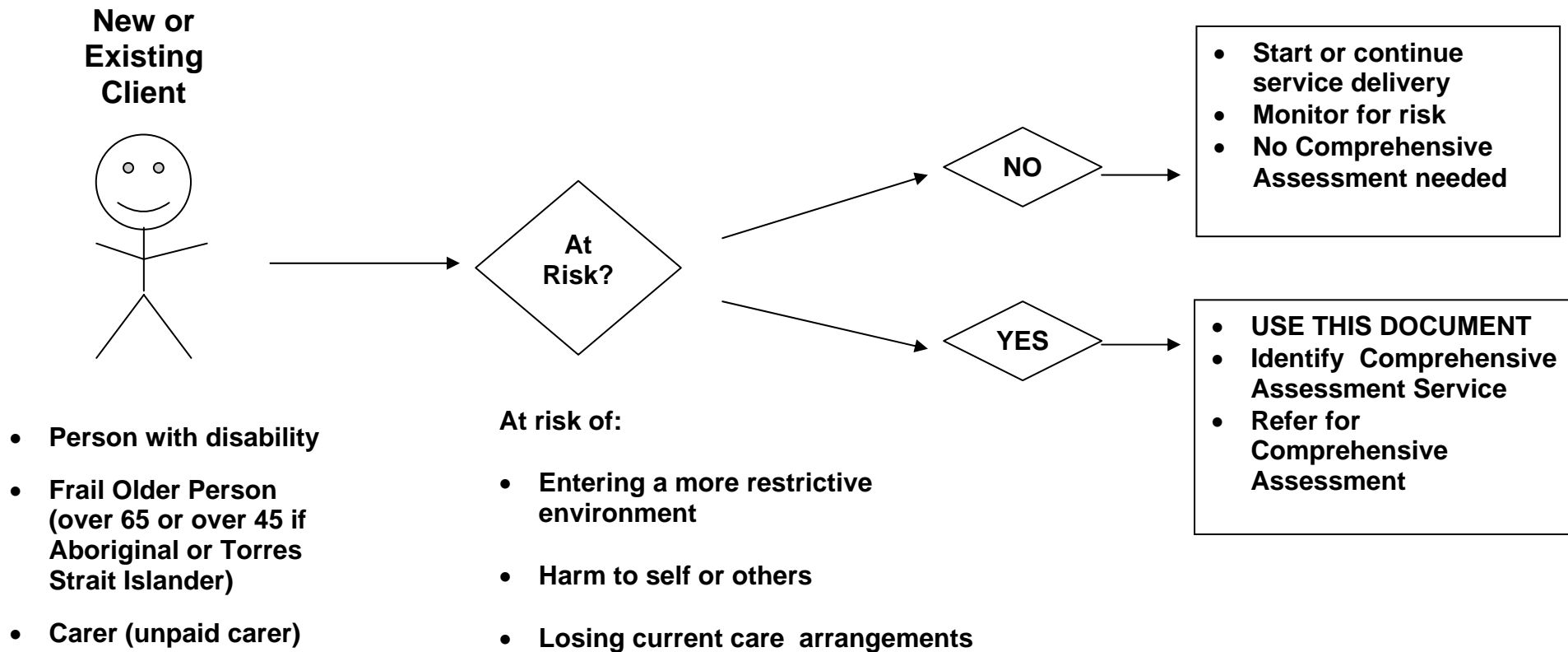
## Monitoring Clients for Risk

Every community care provider has a Duty of Care to monitor their clients for changes in the person's needs. This document will assist you to identify clients who may be at risk, and provides guidelines on where and how to refer the client for a comprehensive assessment.

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<sup>1</sup> National Framework for Comprehensive Assessment in the HACC Program, Aged and Community Care Service Development and Evaluation Reports, Number 34, Lincoln Gerontology Centre, La Trobe University. March 1998, p. 12.

# Who needs a Comprehensive Assessment?





# RISK INDICATOR CHART

The column on the left shows indicators that a person may need a Comprehensive Assessment (CA). The columns on the right show which agency you may be able to refer to. You only need to refer to ONE of these agencies. Note: Indicators marked # may be sufficient alone to seek CA, otherwise a combination of indicators are required. See also the contact information for each agency. Emergencies (including medical emergencies) should be dealt with by emergency services. **Co-ordinators or Supervisors ONLY to make referrals.** Volunteers or field workers please discuss with your supervisor.

Person is at risk of entering a more restrictive environment such as a hospital, nursing home, hostel or criminal justice system etc	ACAT	CSCNS	COPs	CMH	DADHC CST
Weight loss or not eating (If there is a decline in health, refer to General Practitioner)	◆				
Significant confusion or memory loss #	◆			◆	
Recurring falls or injuries #	◆	◆			
Change in continence patterns	◆	◆			
Decline in mobility	◆	◆			
Deterioration in environment or living situation	◆	◆			
Delusions or hallucinations #	◆			◆	
Person has uncharacteristically started to: appear disheveled, wear dirty clothes, appear unshaven, be unwashed, malodorous etc. #	◆	◆	◆	◆	
Social isolation, lives alone, has few visitors and social isolation impacting on mental health	◆		◆		
Absence of carer is placing the person at significant risk #	◆	◆	◆		
Carer dies, becomes ill, extremely frail or relinquishes care #	◆		◆		◆
<b>2. Person is vulnerable and at risk of harm to themselves and/or to others</b>	◆				
Swallowing difficulties	◆				◆
Absence of carer is placing the person at significant risk	◆	◆	◆		
Aggressive behaviours placing the person and /or others at risk of injury #	◆			◆	◆
<b>Suspected abuse # Refer to your agency's INTERNAL policies and procedures first</b>	◆			◆	◆
Need for change of accommodation or assessment for accommodation due to risk or vulnerability #	◆				◆
Extreme financial difficulties or disadvantage such as not enough money for food	◆		◆		
Signs of depression such as being withdrawn, passive, suicidal thoughts, extreme sadness #	◆			◆	
Equipment or modifications needed for access and safety	◆				
Carer dies, becomes ill, extremely frail or relinquishes care #	◆	◆	◆		◆
Person is evicted, at risk of homelessness or is homeless #	◆			◆	◆
Recent loss or changes to care arrangements #	◆	◆	◆		◆
Carer is experiencing extreme stress (eg suicidal thoughts) #	◆		◆		
Recurring falls or injuries #	◆	◆			
Conflict in household is placing a person and / or others at risk	◆		◆		
<b>3. Person is at risk of losing current services</b>					
Person's care needs have increased beyond capacity of current service provider	◆	◆			
Aggressive behaviours whereby person is at risk of losing current service provision	◆			◆	◆

## CONTACT LIST Inner West Area

Agency	Aged Care Assessment Team	Community Nursing Service	Community Options	Community Mental Health	DADHC Community Support Team
<b>Step 1:</b> <b>→</b> <b>Check ELIGIBILITY first</b>	<ul style="list-style-type: none"> <li>Frail older person (65+)</li> <li>Frail ATSI person (45+)</li> <li>Person with disability who have aged related illness (eg. stroke, arthritis etc)</li> <li>Carer of the above</li> </ul>	<ul style="list-style-type: none"> <li>Any person requiring nursing care</li> </ul>	<ul style="list-style-type: none"> <li>Frail older person (65+)</li> <li>Frail ATSI person (45+)</li> <li>Person with disability</li> </ul> <b>AND HAS</b> <ul style="list-style-type: none"> <li>complex care needs requiring case management</li> </ul>	<ul style="list-style-type: none"> <li>Adults (18-65) with mental health problems</li> <li>Area Wide adolescent mental health service (12-16) years</li> </ul> Referrals to Leichhardt number	<ul style="list-style-type: none"> <li>Person with intellectual disability</li> </ul>
<b>Step 2: ↓ What Local Government Area does the client live in?</b>					
<b>Ashfield</b>	Ph: 9767 6931 Fax: 9767 7289	Ph: 9745 4999 Fax: 9745 6742	Ph: 9767 6931 Fax: 9767 7289	Ph: 9798 5111 Fax: 9798 5099	Ph: 8512 1400 Fax: 8512 1411
<b>Burwood</b>	Ph: 9767 6931 Fax: 9767 7289	Ph: 9745 4999 Fax: 9745 6742	Ph: 9767 6931 Fax: 9767 7289	Ph: 9798 5111 Fax: 9798 5099	Ph: 8512 1400 Fax: 8512 1411
<b>Strathfield</b>	Ph: 9767 6931 Fax: 9767 7289	Ph: 9745 4999 Fax: 9745 6742	Ph: 9767 6931 Fax: 9767 7289	Ph: 9798 5111 Fax: 9798 5099	Ph: 8512 1400 Fax: 8512 1411
<b>Canada Bay</b>	Ph: 9767 6931 Fax: 9767 7289	Ph: 9743 6199 Fax: 9736 3493	Ph: 9767 6931 Fax: 9767 7289	Ph: 9798 5111 Fax: 9798 5099	Ph: 8512 1400 Fax: 8512 1411
<b>Canterbury</b>	Ph: 9787 0160 Fax: 9787 0315	Ph: 9787 0599 Fax: 9787 0035	Ph: 9554 8411 Fax: 9554 8532	Ph: 9787 0600 Fax: 9787 0700 Not all Riverwood	Ph: 8512 1400 Fax: 8512 1411 Not all Canterbury
<b>Leichhardt</b>	Ph: 8585 5018 Fax: 9552 6547	Ph: 9560 9711 Fax: 9568 3186	Ph: 9810 4199 Fax: 9810 1464	Ph: 8585 5000 Fax: 9552 6547	Ph: 8512 1400 Fax: 8512 1411
<b>Marrickville</b>	Ph: 8585 5018 Fax: 9552 6547	Ph: 9560 9711 Fax: 9568 3186 Not all Marrickville	Ph: 9810 4199 Fax: 9810 1464	Ph: 9560 4500 Fax: 9564 1167	Ph: 8512 1400 Fax: 8512 1411

**Wrong Number? Ask Commonwealth Carelink 1800 052 222** (A3 size or black font available)

# Comprehensive Assessment Pathway

**Step 1:**  
Referring  
Agency

## Identify client at risk

- See “Risk Indicator Chart” (see page 8).
- What indicators is the person showing?
- If **abuse or neglect** is suspected, refer to your agency’s **internal** Policies and Procedures first.

**Step 2:**  
Referring  
Agency

## Identify Comprehensive Assessment Service (CAS)

- Use “Risk Indicator Chart” to find CAS (see page 9).
- Check eligibility criteria and area of operation for the CAS.
- You may wish to call the assessment agency to discuss the appropriateness of the referral (at this stage, without disclosing the identity of the client).

**Step 3:**  
Referring  
Agency

## Seek client consent for referral

- Prepare for Information exchange with client. Eg. is an advocate, Aboriginal advocate or interpreter required?
- Explain the next step in the process (from the client’s point of view). Gain consent for referral to CAS. This can occur over the phone or in person.

**Step 4:**  
Referring  
Agency

## Referral to CAS Intake

- CAS Intake decides if referral is appropriate.
- If no, Intake provides options on where else to go.
- If yes, discuss what information is needed to refer.
- CAS may require you to discuss level of urgency of this referral.
- CAS explains to referring agency what the next step is (from client’s point of view).
- CAS may send client brochure or other literature to the referring agency which then provides this to the client.

### Note:

- If eligibility is uncertain at this point, CAS provides estimate of time it will take to determine eligibility.

**Proceed to Step 5**

# Comprehensive Assessment Pathway

**Step 5:**  
Referring  
Agency

## Feedback to Client

- Referring agency provides information to client on what the next step is (from their point of view).
- Referrals for interim arrangements / supports are made if required. These arrangements can be formal or informal.

**Step 6:**  
CAS

## Allocation

- Referral is allocated to a worker.
- OR
- CAS takes referral to eligibility meeting and determines eligibility.

**Step 7:**  
CAS

## Comprehensive Assessment

- Assessment process begins.
- Information gathering.
- Appointments made etc.

**Step 8:**  
CAS

## Care Plan

- Identify interventions from assessed needs.
- Identify strengths and resources with client.
- Information to client / family.
- Provide feedback to the referring agency.

**Step 9:**  
CAS

## Care Plan Implemented

- Referrals made.
- Short term Case Management by CAS (not in all cases).

**FINISH**

## Comprehensive Assessment Process Complete

# Referring Agency's Procedures

## Responsibilities of agencies providing community care services

All agencies providing community care have a responsibility to:

- Identify new or existing clients who may be at risk of:
  - harm to themselves or others;
  - entering a more restrictive environment; or
  - losing current care arrangements.
- Check the eligibility criteria for the agency you intend to refer to.
- Contact the Intake Officer of the agency you intend to refer to, in order to discuss the appropriateness of the referral.
- Explain the purpose and arrangements for comprehensive assessment to the client and/or carer and gain permission from the client and/or carer for referral for comprehensive assessment.
- Make a referral to an assessing service using the procedures outlined in this document.
- Make referrals for interim care arrangements if required.
- Provide feedback to the client giving information on the status of the referral.

## Making a Referral to an Assessing Service

1. Is the person "at risk"? Are they showing any of the indicators described in the "Risk Indicator Chart"? (see page 8).
2. Look at the "Risk Indicator Chart" and choose the most appropriate assessing service from the list (see page 8).
3. Check the eligibility criteria for the assessing service to ensure your intended referral is appropriate. Contact the assessing service to discuss the appropriateness of the referral, at this stage *without disclosing the identity of the client*. If you are advised that the referral is not appropriate, ask the Intake for other referral options.
4. The Intake may advise you that the client's eligibility is uncertain at this point. In this case the assessing service may need to send the referral to an eligibility panel (or meeting). If so, ask the assessing service for an estimate on the time needed to determine eligibility. Gain consent for the referral and advise the client of the time / process needed for the assessing agency to determine eligibility.

5. If you are advised that the referral is appropriate, discuss with the Intake what information is required for the referral. Ask the assessing service to:
  - Send some literature that may help you to prepare the client for assessment (eg. assessing service brochure, Rights and Responsibilities Brochure, translated material if required);
  - Provide an estimate of the waiting time before assessment (not every agency may be able to provide this);
  - Describe the next steps (from the client's point of view).
6. If you are advised the referral is appropriate, gain consent from the client for referral. If the client requests or needs an interpreter, ensure you arrange an interpreter to attend the visit where you gain consent for referral. Ensure your referral is as complete and detailed as possible.
7. Ensure your referral includes information about whether a specialist worker (such as an Aboriginal or Torres Strait Islander worker) or an interpreter is required. Make sure any detail about the client's spoken language (including dialect) is included.
8. Provide feedback to the client and / or their carer. Outline the comprehensive assessment process to the client. Provide any materials supplied by the assessing service.

# Assessing Services Procedures

## Responsibilities

Assessing services agree to:

- **Inform all Intake Officers of this Agreement.**
- Receive phone calls from community care services in order to discuss the appropriateness of intended referrals.
- Provide information to community care services about the process for making referrals, documentation requirements and the process from the point of view of the client and their family (to assist the community care service to prepare and inform clients).
- Provide some literature that may help the referring service to prepare the client for assessment (eg. assessing service brochure, Rights and Responsibilities Brochure, translated material if required).
- Provide advice on other referral options if their agency is not the appropriate assessment service.
- Identify which referrals are the result of this Comprehensive Assessment Agreement (in order for the Reference Group to evaluate the operation of the Agreement).

In some situations, it may be necessary for a referring community care agency to put interim community care services in place before a comprehensive assessment can be conducted. In these instances, assessing services agree to assist referring community care agencies to identify other agencies that may be able to assist with interim arrangements.

## Receiving Referrals (services providing assessments)

Assessing services will receive calls from community care providers to discuss the appropriateness of intended referrals. The Intake of assessing services will:

- Inform the referring agency if the client is eligible for assessment from their agency (where eligibility needs to be determined through another process, Intake will explain this process and, if possible, the length of time this may take);
- Note that the call is in reference to comprehensive assessment and note whether the referral was accepted or not.

The assessing service will then follow one of the two following procedures.

## Procedure when a referral is accepted

The assessing service will:

1. Notify the referring agency that the referral has been received (this could be at Intake and over the telephone, or by Fax if documentation has been faxed or posted to the Assessing Agency).
2. Review the received documentation to identify the urgency of the response.
3. Provide an estimate of the time (wait) between referral and assessment (this may not be possible for all assessment services).
4. Provide a basic description of the next steps (from the client's point of view, in order to assist the referring agency to explain the process to the client).
5. Send the referring agency some information about the assessment process (service brochure, Rights and Responsibilities brochure, translated materials where necessary and available).
6. Flag the referral as being for comprehensive assessment (each assessment agency will identify their own process for achieving this).
7. Undertake the assessment process.

### NOTE:

Where a client's needs require it, agencies may seek the skills or knowledge of workers from other agencies. This could be:

- an Aboriginal assessor or trusted other person with relevant cultural knowledge if the person being assessed is Aboriginal;
  - an assessor with relevant cultural knowledge and skills if the person is from a Culturally & Linguistically Diverse background;
  - an interpreter if needed or requested;
  - a service level assessor who has specialised knowledge about specific areas of disability, medical conditions, mental health, community care services or client situations;
  - a general practitioner or specialist clinician.
8. It may be necessary for the **referring agency** to put interim community care services in place before a comprehensive assessment can be conducted. In this situation the assessing service may be asked to assist with advice or suggestions regarding other referrals. **It is the responsibility of the referring agency to make the referrals.**

9. The assessing service will prioritise all referrals for comprehensive assessment according to their internal processes / priorities.
10. The assessing service will identify all referrals for comprehensive assessment in order to pass on information to the Reference Group. This is a crucial element to enable evaluation of this Comprehensive Assessment Agreement.

### **Procedure when a referral is not accepted**

An assessing service may not always be in a position to accept a referral for comprehensive assessment. This can occur when:

- The person is not eligible for the service.
- Based on the client information included in the referral, the assessing service considers that the person being referred does not fit into the comprehensive assessment target group.
- Based on the client information included in the referral, the assessing service considers that it is not the most appropriate assessing service for this client.
- The assessing service does not have the resources available to conduct the comprehensive assessment.

### **When this is the case, the assessing service will:**

1. Notify the agency making the referral AS SOON AS POSSIBLE that the referral cannot be accepted.
2. State the reason for not accepting the referral on this occasion (this reason must be noted and passed on to the Reference Group for evaluation of this Agreement).
3. Discuss available options. This could include:
  - Referral to another assessing service that may be available to conduct the comprehensive assessment.
  - Collection of further, relevant and necessary client (if the information was insufficient to indicate the need for comprehensive assessment).
  - Referral to other agencies (it is the responsibility of the Referring Agency to make the referrals). Client permission will be needed for referral to suggested agencies.

The agency making the referral, and not the assessing service, is responsible for keeping the client updated on the recommended option.

# Agreement Endorsements

# Central Sydney Area Health

I, Dr John Cullen, Clinical Director, General Geriatric and Rehabilitation Medicine, Concord Hospital, on behalf of the following agencies auspiced by Central Sydney Area Health:

- Canterbury Aged Care Assessment Team
- Concord Aged Care Assessment Team
- Glebe Aged Care Assessment Team
- Inner City Live at Home (community options)
- Inner West Live at Home (community options)

Endorse the following Agreement:

The Inner West Area Comprehensive Assessment Agreement

.....

Dr John Cullen  
Clinical Director  
GGRM  
Concord Hospital  
Central Sydney Area Health

.....

Date

# Central Sydney Area Health

I, Ivanka Komsanac, Program Manager, Central Sydney Community Nursing Service, on behalf of the following Community Nursing Branches:

- Croydon
- Lewisham
- Canterbury
- Concord
- Redfern

Endorse the following Agreement:

The Inner West Area Comprehensive Assessment Agreement

.....  
Ivanka Komsanac  
Program Manager  
Central Sydney Community Nursing Service

.....  
Date

# Central Sydney Area Health

I, Sam Vasta, Manager, Community Mental Health, on behalf of the following Community Mental Health Branches:

- Ashfield
- Canterbury
- Marrickville

Endorse the following Agreement:

The Inner West Area Comprehensive Assessment Agreement

.....  
Sam Vasta  
Manager  
Community Mental Health  
Central Sydney Area Health Service

.....  
Date

# Central Sydney Area Health

I, Sam Vasta, Manager, Community Mental Health, on behalf of the following Community Mental Health Branches:

- Glebe
- Adolescent Mental Health Service

Endorse the following Agreement:

The Inner West Area Comprehensive Assessment Agreement

.....  
David McMaster  
A/g Manager  
Community Mental Health  
Central Sydney Area Health Service

.....  
Date

# Department of Ageing, Disability and Home Care

I, Lauren Murray, Regional Director, Metropolitan South West Sydney, Department of Ageing, Disability and Home Care, on behalf of the following agency:

- Community Support Team, Leichhardt Disability Services
- Canterbury Community Options (part of the Canterbury Home Care Branch)

Endorse the following Agreement:

The Inner West Area Comprehensive Assessment Agreement

.....  
Lauren Murray  
Regional Director  
Metropolitan South West Sydney  
Department of Ageing, Disability and Home Care

.....  
Date

**Further information on this Comprehensive Assessment Agreement please contact:**

**Christine Mifsud  
C/- Burwood Council  
Community Services Department  
PO Box 240  
BURWOOD NSW 1840**

**Ph: 9911 9860**

**Fax: 9911 9843**

**Email: [Christine.Mifsud@Burwood.nsw.gov.au](mailto:Christine.Mifsud@Burwood.nsw.gov.au)**