Reference Manual

Long Term Care
and
Community Support Program

Adult Needs Assessment

AUGUST 2008

Adapted from: Provincial Continuing Care Adult Long Term Care Assessment Reference Manual (1999).

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OBJECTIVES OF THE MANUAL

- Supports the implementation of the assessment tool;
- Provides a rationale for use of the assessment;
- Provides information and guidelines to assist in the completion of an accurate and comprehensive assessment of client needs.

INTRODUCTION

The Long Term Care and Community Support Program: Adult Needs Assessment is a comprehensive, functional tool designed to assist health care professionals to objectively assess client's care needs, and determine appropriate placement options.

The format is designed to ensure objectivity and allows comments by the assessor to describe or define client's status or needs. The assessment does not have to be completed in the order of the table of contents.

ASSESSMENT FORM

The Long Term Care and Community Support Program: Adult Needs Assessment is completed upon initial client assessment to access:

- home support services;
- personal care home;
- long term care home;
- respite care;
- alternate family care;
- board and lodging (with relatives or non-relatives);
- independent living arrangements;
- other residential options;
- access professional services; and
- when there is significant change in the client's condition and services are still required.

REASSESSMENT FORM

The Long Term Care and Community Support Program: Adult Needs Reassessment is completed annually and only when there is minimal or no change in the client's condition and services are still required.

DEFINITIONS

Client	An individual requesting access to services through the single point of entry.
Single Point of Entry	A single access point through which client needs are assessed and matched with available services.
Assessment	A collection and coalition of information, which provides an understanding of client needs and assists in the development of an interdisciplinary plan of care consistent with the assessed level of care.
Reassessment	A review of client assessed needs and plan of care.
Placement	Implementation of a plan of care that facilitates matching the client needs to available services.
Respite Services	Provides temporary relief to primary caregivers by utilizing a substitute for the caregiver in the home or in an appropriate care facility outside the home.
Home Support Services	Service provided to supplement client needs based on a plan of care, which promotes, maintains and enhances client independence and responsibility. Home Support Services include: personal care, household management, respite and behavioral aide.
Long Term Care Home	Provides long-term residential services to adults who require on-site professional services.
Personal Care Home	Privately owned facility which is registered and approved by Regional Health Authorities and Government Services Centre. Provides residential services to adults who require supervision and/or assistance with daily activities.
Alternate Family Care	A private residence, which provides room and board, supervision, and personal and social care to an unrelated adult (i.e., 18 or older) with an intellectual disability.
Board and Lodging with Relatives	The Department of Human Resources Labor and Employment funds adults (i.e., 18 to 64 years) with a physical and/or intellectual disability, for board and lodging with families. Individuals may also be eligible to receive additional funding through the Regional Health Authority or access other services (e.g., funding for home support services, health supplies, equipment, oxygen, or orthotics).
Board and Lodging with Non-relatives	The Department of Human Resources Labor and Employment funds adults (i.e., 18 to 64 years) with a physical and/or intellectual disability, for board and lodging with non-relatives. Individuals may also be eligible to receive additional funding through the Regional Health Authority or access other services (e.g., funding for home support services, health supplies, equipment, oxygen, or orthotics).

Independent Living Arrangement	A residential option available to adults (i.e., 18 to 64 years) with intellectual disabilities who require supports but do not reside with their natural or alternate families. Individuals remain in their own homes (usually rented apartments) and are supported by a supervisor and sometimes by additional staff.

COMPLETING A COMPREHENSIVE ASSESSMENT

The rights and dignity of the client must be respected during the assessment process. The client/family are active participants in this process.

- Explain the role of the assessor, the purpose of collection of information and provide information on service options.

- Be aware of discrepancies between what is observed and what the client and/or caregiver are reporting. When possible, have client demonstrate physical ability.

- Information should be obtained directly from the client, in a personal interview, except in the case of clients with cognitive impairment. The client should always be seen during the assessment process and should participate in the process to the degree possible.

- It may be necessary to contact other family members, caregivers, or health professionals to provide or verify information. Ensure consent is obtained in accordance with Regional Health Authority policy.

- It may not be possible to gather all required information in one interview; however, the length of time between interviews should be as short as possible.

- At times, it may be more appropriate to complete the assessment in an order other than that given in the table of contents.

- At times, further assessment by other health professionals or specialists may be necessary. Referrals should be made promptly and the information should be incorporated into the comprehensive assessment. Ensure consent is obtained in accordance with Regional Health Authority policy.

- Assessment information should be as detailed as possible.

- Add full list of children, if possible, to ensure a comprehensive contact list.

EFFECTIVE COMMUNICATION

- Position yourself so that the listener can view your face clearly.
- Position yourself comfortably; listener's posture affects the way a speaker behaves.
- Reduce distractions in the immediate environment.
- Be attentive; listen to what is being said.
- Make good eye contact; it indicates respect and encourages the speaker to continue.
- Please write legibly.

AGENCY PROFILE

File Number: Assign client file number as per policy and procedure. Ensure file number is recorded on each page of the assessment.

RHA: Record Regional Health Authority.

Assessment Sit: Record place assessment was completed.

Assessment Date: Record the date assessment was completed.

Assessor's Name: Print full name of primary assessor.

Assessor's Profession: Print profession title in full.

Telephone Number: Record primary assessor's work telephone number.

Consent for Release of Information

The assessor must obtain consent for release of information in accordance with Regional Health Authority policy (Labrador-Grenfell, Western, Central, Eastern).

It may not be appropriate to obtain the consent at the beginning of the assessment process, but the client must be made aware that a written consent is required.

CLIENT PROFILE

Personal Data

Name: Record client's last, first, middle and maiden name, if applicable.
Permanent Address:
Mailing Address:
Telephone #:

and, if applicable

Current Address:
Mailing Address:
Telephone #:
Directions to Home:

Date of Birth (DOB): Record using year/month/day format
Gender: Record
Religion: Optional
Status: Check appropriate descriptor and record year/duration

Demographic Information

- **Language spoken/written**: Record primary language spoken/written.
- **Is client able to read/write**: Check appropriate descriptors.
- **Education level completed**: Record education level. Assessor should be sensitive to client's feeling when discussing this issue.
- **Does client require an interpreter**: Check appropriate descriptor. If yes, record name and telephone number of interpreter.
- **Occupation**: Record client's occupation and check appropriate descriptor for retirement.
- **Ethnic background**: Country/region of ancestry (optional).
- **Place of Birth**: Record place of birth of client, father and mother.
- **Father's name/Mother's maiden name**: Record name of client's father and mother's maiden name.

Identification Numbers

- **Medical Care Plan Number (MCP) and Expiry Date**: Record using client's MCP card.
- **Service Canada (Old Age Security, Guaranteed Income Supplement, Spouse's Allowance; Canada Pension)**: Record using client's drug card number. Clients must meet eligibility requirements to receive GIS and must reapply annually.
- **Veterans Affairs Canada Number (VAC)**: Record using client's card or cheque stub.
- **Veteran Status**: Record whether client is veteran and of what status; this information may be obtained from VAC
- **Social Insurance Number (SIN)**: Record using client's card.
- **Human Resources, Labour & Employment (HRLE)**: Record using client's cheque stub if client is in receipt of Income Support.
- **Client Referral Management System (CRMS):** Record number.
- **Private Insurance:** Record name of insurance company, group number and policy number.
- **Other**: Record numbers and specify services (e.g., private pension, disability pension, Canada Pension, Employment Insurance).

Note: If there are services the client should be eligible to receive but does not, refer to appropriate agency:
Income Support Programs (OAS/GIS/CPP) 1-800-277-9914
Veterans Affairs Canada (VAC/DVA) 1-866-522-2122

Spousal Data Record if applicable

REFERRAL PROFILE

Name of Person Initiating Referral: Record name of person making referral.

Relationship to Client: Record relationship to the client of the person making the referral.

Address: Record address, including mailing address of the person initiating the referral.

Telephone Numbers: Record residence and business telephone numbers of person initiating referral.

Referral Date (y/m/d): Record date referral was received.

If client is in hospital: Record date (y/m/d) of admission and medical discharge date, if applicable.

What recent event(s) precipitated this assessment?: Record details of why assessment is being completed at this time.

Note: It is important to know why an assessment is being completed before a client is medically discharged. If an assessment is done prematurely, the client may not have reached an optimal level of recovery. Adequate time may not have been given to the client/family to explore all placement options.

POWER OF ATTORNEY . ENDURING POWER OF ATTORNEY . GUARDIANSHIP . TRUSTEE

A client may have none or more than one of the above. Record type (Power of Attorney, Enduring Power of Attorney, Guardianship, Trustee) name, address, postal code, residence and business telephone numbers and relationship to client.

Power of Attorney	A delegation of decision-making concerning the estate of the donor to another person known as the donee within defined parameters (e.g. scope, time frame). A power of attorney ceases to be effective upon the incapacity or death of the donor.
Enduring Power of Attorney	A delegation of decision-making concerning the estate of the donor to another within defined parameters. By virtue of the statute, the enduring power of attorney survives the incapacity of the donor. The donee has the authority to act in accordance with the instructions of the donor.

Guardianship	A person who, by appointment of the Court or operation of law (e.g., parent) has the management of the estate of a person who is unable to manage one's own affairs due to incapacity (e.g., age, disability or illness).
Trustee	A person who is acting on behalf of another person under a document or court order who, as trustee, is responsible in law to act in good faith, honesty and in the best interests of the person the trustee is acting. There is a high standard imposed on a trustee. The trustee will be held to account for the actions taken in this capacity.

Note: Clients requesting more information should be advised to seek legal counsel.

CONTACTS

Record name, address, postal code, residence and business telephone numbers and relationship. Provide list of children, if possible. Indicate which contacts to be notified in case of emergency.

ADVANCE HEALTH CARE DIRECTIVE (AHCD)

An ACHD is a written statement of an individual's health care wishes. It is used in the event of an illness or injury that leaves a person unable to communicate his/her health care wishes to others. An AHCD will **not** be used at any time when the individual can communicate one's health care wishes to others.

Is there an Advance Health Care Directive? Check the appropriate descriptor. Record the location of the AHCD.
Name of Substitute Decision Maker: Record name, address and telephone number(s) of substitute decision maker(s).

Have burial arrangements been made: Check the appropriate descriptor. If yes, complete Appendix A.

ORIENTATION/COGNITION

At the time of this assessment, the client is: Check the appropriate descriptor indicating the client's state of awareness of surroundings at the time of assessment.

- **Responsive** – normal, no problems, alert and aware.
- **Drowsy, but responsive to verbal commands** – some limitations and reduced awareness but able to shift focus and sustain attention to environmental stimuli.
- **Drowsy, responsive only to touch** – client does not respond to verbal commands – responds only to touch.
- **Non-responsive**

Comments: Use to elaborate on the above responses, if applicable.

Is the client oriented to: Check appropriate descriptor.
Comments: Use to elaborate on the above responses, if applicable.

Has there been a change in client's orientation? Check the appropriate descriptor. If yes, record change and duration.

See page 3 of the assessment tool for guidelines on when to complete the Standardized Mini-Mental State Examination (SMMSE).

The SMMSE is not included in the assessment tool. A copy is included in this manual for your reference along with some information regarding the test.

Comments: Record reason why SMMSE is **not** being completed.

PHYSICAL ASSESSMENT

Current Health Problems/Diagnoses: Record all known medical diagnoses in order of importance; if unknown, consult with client's primary physician.

Health History: Record hospital admissions within the last 12 months and identify the reason for each admission. Frequent hospital admissions may indicate a need for a referral to address a specific need.

Surgery: List most recent first. List dates/place.

Allergies/Sensitivities: Check the appropriate descriptor and identify type of reaction. Differentiate allergy from sensitivity in the "specify" section.

Health Care Practitioners: List all members of health team currently providing services to the client. Specify type of service and frequency of visits.

Screening

Women's Health: Check the appropriate descriptor and record date, if appropriate.
Date of Pap Test: Women of all ages who are, or ever have been, sexually active should be screened annually. When possible, the date of last Pap test should be collected from the medical record not a self-report.

Note: The recommendation for Pap testing does vary;

- subtotal hysterectomy (cervix intact) annual screening;
- history of malignancy/premalignancy or immuno-compromised, annual screening;
- total hysterectomy and benign history, no Pap test is required. However, a vaginal vault test may be recommended every five years as part of an overall reproductive health assessment.

Has client had hysterectomy: Check appropriate descriptor.
Comments: Use to elaborate, if appropriate.

Men's Health: Check the appropriate descriptor and record date, if appropriate.
Comments: If necessary, refer for further investigation. Record the action taken.

Vaccines/TB Screening

Vaccines: Record dates of last vaccine given for influenza, tetanus and pneumococcal.
TB Screening: It is important to gain information to assess client's potential for tuberculosis.
Has the client had a tuberculin skin test? Check the appropriate descriptors, if yes, identify type of reaction.
Has the client ever had a BCG vaccination? Check the appropriate descriptor.

Note: If the client was born after 1950, immunization records may be accessed by contacting your local Public Health Office.

Date of last Chest X-Ray: Record the date (y/m/d).
Comments: Record if chest x-ray required. If required refer to primary physician.

Note: If client is seeking respite care, personal care home or long term care home placement, the date of the last chest x-ray must be within the last year.

Has the client had tuberculosis?: Check the appropriate descriptor.
Comments: Elaborate regarding duration, and reoccurrence.

Has the client had contact with an individual who has had tuberculosis?: Check the appropriate descriptor.
Comments: Elaborate on date/time of contact.

Does the client have?: Check all appropriate descriptors.
Comments: Record referral to primary physician, if required.

Note: Checked descriptor(s) indicate the potential of active tuberculosis. Immediate referral to primary physician is required.

Medications

List all medications the client is currently taking.

Section A: List Prescription medications including dose, frequency, route, ordering prescriber (e.g., physician/nurse practitioner) and the pharmacy responsible for filling the prescription. Reference: Examples of common terminology and abbreviation used for frequency and route.

Section B: List Non-Prescription/Alternative Forms of Medicine(s) (e.g., any over-the-counter medications including herbs, oils, vitamins, etc.).

Note: Examples of common terminology and abbreviation used for frequency and route.

Frequency	Abbreviation
daily	od
twice daily	bid
three times a day	tid
four times a day	qid
bedtime	hs

Route	Abbreviation
taken orally	po
under tongue	sl
Subcutaneous (injection beneath the layers of skin)	sc
Intramuscular (injection in the muscle)	im
Intravenous (injection in a vein)	iv
transdermal	td
rectal	r
Other	e.g.,drops, ointment, suppositories, etc.

Can client self-medicate?: Check the appropriate descriptor. If client cannot self-medicate, is authorization for delegation of function required?

Medication Review Requested: Check the appropriate descriptor.

Comments: Record client's ability to manage medications, including obtaining prescriptions, safety, compliance, abuse, incompatibilities and monitoring of drug levels.

Special Authorization: If required, has this authorization been requested by physician?

Pain

Acute Pain has a rapid onset, which may vary in intensity from mild to severe and last for a very brief period to any period of time less than six months. In acute pain there is an end in sight to the suffering and the client is pain-free between episodes.

Note: Six months or more is the time frame most frequently used for pain research purposes.

Chronic Pain is ongoing and usually lasts for more than six months. There may or may not be known active pathology. The onset of chronic pain may be acute or gradual.

Does the client have acute pain and/or chronic pain?: Check the appropriate descriptor and record site and frequency of pain.

Body Charts: Front and back body charts for both acute and/or chronic pain. Shade the area(s) on the body charts where pain is experienced.

Limitations due to pain: Check the appropriate descriptor(s).

Is pain management satisfactory?: Check the appropriate descriptor.

Comments: Record limitations resulting from pain; how client manages; how, when and what relief is obtained from treatment. Indicate whether treatment is administered independently.

Note: Pain Assessment Tools (Appendix B). Optional Use to obtain measurable indications of intensity of pain experienced at time of assessment.

Skin Integrity

Check the appropriate descriptor.

Comments: Record skin care needed (i.e., turning, dressing), who manages care and if a referral is necessary. Identity if there is a new or long-standing infection present.

Respiration/Respiratory Care

Check the appropriate descriptor(s).
Indicate whether dependent or independent with respiratory care.

Comments: It is necessary to record how client's respiratory issues impact on activities of daily living, what management strategies are currently utilized and whether a referral is necessary.

Circulation

Check the appropriate descriptor(s).

Comments: Record if client has aids (e.g., pacemaker, Hickman Catheter, etc.), who ordered aids, who monitors and who performs required care.

Vision

Assess client's vision with visual aids, if applicable. Check the appropriate descriptor.

Client Has: Check appropriate descriptor:

Date of last eye examination?: Record using y/m/d format.

Eyeglasses/Contact Lens: Where Purchased: Record place and date of purchase.

Comments: Record history of eye disease, change in habits (i.e. reading, hobbies, TV viewing, recognition of people), duration of any problem, adaptation of environment.

Note: If vision problems noted and/or no regular assessment by physician/optometrist, recommend a prompt assessment. Indicate action taken (i.e. family arranging, assessor arranging).

Hearing

Check the appropriate descriptor. If client has a hearing aid and if it is satisfactory. Indicate the name of the individual who did the hearing test and record the place and date (y/m/d) of the test.

Comments: Record in this section social functioning, misunderstanding; asking for repetition; speaking in a loud voice; complaints of people speaking in low tones; history of hearing loss over past years, sudden/gradual; earaches, drainage; fit and satisfaction of hearing aid. Indicate the most effective means of communication with the client.

Note: If hearing problems noted and/or no regular assessment by physician/audiologist, recommend a prompt assessment. Indicate action taken.

Communication

Include speech, sign language, gestures, symbol board or written.

Expressive: Check the appropriate descriptor.

Comments: Record in this section history of medical condition affecting speech and language, duration of problem and potential for improvements. Indicate what alternate form of communication is used, if applicable.

Note: If expressive speech problems noted and/or no regular assessment by physician/speech and hearing department, recommend a prompt assessment. Indicate action taken.

Receptive: Check the appropriate descriptor.

Comments: Record in this section history of medical condition affecting receptive communication, duration of problem and potential for improvement.

Note: If receptive communication problems noted and/or no regular assessment by physician/speech language pathologist/audiologist, recommend a prompt assessment. Indicate action taken.

Nutrition

Obtain client's appraisal of state of appetite.
Record changes in appetite and give details, noting time frame.
Record current weight: actual or approximate.
Record any change in weight and give details, noting time frame.
Record how many times a day client eats or drinks. Number of meals and snacks.
Ask client what he/she has eaten for 1-2 days and check appropriate descriptor to indicate food groups used.
Record if client is on a special diet; specify type.
Record if food requires special preparation, specify.
Record if client is using a supplement; specify type and frequency.

Comments: Record any unusual eating habits and who prepares meals and snacks.

Note: If any problems are identified, prompt referral for nutritional counselling should occur. Indicate action taken.

Record if client is tube fed. Record route, type, amount, frequency and time administered. If extra water is given, record amount.

Comment: Elaborate on above (e.g., time of day)

Note: If any problems identified, prompt appropriate referral should occur. Indicate action taken.

Dental/Oral Hygiene

Check all descriptors that apply and record date of last dental examination.

Comment: Record frequency, trigger foods, management of choking/swallowing problems.
Has referral for assessment been made?

Nausea

Check the appropriate descriptor(s). If yes, record the usual time of occurrence, frequency and duration.

Comment: Elaborate on above.

Vomiting

Check the appropriate descriptor(s). If yes, record the usual time of occurrence, frequency and duration.

Comment: Elaborate on above.

Sleep Pattern

Check the appropriate descriptor.

Comments: Record if client has disruptive sleep pattern. Indicate duration of sleep pattern and whether there are unmanageable behaviors. Identify management strategies.

Note: Problematic sleep patterns should be referred for further investigation. Indicate action taken.

Urinary/Bowel Function

Urinary and Bowel Functions: Check the appropriate descriptor(s) in each group.

Record client's usual urinary/bowel pattern.

Comments: Record details of current management and who assists/manages. Indicate whether this is an acute or chronic problem.

Note: When acute problems are noted and no current treatment is in place, client should be referred to appropriate health care provider.

Foot Care

Check appropriate descriptor(s).

Comments: Record foot care affecting independence/mobility. When problems noted refer to appropriate health care professional. Record frequency of foot care visits provided.

Risk/History of Falls

Indicate if client has a history of falling or is at risk for falling. Record the frequency and ways used to minimize/eliminate risk.

Comments: Include possible causes of history/risk of falls (e.g., poor balance, obstacles in home, inner ear dysfunction, medication side effects).

Physical Function

Check the appropriate descriptor(s).

Comments: Record the date of when the disability occurred. Record the cause of the disability (e.g., congenital, traumatic, or as result of illness).

Mobility

Check the appropriate descriptor(s). Where applicable, observe the client's mobility.

Comments: Record whether new or long standing problem. If assistance is required – indoors and outdoors, identify type.

Type of Assistance	Definition
Minimal assistance	Requires one person on stand by to give occasional support/move obstacles/precaution/boost confidence; or assistance from sit to stand.
One person assist	Requires assistance of one person only to complete activity.
Two person assist	Requires assistance of two persons at all times to complete activity.

Activity Tolerance

Check appropriate descriptor.

Comments: Record level of normal activity and reason for referral if necessary.

Equipment/Assistive Devices Used

Check the appropriate descriptor(s). Where applicable, observe the client using equipment/assistive devices/bed attachments.

Comments: Record why equipment is used, if client is independent or requires assistance and if referral is necessary. Record, if applicable, if one or two-person assistance is required. Record the name of the company supplying the equipment.

Referral may be necessary if equipment is inadequate, in poor condition, or unsuitable.

Activities of Daily Living

Physical: Check the appropriate descriptor.

Note: It is advisable to observe the client completing tasks. It is essential to establish if the client has the ability to perform the function. If the client is capable of performing ADL but currently does not do so, indicate why.

Comments:

- Refer to specific ADL when commenting.
- Elaborate on the type of assistance required with ADLs; this information is critical to matching client need to appropriate placement options.
- If a client requires moderate assistance or is dependent, record if one or two person assistance is required.

Instrumental: Check the appropriate descriptor.

Note: When necessary, check with family/caregiver about client's ability to complete task. It is essential to establish if the client has the ability to perform the function rather than whether the client is currently doing so. If the client is capable of performing ADL but currently does not do so, indicate why.

Comments:

- It may not be necessary to comment on each ADL.
- Refer to specific ADL when commenting.
- Elaborate on the type of assistance required with each ADL; this information is critical to matching client need to appropriate placement options.

BEHAVIORAL ASSESSMENT

It may be necessary to obtain information from a variety of sources to complete an accurate behavioral assessment and to identify needs. The information should be obtained from a resource person.

Record the name of the individual who provided the information and relationship to client.

The behavioral assessment should be used as a tool to assist in determining whether referral to other agencies is necessary (i.e., geriatric assessment centre, mental health unit or facility based assessment).

Smoking Behavior

Check the appropriate descriptor.

Comments: Record if client/family is at risk and strategies to eliminate/modify risk.

Substance Abuse

Check the appropriate descriptor.

Comments: Record if a new or chronic behavior, if client/family are at risk and strategies to eliminate/modify risk.

Note: If problems identified, it may be necessary to refer for further investigation/counselling. Record action taken.

Wandering
Check the appropriate descriptor.

Comments: Record how potential to wander beyond the familiar environment is minimized (for example, locks on doors or supervision).

Hoarding/Rummaging
Check the appropriate descriptor.

Comments: Record, if this is a new behavior and specify the duration and frequency. Record strategies to eliminate/modify behavior.

Social Behavior
Check the appropriate descriptor.

Comments: Describe the actual behavior. Record the frequency, time of day behavior most often occurs, and what provokes the behavior. Record any strategies used to minimize the behavior.

Aggressive Behavior
Check the appropriate verbal and physical descriptors.

Comments: Describe the history, actual behavior, frequency, time of day, and what provokes the behavior. Indicate strategies used to eliminate/modify the aggressive behavior.

Note: If aggressive behavior reported, it may be necessary to refer for further investigation/counselling. Record any action taken.

Self-Injurious Behavior
Check the appropriate descriptor.

Comments: Describe the history, actual behavior, frequency, time of day and what provokes behavior. Indicate strategies used to eliminate/modify behavior.

Note: If self-injurious behavior reported, it may be necessary to refer for further investigation/ counselling. Record any action taken.

Sexual Behavior
Check the appropriate descriptor.

Comments: Record if information was obtained through observation, interview and/or past history. Describe actual behavior, frequency, time of day, and what provokes the behavior. Indicate strategies used to eliminate/modify the aggressive behavior.

Note: If problems identified, it may be necessary to refer for further investigation/counselling. Record any action taken.

MENTAL HEALTH ASSESSMENT

Mental Health History
Check the appropriate descriptor.

Comments: Record any pertinent information, elaborate on treatment, effects of treatment, etc.

Note: If problems identified, it may be necessary to refer for further investigation or counselling. Record any action taken.

Potential For Suicide
Check the appropriate descriptor.

Comments: Record any pertinent information.

Note: If there is a potential for suicide reported, it may be necessary to refer for further investigation/counselling. Record any action taken.

Mental Health Indicators

Check the appropriate descriptor(s), more than one response may be applicable.

Comments: Record any pertinent information (elaborate if necessary) noting onset and duration. List all changes that have occurred in the past year.

Note: If problems noted, it may be necessary to refer for further investigation/counselling. Record any action taken.

SOCIAL ASSESSMENT

This section should provide an overview of the client's support system considering client/caregiver/family strengths and interactions, and the identification of service needs. All descriptors may not apply to all clients; however, they are meant to serve as reminders to assist in completing this section. There may be descriptors not included that need to be considered.

Information may be obtained from a resource person.

Household Composition: Check appropriate descriptors.

Supports Available (Persons Available and Willing to Provide Assistance/Support)

Record name(s), relationship, telephone number(s), type of assistance and/or support the person(s) can offer (e.g., transportation, accompanying to medical appointments, visiting, meal preparation).

Employment/Training Program Status

Check the appropriate descriptor.

If employed, record employer name, address, and telephone number.

If attending school/training program record name, address, and telephone number.

Record level of support required while at place of employment or school/training program.

If possible obtain name, and telephone number of person who may be contacted at the employment site/school/training program.

Coping Skills

Check the appropriate descriptor and comment accordingly.

Leisure/Recreation/Hobbies:
Check the appropriate descriptor and comment accordingly.

Community Participation

Check the appropriate descriptor and comment accordingly.

Comment: Record community inclusion activities, site and mode of transportation to access activities.

ENVIRONMENTAL ASSESSMENT

Complete this section for any client living in a community residential setting or for a client returning to the community. If on-site visit is not possible, information should be obtained from a person knowledgeable about the residence.

Provider of Information/Relationship to Client: Record the name and telephone number of the individual providing the information and relationship to the client.

Household Amenities/Accessibility: If there are problems with the current or anticipated home environment, check the appropriate descriptor.

Comments: Record identified safety hazards in the current or anticipated residence. Record the environmental modifications required to increase the client's level of independence and/or safety. Record any action taken.

Safety

Check the appropriate descriptor.

Home safety may include knowledge of the safe operation of household appliances, safety around electrical outlets. Public safety may include awareness of crossing roads safely, ensuring wallet/money carried in safe manner, keeping on the curbside/sidewalk when walking in public thoroughfare.

Comment: Record specific cuing necessary to ensure safety.

COMMUNITY SERVICE PLAN

The plan reflects the needs and recommended placement options for the client based on information gathered in the assessment.

Services: Current/Referral

Check the appropriate descriptor, which indicates the current service utilization, and/or need for further referral as identified in the assessment.

Comments: Record any additional comments, if necessary.

Home Support Services

Check the appropriate descriptor, if applicable, for home supports currently received or to be initiated.

Comments: Record the type of service client currently receives, elaborating on current hours utilized, if adequate or inadequate and the recommended change, if applicable.

Home Support Agency: Record the name/address of agency currently providing home support.

Residential Respite Provider: Record the name and address of person(s) providing residential respite.

RESIDENTIAL SERVICE PLAN

Geriatric Assessment

Check appropriate descriptor:

Comments: Elaborate (e.g., date of assessment, any action taken).

Facility Based Respite

Personal Care Home/Long Term Care Home – Check appropriate descriptor:

Record name/address of facility requested/accessed
Record level of care required (L1, 2, 3, 4)
Record dates of respite required (inclusive)

Long Term Placement

Check appropriate descriptor:

Record level of care required.
Record preferred facilities, if known.
Explain local RHA first available bed/transfer policies, if applicable.

SUMMARY AND RECOMMENDATIONS

This section should provide a narrative overview of the client's support system considering client/caregiver/ family strengths and interactions, and the identification of service needs. All descriptors may not apply to all clients; however, they are meant to serve as reminders to assist in completing this section. There may be descriptors not included that need to be considered. Descriptors to consider include:

- orientation/cognition;
- physical assessment;
- physical activities of daily living;
- instrumental activities of daily living;
- behavioral assessment;
- mental health assessment;
- social assessment;
- environmental assessment;
- personal hobbies/interests;
- equipment (to accompany, or required);
- changes in life circumstances;
- perception of needs;
- client's strengths;
- client's limitations;
- current conflict/stress;
- other family/caregiver dynamics.

APPENDIX A

Burial Arrangements

If client/family have made burial arrangements please ensure Appendix A is completed in the Assessment Instrument.

APPENDIX B

Pain Assessment Tools

PAIN ASSESSMENT TOOLS

Pain Assessment Tools help clients describe their pain. The pain scale is one tool commonly used to describe the intensity of the pain or how much pain the client is feeling.

Two of the pain scale tools are:

The Wong-Baker Faces Pain Rating Scale: This scale uses 6 faces with different expressions on each face. Each face is a person who feels happy because he/she has no pain or feels sad because he/she has some, or a lot of pain. The client is asked to choose the face that best describes how he/she is feeling. People aged 3 years and older can use this rating scale. It is helpful for the client with cognitive impairment, language barriers, and seniors as it offers a visual, rather than verbal, descriptor.

Visual Analog Scale: This is a straight line with the left end of the line representing no pain and the right end of the line representing the worst pain. The client is asked where they think the pain is by marking on the line.

APPENDIX C

Standardized Mini-Mental State Examination (SMMSE)

STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)

The Standardized Mini-Mental State Exam (SMMSE) has been used since 1975 and was developed by Marshal F. Folstein, Susan E. Folstein and Paul R. McHugh. The SMMSE was standardized in 1989 by Dr. D.W. Molloy and staff.

The SMMSE is not intended to replace a complete clinical assessment and is not intended to provide diagnosis.

The SMMSE:

- → is **quick** and **easy** to use - taking 10-15 minutes to administer,
- → is easily administered to individuals who can cooperate for **short** periods of time,
- → can be administered by clinical or lay personnel with minimal training.

Studies have shown that the SMMSE:

- → is a valid and reliable test of cognitive function,
- → permits comparisons to be drawn between intellectual changes and other aspects of cognitive functioning,
- → can be used in initial and serial measurements of cognitive functioning and allows for identification of worsening or improvement of cognitive functioning over time or with treatment,
- → can be repeated during an illness and shows little practice effect,
- → aids in determining competency to manage daily affairs,
- → aids in identifying client need for social supports.

File No. _____

STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)

Questions are asked in the order given and are scored immediately. Ask each question a maximum of 3 times; if no response, score 0. Do not hint or give physical clues (e.g., head shaking). Establish rapport.

I would like to ask you some questions to check your concentration and your memory. Most of these will be easy.

		Maximum Score	Client's Score
1.	Allow 10 seconds for each reply?		
	a. **WHAT YEAR IS THIS?** (accept exact answer only)	1	
	b. **WHAT SEASON IS THIS?** (During last week of old season or first week of a new season, accept either season.)	1	
	c. **WHAT MONTH OF THE YEAR IS THIS?** (On the first day of new month, or last day of previous month, accept either month.)	1	
	d. **WHAT IS TODAY'S DATE?** (Accept previous or next date, e.g., on the 7th, accept 6th or 8th.)	1	
	e. **WHAT DAY OF THE WEEK IS THIS?** (Accept exact answer only.)	1	
2.	Allow 10 seconds for each reply.		
	a. **WHAT COUNTRY ARE WE IN?** (Accept exact answer only.)	1	
	b. **WHAT PROVINCE ARE WE IN?** (Accept exact answer only.)	1	
	c. **WHAT TOWN ARE WE IN?** (Accept exact answer only.)	1	
	d. **WHAT IS THE NAME OF THIS HOME/FACILITY?** (Alternate: **WHAT IS YOUR ADDRESS?** Accept exact answer only.)	1	
	e. **WHAT IS YOUR ROOM NUMBER?** (Alternate: **WHERE ARE WE?** Accept exact answer only.)	1	
3.	**I AM GOING TO NAME 3 OBJECTS. AFTER I HAVE SAID ALL 3 OBJECTS, I WANT YOU TO REPEAT THEM. REMEMBER WHAT THEY ARE BECAUSE I AM GOING TO ASK YOU TO NAME THEM AGAIN IN A FEW MINUTES.** (Say them slowly at approximately 1 second intervals.) **BALL CAR MAN** **PLEASE REPEAT THE 3 ITEMS.** (Score 1 point for each correct reply on the first attempt; if all 3 items are not repeated, repeat until they are learned or to a maximum of 5 times.)	3	
4.	**SPELL THE WORD 'WORLD'.** (Help with correct spelling, if necessary.) **NOW SPELL IT BACKWARD PLEASE.** (Allow 30 seconds to spell backwards; see guide for scoring. (Alternate: Serial sevens, counting backwards from 100 by 7s five times - 93, 86, 79, 72, 65, may be used instead of spelling 'World' backwards, but this must be decided beforehand, i.e., if client is not able to do one task, do not use other task).	5	

File No. _____

STANDARDIZED MINI-MENTAL STATE EXAMINATION (SMMSE)

5.	**WHAT WERE THE 3 OBJECTS I ASKED YOU TO REMEMBER?** (Score 1 point for each correct answer regardless of order.)	3	
6.	**WHAT IS THIS CALLED?** (Show wristwatch; accept wristwatch or watch - not clock, time, etc.)	1	
7.	**WHAT IS THIS CALLED?** (Show pencil: accept pencil only - score 0 for pen.)	1	
8.	**REPEAT THIS PHRASE AFTER ME: "NO IFS ANDS OR BUTS".** (Allow 10 seconds for response; repetition must be exact.)	1	
9.	**SHOW ENLARGED COMMAND 'CLOSE YOUR EYES'.** (See guide) **READ THE WORDS ON THIS PAGE AND DO WHAT IT SAYS.** (If client just reads and does not close eyes, then repeat original instructions to a maximum of 3 times; allow 10 seconds for answer. Score 1 point only if client closes eyes. Client does not have to read aloud.)	1	
10.	**I AM GOING TO GIVE YOU A PIECE OF PAPER. WHEN I DO, TAKE THE PAPER IN YOUR HAND, FOLD THE PAPER IN HALF WITH BOTH HANDS, AND PUT THE PAPER DOWN ON YOUR LAP.** (Allow 30 seconds; score 1 point for each instruction executed. Takes in Hand: Folds: In Lap:	1 1 1	
11.	(Hand client a pencil and paper.) **WRITE ANY COMPLETE SENTENCE ON THIS LINE.** (Allow 30 seconds. The sentence should make sense; ignore spelling errors.)	1	
12.	**HERE IS A DRAWING; PLEASE COPY THE DRAWING.** (Allow multiple tries until client is finished and hands it back. There must be a 4-sided figure between the two 5-sided figures. Maximum time - 1 minute. See scoring guide.)	1	
	Total Maximum Score;	30	

_____ Normal Range (24-30)

_____ Mild Cognitive Impairment (20-23)

_____ Moderate Cognitive Impairment (11-19)

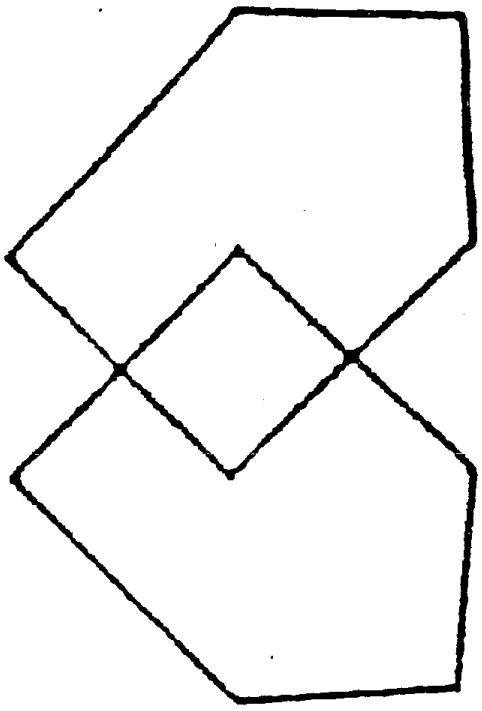
_____ Severe Cognitive Impairment (0-10)

Assessor's Signature: _____ Date of Assessment (y/m/d): _____

File No. _____

WRITE SENTENCE BELOW

COPY DESIGN BELOW



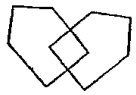
SCORING 'WORLD' BACKWARDS

Correct Response	DLROW	Score 5
Omission of one letter e.g., DLRW, DLOW, DROW, DLRO		Score 4
Omission of two letters e.g., DLR, LRO, DLW		Score 3
Reversal of two letters e.g., DLORW, DRLOW, DLRWO, DLWOR		Score 3
Omission/Reversal of three letters e.g., DORLW, DL, OW		Score 2
Reversal of four letters e.g., DRLWO, LDRWO		Score 1

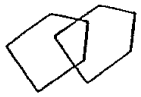
SCORING THE FIGURE

The client must draw 5-sided figures intersected by a 4-sided figure.

CORRECT
Score 1

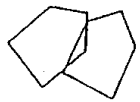


INCORRECT
Score 0

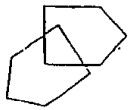


CORRECT
Score 1

INCORRECT
Score 0



CORRECT
Score 1



INCORRECT
Score 0

Close Your

Eyes

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- can be repeated during an illness and shows little practice effect;
- aids in determining competency to manage daily affairs;
- aids in identifying client need for social supports.

Tufts University School of Medicine/Tufts-New England Medical
Department of Psychiatry
The Mini-Mental State Examination

The Mini-Mental State Examination (MMSE) is a widely used method for assessing cognitive mental status. The evaluation of cognitive functioning is important in clinical settings because of the high prevalence of cognitive impairment in medical patients. As a clinical instrument, the MMSE has been used to detect impairment, follow the course of an illness, and monitor response to treatment. MMSE has also been used as a research tool to screen for cognitive disorders in epidemiological studies and follow cognitive changes in clinical trials.

While the MMSE has limited specificity with respect to individual clinical syndromes, it represents a standardized method by which to grade cognitive mental status. It assesses orientation, attention, immediate and short-term recall, language, and the ability to follow simple verbal and written commands. Furthermore, it provides a total score that places the individual on a scale of cognitive function.

The normative data for different ages and educational levels are presented below, as is a list of references on the use of the MMSE. Further information on the MMSE may be obtained at WWW.MINIMENTAL.COM.

Normative Data on the MMSE

Cognitive performance as measured by the MMSE varies within the population by age and educational level. There is an inverse relationship between MMSE scores and age, ranging from a medium of 29 for those 18 to 24 years of age, to 25 for individuals 80 years of age and older. The median MMSE score is 29 for individuals with at least 9 years of schooling, 26 for those with 5 – 8 years of schooling and 22 for those with 0 to 4 years of schooling.

The results in the following table (from Crum et al., 1993) can be used to compare your client's MMSE score with those determined from a population reference group based on age and educational level.

	Age													
Education	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	>84
4th Grade	22	25	25	23	23	23	23	22	23	22	22	21	20	19
8th Grade	27	27	26	26	27	26	27	26	26	26	25	25	25	23
High School	29	29	29	28	28	28	28	28	28	28	27	27	25	26
College	29	29	29	29	29	29	29	29	29	29	28	28	27	27

Selected References on the MMSE

1. Folstein, MF, Folstein, SE and McHugh, PR (1975) Mini-Mental State: A practical measure grading the state of patients for the clinician, *Journal of Psychiatric Research*.
2. Anthony, JC, LeResche, L, Niaz, U, VonKorff, MR, and Folstein, MF (1982) Limits of the state as a screening test for dementia and delirium among hospital patients. ….12: 397-408.
3. Cockrell, JR an Folsetin, MF (1988) Mini-Mental State Examination (MMSE)
4. Crum, RM, Anthony, JC, Bassett, SS and Folstein MF (1993) Population-based norms mental state examination by age and educational level, *JAMA*, 18: 2386-2391.