

NURSING HOMES SUPPORT SCHEME 2009

COMMON SUMMARY ASSESSMENT REPORT

GUIDANCE DOCUMENT

The Common Summary Assessment Report and this Guidance Document are part of a process of developing a national common assessment approach, primarily for older persons seeking access to long term residential care for in the public, voluntary or private sectors. An assessment of needs is a legislative requirement. This Guidance Document has been produced to assist practitioners in the completion of the Common Summary Assessment Report (CSAR).

Admission into long term residential care is a significant life decision. It is best practice that older people should have an assessment specifically to determine whether: a) there are remedial factors which might avert admission to long term residential care; b) the older person is under inappropriate pressure to enter long term residential care; and c) to provide recommendations to maximise health, by a Consultant Geriatrician or Consultant in Psychiatry of Old Age. Where available, this assessment has a key role as part of the multidisciplinary team process in reaching a decision on the individual's need for long term residential care. Exceptionally, adults with chronic and significant disabilities may also apply for state support. A similar approach applies to this care group, although the professions involved may vary.

Health and social care professionals have a duty of care to ensure that people have been given sufficient and appropriate information for them to make an informed choice about whether they wish to enter long term residential care; this includes discussing with that person the reasonably foreseeable pros and cons of long term residential care. The rights and wishes of the person will be paramount in the decision making process.

Whilst local arrangements will be made for the completion of the CSAR, it is generally envisaged that health professionals with the most comprehensive knowledge of the applicant will be central to the process.

Values and Principles

- Admission to Long Term Residential Care is a significant life decision
- People should not be admitted to long term residential care against their wishes, irrespective of the views of carers and others or of the likely safety of remaining in the community
- The decision-making process should include the older person to the fullest extent possible
- The needs and preferences, if ascertainable, of the individual are the primary consideration when determining whether continuing care is appropriate
- The decision should only be taken when all other care options have been exhausted
- Placement must be appropriate
- To ensure appropriate placement, it is vital that each person has a comprehensive assessment
- Arrangements for the provision of on-going care should be fair and seen to be fair
- People have a right to sufficient and appropriate information on the range of services available to them with in order to make an informed choice about whether they wish to enter long term residential care

General Points of information:

Why have a "Common Summary Assessment Report" (CSAR)?

- The Nursing Homes Support Scheme Legislation requires that
 - Individuals seeking state support for continuing care must have a care needs assessment report
 - Individuals must be provided with a copy of their care needs report
- Expert opinion on Older Persons is that care needs are best determined by multi-disciplinary assessment, involving a consultant geriatrician or psychiatrist of old age, where available.
- A CSAR will combine assessment information from various sources, thereby creating a single, permanent and transferable record of the information relevant to a decision on an individual's care needs at a given point in time.
- An up-to-date CSAR may meet the requirements of the Integrated Discharge Planning code where a patient is being discharged to residential care.

A completed CSAR must clearly show why long term residential care is, or is not, required.

Who should complete a CSAR?

- The HSE supports the concept of multi-disciplinary (MDT) working. It also recognises that there is considerable variation nationally regarding the availability of staff. Therefore it is not possible to be prescriptive about who should complete a CSAR.
- Each local area/ agency should therefore devise and document their processes for the completion of the report. The goal is to capture the best information available as efficiently as possible. The CSAR has been designed so that any single professional who knows the patient well can complete it, but where an MDT is available they should be involved in the completion. Apart from reports from named professions, the information sought on a CSAR form can be provided by a range of staff. For example, Barthel or cognitive assessments may be completed by a nurse, therapist or medical practitioner.
- Where a Multi-disciplinary team exists, it is envisaged that one person will act as a coordinator for the completion of the form.

Who should be the 'coordinator' and what is their role?

This should be determined locally. It may vary from place to place, or even, where a 'key worker' system is in operation, from patient to patient. In general terms, it is envisaged that the coordinator will:

- Ensure that the relevant MDT members have contributed to the completion of the form, as required by local policy
- Sign the form to confirm:
 - that the relevant MDT members have been involved

CSAR-Guidance (NHSS 2009)

- that any information on the form (apart from contributions signed by other professionals) is accurate
- that the CSAR presents an accurate profile of the care needs of the patient, as of the date of signing.

Professional contributions to the CSAR

If a professional completes a particular sub-section of the form or appends a report, they should print their name, role and then sign and date that information in order to meet medico-legal requirements. The form has signature prompts for this purpose.

The coordinator is not responsible for information signed-off by another professional.

Can the CSAR be modified to meet local needs?

The CSAR is a national document. It cannot be modified or altered by an individual agency. The form will be evaluated and updated over time. Proposals for changes may be discussed with the HSE.

Section 1: Source of referral

- Please include the name of the location from which the referral is originating from or the name of the person who has made the referral.
- It is useful for audit purposes to identify the location of the applicant e.g. name of acute hospital, name of community hospital name or community area

Section 2: Personal Details

- If available please use the addressograph (personal details) to complete this section.
- The hospital number may be known as the medical records number or patient control numbers in some areas.
- Preferred Name: the applicant may have a nickname or a pet name to differentiate them from other common names used in a geographical area.

Section 3: Personal Circumstances

Marital status: Please indicate if the person has any other type of arrangement under OTHER

Contact Person, Specified Person and Care Representatives

Where the applicant is able to manage their own application, they may choose to nominate a contact person. The HSE will still send confidential information to the applicant, but will address queries to the contact person. The applicant must personally sign any agreements with the HSE.

Where the applicant is not able to manage their application, a 'Specified Person' may act on their behalf. The HSE must be clear as to the identity of the Specified Person and their relationship to the applicant. In certain circumstances, the HSE may decline to deal with a person seeking to act as a Specified Person.

Where an applicant applies for Ancillary State Support but is not able to enter into a financial agreement, a Care Representative has to be appointed by the Circuit Court to deal with aspects related to the legal charge.

In some cases, the Specified Person and the Care Rep. may be separate individuals.

Housing

The purpose of this section is to obtain details of the person's current housing situation and to record any issues that may hinder the person from returning home:

- Does the person live in: town, village, or isolated rural area?
- What distance is the applicant from the nearest neighbour etc?
- House type e.g. bungalow, 2 storey etc, location of bedroom and bathroom
- Home Condition: good/fair/poor (poor windows etc)
- Sanitary facilities to include indoor/outdoor toilet, shower/bath
- Is there heating in the house? An electricity supply?
- Running water, hot or cold water available?
- Outline any access issues that will influence mobility, ability of transport to access location
- Please identify the presence of any environmental hazards e.g. steps

Principal carer

(The term 'carer' generally refers to 'unpaid' carers, such as a spouse, rather than a paid carer, such as a home-help)

- This is the person who provides a significant amount of direct care for the person, e.g., calls daily, supplies meals etc
- Please state the relationship of this person to the applicant.
- Also include name and relationship of anyone who may stay overnight e.g. grandchild, son/daughter who stays the night or family rota in place to stay overnight.
- Please indicate if an assessment of the carer's needs have been completed. Please attach if available.

Section 4: What options of care have been discussed and what is the person's preferred option

The purpose of this section is to capture all the care options discussed with the applicant.

- The needs and preferences, if ascertainable, of the individual are the primary consideration when determining whether continuing care is appropriate. The needs and preferences of the carer will also be taken into account.
 - People should not be admitted to long term residential care against their wishes, irrespective of the views of carers and others or of the likely safety of remaining in the community
 - For the person with a cognitive impairment or communication difficulties, care options should be discussed and information should be provided at a level that is appropriate to that person.
 - Examples of Care Options may include residential care in the public and private sector, sheltered housing, home with a home care package and planned respite care and day care. It is also important to identify if the applicant has refused any or all alternative care options offered.
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Section 5 Record of current community/home support services

The purpose of this section is to record the type and level of community supports (either statutory or voluntary) that the person is currently receiving.

Please indicate the levels of support the applicant avails of from community supports listed, in as illustrated (p/w = per week, 3/7 = 3 days each week. Detail relevant information e.g. which days and explain any other abbreviations used).

5. RECORD OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (SEE GUIDANCE NOTE BEFORE COMPLETING)												
SERVICE (Tick)	Home Help/Support	<input checked="" type="checkbox"/>	Day Care	<input checked="" type="checkbox"/>	Respite	<input checked="" type="checkbox"/>	Meals Supply	<input checked="" type="checkbox"/>	Laundry	<input checked="" type="checkbox"/>	Day Hospital	<input checked="" type="checkbox"/>
Hours/Times p/w or relevant time or if refused services	15 hrs p.w.		3/7		Every 6 weeks for 2 weeks		5/7		N/A		N/A	
SERVICE (Tick)	PHN/CMHN	<input checked="" type="checkbox"/>	Family support/Private Carer	<input checked="" type="checkbox"/>	Therapy or other discipline	<input checked="" type="checkbox"/>	Other (Spec.)	<input checked="" type="checkbox"/>	Services Refused	<input checked="" type="checkbox"/>		
Hours/Times p/w or relevant time or if refused services	PHN visits 3/7		None		N/A				Boarding Out			

N/A: Not applicable

Please indicate if the person has refused community supports and specify those refused.

Section 6 Current diagnosis and Medical/Mental Health summary

Please include details of the person's diagnosis, medical history and/or mental health history.

- This section may be completed by the relevant medical staff or by the person completing the CSAR by obtaining information from the medical notes or other relevant sources.
- It should be noted that legislation indicates that a copy of the CSAR report be made available to the applicant. In certain rare circumstances, a medical decision may have been made that information on diagnosis should not be made available to a patient. The person(s) completing the CSAR should be alert to any such issues.

Section 7 Current medication

The information documented in this section is to be used as part of the assessment process and not for the administration of medication. For patients in hospital, this section may be completed once key medication has been prescribed as medication frequently changes with the patient's condition. Alternatively, a list of medications on discharge may be appended to the CSAR.

Please list the name of the drug, the dose and the frequency that the drug is administered, for example:

NAME OF DRUG	Dosage	Frequency
Drug W	500mgs	T.D.S
Drug M	375mgs	Q.I.D.

Use additional blank A4 page to record additional information if required. Please clearly use relevant headings e.g. Section 7 current medications (continued)

Section 8: Assessments

The primary purpose of this section is to profile the person's individual characteristics in terms of the physical ability, mental health, cognitive status and any other aspect relevant to their individual health needs, using (where available) valid and reliable assessment tools appropriate to the applicants age and medical status.

It is important that the practitioner undertaking the Modified Barthel and the cognitive assessment have knowledge and experience on the use of tools used. The Barthel is sought as an assessment of personal activities of daily living. Cognitive function should also be assessed using a valid and reliable assessment tool. The tool used and the outcome should be clearly identifiable. Results from such assessments may be transcribed to the CSAR, or the completed assessment tools may be appended to the document. Where applicable, practitioners should be compliant with copyright.

It should also be noted that neither the Barthel nor cognitive assessments alone predict the need for long term residential care.

8A Guidelines for the use of Barthel

- The index should be used as a record of what the patient does, not a record of what the patient could do.
- The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
- The need for supervision renders the patient 'not independent'.
- A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses will be the usual

source, but direct observation and common sense are also important. However, direct testing is not needed.

- Usually the performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.
- Unconscious patients should score "0" throughout, even if not yet incontinent.
- Middle categories imply that patient supplies over 50% of the effort.
- Use of aids to be independent is allowed

Please summarise the physical dependency of the applicant by recording the total score.

- 8(B) Please indicate the individual's ability to communicate and retain information.
8(C) A cognitive assessment, appropriate to the patient's age and medical status, is required. Please also record any other risk/assessments completed if relevant, e.g. pressure sore, falls, nutritional etc.
8(D) Mental Health Status: please include in free text relevant details and attach any supporting assessments or documentation which assists the application.
8(E) If the individual has specific employment, recreational or social needs, please enter these into section 8 or provide a separate report. It is envisaged that this aspects may particularly apply to adult applicants.

Section 9. Medical/social/other risk factors

The purpose of this section is to capture any significant medical or social factors that indicate that this person's needs would be best met within a long term residential care setting.

Examples:

- Care Needs are required to be met at greater intervals than can be met within existing community supports (see below re need intervals)
- Carer is no longer able to continue caring
- The unavailability of a main carer

There are 3 need intervals: long, short and critical:

1. People with **critical interval needs** are the most dependent, requiring assistance on a frequent and unpredictable basis. People with critical interval needs are **unable** to carry out certain activities of daily living **unaided**, such as:
 - Getting in and out of bed or a chair
 - Getting to and using the toilet
 - Controlling bladder or bowel movements
 - Demonstrating inappropriate/anti-social/violent or risky behaviour due to severe mental impairment
 - Being disoriented for time, person and place and being liable to wander if left unattended
 - Being acutely ill and needing constant nursing attention

2. People with **short interval needs** also need assistance several times a day but at longer, usually predictable intervals.
3. People with **long interval needs** are more independent, requiring assistance with several activities but usually less than once in twenty-four hours, and predictably.

Section 10. Health Professional Reports

The purpose of this section is to include a summary of any nursing/therapy/social work summary. It may also indicate the need for ongoing support for the person.

Please include relevant reports in relation to nursing physiotherapy, occupational therapy, speech and language therapy, dietician, social work. Tick relevant boxes to indicate that a report has been appended.

Section 11. Specialist Assessment

The HSE is working towards best practice. All older people seeking HSE support for continuing care should have a clinical assessment by either a Consultant Geriatrician or a Consultant in Psychiatry of Old Age and associated members of the MDT prior to the decision being made. This assessment should be specifically to address the appropriateness of the proposed admission into long term residential care.

Adults seeking care may be assessed by other professions, including neurology or rehabilitation.

All those undertaking specialist assessment may add a comment that long term residential care is or is not required, or may append a report

Section 12. To be completed by Multi-disciplinary decision-making team

The purpose of this section is to record the decision regarding the applicant's current care needs. Each individual should have all their physical, psychological, mental and social care needs assessed, including any significant risk factors, before a final decision is reached. A need for care is not based on one single aspect such as physical dependency, but on the totality of an individual's circumstances.

Note that it is current care needs that are being considered. An applicant may currently need a long term residential care setting, but may not require care at some point in the future e.g. because their home is undergoing adaptations.

Material Alteration in Personal Circumstances

Legislation requires that HSE makes a judgement in relation to the likelihood of a material alteration in personal circumstances. An MDT may decide that care is or is not required. In either case, it should evaluate the likelihood of a material change. For example, an individual may not currently require residential care because of the input of a very elderly carer. There would be a high risk of a change in their circumstances.

Services Recommended

This section may be useful for strategic planning purposes in identifying future service developments. It should be completed whether or not residential care is

recommended i.e. to identify the type of services that may negate the need for long term residential care

Section 12 sign-off

This should be signed by the chairperson of the Local Placement Forum in your area, or by all of the members of the forum, depending on locally agreed protocols.

Signatories to this section are taking responsibility for verifying that, in their judgement and/or that of the professionals involved, the patient does or does not require residential care at the date of signing.

If care is required, the decision as to where that care should be provided is a completely separate decision process.