



The Aged Care Assessment Program

Learning Guide



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About the Rural Health Education Foundation

Originally established in 1992, the Rural Health Education Foundation provides independent, accredited education services to general practitioners and other health professionals working in rural and remote Australia.

Health education via satellite, the Internet and DVD

The Foundation produces and broadcasts distance education programs using digital satellite technology, the Internet and DVDs. The Foundation operates a growing network of more than 660 receiving sites, called the Rural Health Satellite Network. Today, the Foundation's satellite network is one of the largest dedicated networks of its kind in the world, reaching more than 90 per cent of rural doctors and other health professionals.

A non-profit lifeline to the bush

The Rural Health Education Foundation is a non-government, not-for-profit organisation that provides an education and information "lifeline" to rural and remote health professionals.

The latest topics via the latest technology

The satellite and Internet technology ensures that health professionals gain access to continuing education, without the need to find locum support or leave their communities. The Foundation's programs are broadcast and distributed in Australia a number of times each month and meet the professional development needs of all disciplines. They dissect major health issues and provide information on the latest and best health and community care practices. They also address the prevention and current management of common health problems.

Presented by experts

The programs feature presentations from medical and health professionals who are leaders in their disciplines, and allow for input from the target audience on material presented. The panels usually include a rural health professional.

We aim to address the unique education and information needs of medical practitioners, health workers and communities in rural and remote Australia.

Learning Guide

This Learning Guide for the Aged Care Assessment Program has been designed to provide a framework for facilitating discussion of the key issues raised in the program. It broadly follows the program discussion, amplifying some of the points raised, and adding others. The Learning Guide is mainly directed at health professionals who are part of ACAT teams, but is also able to be used by anyone working in the field of aged care. It includes a number of activities that can be used to facilitate individual learning and group discussion. You are encouraged to select from these, depending on your own professional needs or those of your group.

A Guide to Facilitating Adult Learning has been developed by the Foundation to support the facilitation of discussion with small groups. It covers the basic aspects of how people think and learn, and is designed to provide some basic instructional information to assist group and face-to-face learning. The Guide can be found on the Foundation's website on the Programs page.

(<http://www.rhef.com.au/programs/learning-guides/>)

Aged Care Assessment Program

Program Summary

Australia has an ageing population. People are living longer and the birth rate has dropped. The proportion of the population aged 65 years and over is projected to rise from around 12% in 2010 to 25% by the year 2051. As a consequence, services for older people are increasingly in demand. Frail older people, along with their family or carers, often require support and assistance at home, or they may need to make the difficult decision to enter a residential aged care facility.

The role of Aged Care Assessment Teams (ACAT) is to assess the care needs of frail older people and to assist them to gain access to the most appropriate types of care, including approval for Australian Government-subsidised aged care services. In doing this, ACATs conduct multidisciplinary comprehensive assessments, taking account of the restorative, physical, medical, psychological,

cultural and social dimensions of frail older people. Assessments are usually conducted in a community or hospital setting. ACATs make their recommendations in consultation with the client and their carers, and are encouraged to involve the client's General Practitioner.

The program on which this Learning Guide is based features the work of the Aged Care Assessment Teams. It involves a live panel discussion, using leading clinicians in the area of aged care assessment, and is chaired by Dr Norman Swan. Several case studies are used to illustrate the many issues involved, and to help identify 'best practice' in this area.

Learning outcomes

The Learning Outcomes that were identified for the program are described below.

After viewing the program, participants will be able to:

- Undertake an appropriate referral to an Aged Care Assessment Team
- Describe the process and benefits of a multidisciplinary assessment by an ACAT
- Effectively manage the challenges of aged care assessment and referral in rural and remote Australia
- Describe recent developments and new initiatives in the Aged Care Assessment Program

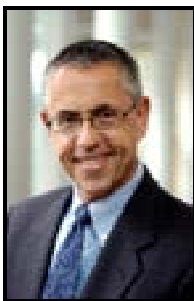
Presenters

Dr Norman Swan (Panel Chair)

Dr Norman Swan regularly presents Rural Health Education Foundation satellite broadcasts.

He is best-known for his wide broadcasting experience, including the award-winning *Health Report*, which he produces and presents for ABC Radio National, as well as his other ABC Radio and Television program hosting.

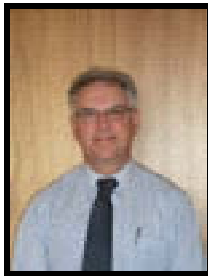
Dr Swan trained in Medicine in Scotland and in Paediatrics in London and Sydney. A broadcaster and journalist with the ABC's Science Unit since 1982, he has been Australian Producer of the Year and was awarded a Gold Citation in the United Nations Media Peace Prizes.





Dr Jane Tolman

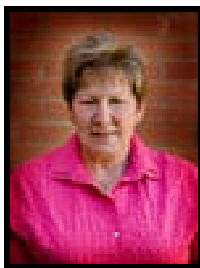
Jane is a Geriatrician, and native of Hobart, who returned to the state in 2006 after spending 16 years at the Prince of Wales Hospital at Randwick, Sydney and 2 years setting up the geriatric service in the Shoalhaven region on the NSW south coast. Jane's career background is originally in teaching. However, after a career change in the 1980's led her to study medicine at the University of Tasmania, Jane went on to gain specialist qualifications in Respiratory Medicine as well as Geriatrics. In June 2006, she took up the newly established position of Director of Rehabilitation and Geriatric Services at the Royal Hobart Hospital (RHH). This position encompasses a range of initiatives around aged care bringing together a whole new service for southern Tasmania. Her role also has a strong emphasis on adult rehabilitation services spanning both the acute and community sectors. It therefore provides a unique opportunity to bring allied health professionals together with nurses and medical practitioners from both these fields to form a comprehensive and coordinated continuum of care.



Dr Max Graffen

Dr Max Graffen emigrated from Scotland in 1964 and was raised in Melbourne. He graduated from Sydney Uni MBBS (Hons 1) in 1981. He describes himself as having had a 'chequered' career with 3 years in Military medicine (Brisbane), 4 in a regional hospital (Wagga Wagga, NSW), 2 in the UK doing anaesthetics, then returning to Wagga as a GP/ obstetrician.

He has spent the last 9 years as a geriatrician for the Greater Southern Area Health Service NSW, recently returning to blended GP/geriatric practice in Wagga for the past 3. He has post graduate diplomas in obstetrics, anaesthetics and geriatric Medicine as well as Fellowship of RACGP. He is a Board member for his local Division of GP and for a disability service.



Ms Debra Tooley

Debra Tooley has been working in rural NSW for the past 24 years with the Aged Care Assessment Program. Initially she worked as a CNC Aged Care and in the Aged Care Assessment Program in rural central NSW. In early 2009 Debra took over the management of the Far West service which predominately services remote NSW. She is an ACAT Education Officer (AEO) for the Greater Western Area Health Service.

Debra's background is nursing and she holds nursing certificates, Diplomas in Community Health and in Psychiatry of Old Age. She holds a Masters of Nursing and has conducted research in falls related to older people. She is currently completing a Diploma in Management.



Dr Kate Smith

Dr Kate Smith is a Research Fellow with the WA Centre for Health and Ageing, University of Western Australia, Perth. Kate worked for many years in aged care assessment as an Occupational Therapist in the Kimberley region of Western Australia. Her PhD was entitled “Assessment and prevalence of dementia in Indigenous Australians”, and she worked with colleagues to develop the Kimberley Indigenous Cognitive Assessment (KICA).

She is currently the Project Manager for the NHMRC funded ‘Indigenous Dementia Services Study’ developing and trialling a model of care for people with disabilities and the frail aged living in remote Aboriginal communities.

Introduction

Main Points from the discussion

- Currently about 13% of the Australian population is aged over 65; it is estimated that this will rise by 2031 to about 25%
- By 2051, the expected number of people over 85 is 1.3 million
- The patterns of disease are now changing: in the 19th century, most people suffered from infectious diseases; in the 20th century, from systemic illness (cardiovascular diseases, diabetes); and in the 21st century, old people are more likely to suffer from neuro-degenerative conditions (disorders of the senses, disorders of balance and gait, and disorders of cognition)
- The impact of neuro-degenerative conditions is seen much earlier in the Indigenous population – for example, dementia affects about 2% of the over 45-year olds amongst the non-indigenous population, but up to 12% of the same age group amongst Indigenous people

Activity 1

Activity 1

Review the above statistics, and the accompanying graphics in the program, and then discuss the implications for your local community.

- (i) What percentage of your local population is aged over 65? Over 85?
- (ii) Discuss how community expectations for the care of older people have changed over the last 20 years.
- (iii) What differences do you notice in your community regarding cultural understandings of families and family responsibility for older people?

Activity 2

Activity 2

- (i) How effective are local health care systems at identifying those at increasing risk of neuro-degenerative disorders, and those who may already have the condition?
- (ii) What opportunities are there for educating other health professionals in your community about these disorders?
- (iii) What are the implications of the anticipated rise in neuro-degenerative disorders for the commitment to maintain older people in independent living?

Activity 3

Activity 3

Dr. Graffen comments in the discussion that rural areas have a higher proportion of old people, and fewer family supports. What impact does geographical location have on your local aged population? And on the services available to support them?

Activity 4

Activity 4

Dr. Swan asks in the program about the definition of ‘frailty’? How would you define the term? Is it a useful term for the aged care worker?

ACATs – Objectives, Composition, Assessments, Packages

Objectives

According to the Aged Care Assessment Program Guidelines, the core objective of the ACATs is to comprehensively assess the needs of frail older people to determine their eligibility for appropriate community and residential care services and to approve them to receive that care.

The following objectives are designed to achieve the core objective:

- To ensure that older persons who belong to the following groups have equitable access to ACAT services (Aboriginal and Torres Strait Islander people; people of culturally and linguistically diverse backgrounds; people who are financially and socially disadvantaged; people living in rural and remote areas; veterans, their spouses, widows and widowers; people with dementia; homeless people; forgotten Australians and Former Child Migrants)
- to ensure that access to ACAT services is based on need
- to prevent premature or inappropriate admission to residential aged care
- to help frail older people live in the community
- to facilitate access to the combination of services that best meets the needs of assessed clients
- to ensure that assessments of the care needs of frail older persons are comprehensive, incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care need
- to involve clients, their carers and other service providers in the assessment and care planning processes
- to promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people; and
- to optimise assessment services provided within available resources.

Main Points from the Program Discussion

- There has been an impression that the service is aimed at getting people into nursing homes, and this has hindered people seeking appropriate access and receiving services. It's important to make clear that the Aged Care Assessment Program is also about keeping people at home, resourced, and as healthy as possible
- The Aged Care Assessment Program is particularly suitable for people who are coming into hospital repeatedly, or who suffer continuing accidents and injuries at home, or people who are prematurely considering residential care because of lack of supports at home.
- Early referrals can make a big difference to patient outcome.

Activity 5

Activity 5

- (i) Review the above objectives. How do you rate your ACAT in terms of them?
- (ii) How well understood are the objectives of the Aged Care Assessment Program in your area, and how effectively utilised is the ACAT?
- (iii) Are there ways in which the aims and objectives of the program can generally be better communicated to other professionals in your community, and to the ageing population and their carers?

Activity 6

Activity 6

- (a) Who refers to your local ACAT, and what opportunities exist for broadening your referral base?
- (b) Are your referrals timely? Think of a case where the outcome could have been different if an earlier referral had been made.
- (c) Are there ways in which the team could promote earlier referrals?

Activity 7

Activity 7

- (i) Choose one group from the list identified above - Aboriginal and Torres Strait Islander people; people of culturally and linguistically diverse backgrounds; people who are financially and socially disadvantaged; people living in rural and remote areas; veterans, their spouses, widows and widowers; people with dementia; homeless people; forgotten Australians and Former Child Migrants - that is particularly relevant to your geographical location. Discuss the needs that are specific to that group, and assess how adequately those needs are addressed by the local ACAT.
- (ii) How would you raise the profile of the Aged Care Assessment Program, and the programs they provide access to, amongst that group?

Composition of the team

ACATs are multidisciplinary teams, with access to a range of disciplines and skills necessary to making comprehensive assessments of an older person's physical, emotional and social support needs. The composition of the teams varies widely, though generally they include geriatricians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. In rural and remote locations, the ACAT might comprise one part-time allied health professional – such as an occupational therapist – who nevertheless has access to other professionals on a consultative basis.

Activity 8

Activity 8

- (i) In the program, Dr Swan notes that the composition of the ACATs varies greatly across the country. Identify the members of your ACAT. If you could add another professional, who would you choose and why?
- (ii) How easy is it for your team to consult with other relevant health professionals?
- (iii) Dr Graffen notes the importance of the relationship between the ACAT and the local General Practitioners. How well does this relationship work for your team? What might be done to facilitate that connection?

Components of the assessment

The panel refers to the assessment process on several occasions, but it is perhaps helpful to identify the various components in more detail. A number of factors need to be a part of every assessment.

(i) Medical condition

A person's medical condition, as decided by suitably qualified medical personnel, should be obtained and assessed. If the person is medically unstable in hospital, the assessment should not proceed until their condition is stabilised and any rehabilitation is completed.

(ii) Physical capability

The assessor should use appropriate validated tools to gather evidence of the person's capacity to perform the activities of daily living, with specific regard to:

- mobility
- maintenance of personal hygiene
- eating and drinking;
- the client's level of independence, and
- ability to manage health conditions, including medication compliance and management.

The assessor should also consider the person's potential for rehabilitation, which might be based, for example, on their capacity to benefit from a period of short-term low-intensity therapy and support, such as physiotherapy, occupational therapy and social work, that might be provided in transition care.

(iii) Cognitive/behavioural aspects

Assessment should determine whether the person has dementia or other cognitive conditions, or behavioural problems related to these or other conditions and/or the presence of depression or delirium and will have specific regard to:

- evidence of verbal and physical aggressiveness and disruption, self-destructive behaviour, confusion and/or impaired judgement, reasoning or attention; and
- medical tests from the person's general practitioner or medical specialist for a more detailed picture of their health status.

The need for a guardianship order may also be considered, where appropriate and necessary. Other psychosocial factors such as the person's perception of loneliness, bereavement or loss of motivation also need to be considered.

(iv) Social factors

ACATs should fully assess the person's support networks, including the identification of the social needs of the person and the extent and availability of social support (including family, carers, neighbours and friends).

The needs of a person's carer should also be considered to assess their ability to continue to provide care and support. Referral to carer specific support services should also be considered.

If a person does not have informal social networks, other ways to assist them to meet their social needs should be considered. Social issues may also include cultural factors, financial considerations and possible cases of neglect or abuse.

(v) Physical environmental factors

These factors relate to abilities and limitations within the person's living environment. ACATs should consider the nature and suitability of the physical environment, including safety issues which may require resolution, and modifications or equipment that a person may require to remain in their own home as independently as possible.

(vi) Personal choice

ACAT assessments involve a consultative process. ACATs therefore need to ensure the person being assessed has access to information about the process and all appropriate care options available to them. The person's preferences of care services and living arrangements must be considered within the assessment process.

Main Points from the program discussion:

- The aged care assessment process is intended to be comprehensive, involving older people and their carers, and their families

- ACATs usually seek to enable older people to remain healthy and living independently; the assessments are intended to delay entry into residential care where appropriate
- Anyone can refer to the ACAT, but the client needs to give consent and to be involved in the application for an assessment (although consent and application for approval can be signed by a carer when necessary)
- Urgent referrals can be responded to within 48 hours
- It's useful when working with Indigenous communities to work with one of the community members as a liaison person
- In areas of limited resources there is a lot more 'multi-tasking' on the part of professionals when it comes to making the relevant assessments

Activity 9

Activity 9

In the program, Dr. Swan asks about the variability of the assessment process. Review the above components of the assessment process and select one that you think your team does not address as well as it might. Identify the reasons. What extra resources (professional, informational, educational) are needed to increase your assessment skills in this area?

Activity 10

Activity 10

What multi-tasking is necessary in your team? What resources and information do you need to increase the team's capacity in this regard?

Available Care Packages

The ACAT approves people for Australian Government subsidised aged care services, including Residential Care, Residential Respite care, Community Aged Care Packages, Extended Aged care at Home Packages, Extended Aged Care at Home Dementia Packages, and Transition Care. They also refer people to other appropriate care services.

Residential Care

Residential care is for frail older people whose overall care support needs cannot be adequately met in the general community. ACATs assess people for either low or high levels of residential care, depending on their level of care needs.

Low level residential care may include:

- assistance with bathing, showering/personal hygiene;
- organising and supervising and administering of medication;
- toileting and continence management;
- meals;
- transfers/mobility;
- dressing;
- fitting sensory/communication aids;
- assessment and referral for appropriate support;
- communication assistance;
- provision of special diets and emotional support.

High level residential care is provided to very dependent people either by registered nurses or under the supervision of registered nurses. In general, these clients would require complete or almost complete assistance with the majority of the activities of daily living, and no longer be able to be adequately supported at the low care level.

Residential Respite Care

Residential respite care may be used on a planned or emergency basis to help with carer stress, illness, holidays, or non-availability of the carer for any other reason. Respite care is provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. An ACAT assessment is required for residential respite care.

Community based respite does not require an ACAT approval and can be accessed directly through the Commonwealth Respite and Carelink Centres, HACC and planned activities groups.

Residential respite care is available at a high or low level and ACAT assessors should assess a person's eligibility as they would for permanent residential care.

A person can be approved for residential respite care and other care types at the same time.

Community Aged Care Packages (CACPs)

The Community Aged Care Packages are individually planned and coordinated packages of care tailored to help older Australians remain living in their own homes.

CACPs are very flexible and are designed to help with individual care needs. The types of services that may be provided as part of a package include:

- personal care;
- social support;
- transport to appointments;
- home help;
- meal preparation; and
- gardening.

Extended Aged Care at Home Packages (EACH)

The EACH packages are also individually planned and coordinated, assisting older people who require a high level of care to remain living in their own homes.

The types of services that may be provided as part of an EACH package include:

- registered nursing care;
- care by an allied health professional such as a physiotherapist, podiatrist or other type of allied health care;
- personal care;
- transport to appointments;
- social support;
- home help; and
- assistance with oxygen and/or enteral feeding.

Extended Aged Care at Home Dementia packages (EACHD)

The EACHD packages are aimed at helping older Australians who experience difficulties in their daily life because of behavioural and psychological symptoms associated with their dementia. The types of services available are similar to those provided with the EACH packages; but they also include strategies to meet the specific needs of care recipients with dementia who experience behaviours which may impact their daily quality of life.

Transition Care Program

The Transition Care program is designed to improve older people's independence and confidence after a hospital stay. The Transition Care Program is for older people who would otherwise be eligible for residential aged care.

It aims to help older people leaving hospital to return home rather than prematurely enter residential care. It provides older people with a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and nursing support and/or personal care. It helps older people complete their restorative process and optimise their functional capacity, while assisting them and their family or carer to make long-term care arrangements.

Clients must be assessed by an ACAT while they are still an in-patient of the hospital. A transition care client can only enter transition care directly upon discharge from hospital. Care can be provided in either a home-like residential setting or in the community. The average duration of care is 7 weeks, with a maximum duration of 12 weeks that may in some circumstances be extended by a further 6 weeks.

Activity 11

Activity 11

Dr. Graffen comments in the program that the EACH packages only work if there is a full-time capable carer at home, because there is no provision for care after hours. What do you think of his comment? What are the implications?

Case Study 1

CASE STUDY 1: Stefano

Stefano

- 90 year old Italian man living with his 2nd wife, Rosa
- One son from previous marriage
- Son lives interstate, visits 3 x per annum, some conflict with stepmother over father's care
- Stefano -some confusion, occasional reversion to Italian, wanting to stay at home, still driving

Stefano

- Rosa, 81 yrs, fears for Stefano's safety when he is alone,
- has enduring power of attorney for husband
- Stefano presents to local hospital after a fall.
- Rosa complains of stress and fatigue

Activity 12

Activity 12

- (i) What members of your team would be involved in Stefano's assessment?
What other professional resources might be necessary and how would you access them?
- (ii) What family members would you involve in this assessment? What difficulties might you anticipate and what would you do to address them?
- (iii) How do you manage a potential conflict between the client's rights, and those of the carer?
- (iv) How would you balance Stefano's independence on one hand, and any potential risks on the other e.g. driving?
- (v) How might the family issues affect your decision about recommendations for care?

Activity 13

Activity 13

- (i) On the basis of the limited information available here, what would you consider is the best 'package' for Stefano?
- (ii) Do you have the resources available in your community to put your intervention plan into effect? If not, identify how lack of resources affects your assessment and your intervention recommendations.
- (ii) What resources could be put in place to assist Rosa in caring for Stefano at home?

Main Points from Discussion

- There are two major issues of concern: first, to get an accurate diagnosis (is Stefano acutely ill, or is he suffering from dementia, depression, or delirium?); second, to assess Rosa's level of exhaustion, as it is central to the question of what sort of ongoing service provision is most appropriate
- It is important to distinguish between dementia and delirium: dementia starts imperceptibly, whereas delirium starts suddenly, but may last a long time and become permanent
- Such a presentation often does involve the whole family, and family history and observations over time can be a very significant part of the assessment process
- There are a number of options available for Stefano, depending on the family situation

Activity 14

Activity 14

- (i) Does your team have the resources and skills to distinguish between delirium, dementia, and depression? Plan a professional development presentation that would help familiarise all members of your team with these differential diagnoses.
- (ii) How would your recommendations for Stefano be different in each case?

Case Study 2

CASE STUDY 2: Mary

Mary

- 87 year old pensioner
- Lives independently in country town (pop. 8000)
- Husband died 5 years ago
- Two children- son lives interstate, daughter local
- Working daughter visits twice a week

Mary

- 3 falls in the last 3 months, usually in the evening
- Forgetting to take evening medication
- 2-3 glasses of wine an evening
- Uses walking stick, no longer drives
- Mary hospitalised after a fall and a fracture
- Hospital based Aged Care Assessment Team has assessed Mary

Activity 15

Activity 15

- (i) What do you think are the most important diagnostic factors to consider here?
- (ii) What might be some of the barriers to Mary accessing the services she needs?
- (iii) Do you agree with the recommendation mentioned in the program that Mary be offered a Community Aged Care package? If not, what would you be recommending?

Main Points from Program Discussion

- It is unclear whether Mary's degree of cognitive impairment is reversible, and thus whether she really needs residential care
- It's also unclear what is the burden of care on Mary's daughter, given Mary's drinking and possible dementia
- It can be difficult if an aged person – like Mary – resists the intervention of an ACAT

Activity 16

Activity 16

Dr. Swan raised the situation of an aged person resisting the intervention of the ACAT.

- (i) Think of someone you have come across who has resisted your help. What do you think were the factors involved? How does your team usually manage such a situation?
- (ii) What factors might prompt Mary to refuse assistance?
- (iii) How could the team help Mary to access the recommended care and services?

Activity 17

Activity 17

This case raises the situation faced by carers.

- (i) What level of risk do you think Mary's daughter should be asked to manage?
- (ii) Think of a family you know where the responsibility of caring for an aged person has become unmanageable for the carer. How can the team help address this?
- (iii) What resources are available for carers in your community? What possibilities exist for developing more supports for carers?

Case Study 3 CASE STUDY 3: Joe

Joe

- 63 year old Aboriginal man living in remote community
- Preferred language - Ngarinyin
- Retired, previously worked as a drover
- Wife deceased, 3 children- 2 deceased
- Son lives in town 450kms away, visits 2 x year
- Mild cataracts, hypertension, past history of Hansen's disease

Joe

- Joe had a stroke and was flown by RFDS to Perth 3000 kms south of his community , where he stayed for 6 weeks
- He has returned to the community with mild left hemiparesis and is able to walk with the aid of a walking frame
- Nephew Bert is assisting with care
- Clinic nurse contacted the ACAT clinician in nearest town, 320 kms on unsealed road, requesting urgent assessment

Activity 18

Activity 18

- (i) In the program, Dr Swan asks one of the panel members what their response would be if they received the request for an urgent assessment. How would you answer that question?
- (ii) What particular issues do you think need to be taken account of when working with Indigenous older people?
- (iii) Develop an outline for a professional development presentation dealing with issues of cultural awareness and cultural safety when it comes to working with Indigenous older people in your local area. What resources can you draw on in your community to help with this?

Activity 19

Activity 19

- (i) Download and look at the KICA (Kimberley Indigenous Cognitive Assessment tool) from the website address given in the program (www.wacha.org.au/kica.html).
- (ii) Discuss the difficulties of assessing an older person whose first language is not English, or who has reverted to their original language, for signs of cognitive impairment.
- (iii) How successfully is your team able to address this difficulty?

Activity 20

Recent Developments in the Aged Care Assessment Program

Activity 20



National Review of Aged Care Assessment Teams, 2007

- **National Training Strategy / National Training Resources**
- **Information sheets and website information**
 - www.health.gov.au/acats
 - www.agedcareaustralia.gov.au
- **Legislative changes- to reduce unnecessary assessments and reassessments**
(www.health.gov.au/acats for more info)

- (i) Discuss the recent changes to the legislation. Make an outline for a professional development presentation that summarises the most important changes, and their impact on the team's work, for your team members.
- (ii) Do you think other health professionals in your area are aware of the changes? Which ones do you think would be helpful for them to know about? How would you go about publicising them more effectively?
- (iii) Do you agree with the panel members that the changes have had a significant impact on waiting times in your community?
- (iv) If you are not already using them, download the appropriate information sheets for consumers from the website address provided in the slide.

Take Home Messages

KATE SMITH: It's really important to build relationships with the aboriginal community and local services.

DEBRA TOOLEY: I think the Aged Care Assessment Program needs to be seen as a program that can offer people interventions to improve their health and lifestyle, rather than just assessing eligibility for Commonwealth subsidised aged care services.

DR MAX GRAFFEN: For General Practitioners, I think it's really important to get to know the full range of aged care services, in your area, and also to get to know your aged care team on a personal basis. Be open to their feedback, and think about the possibility of dementia early on.

DR JANE TOLMAN: It's important to acknowledge that old people have low reserve and that if we are going to meet their needs we need to work collaboratively. We need a good history. We've got to acknowledge who we are dealing with here, who's got the problem, what is their problem, and what do they want. Let's be focused on the client.

Activity 21

Activity 21

Review the take-home messages from the panel members. What would your take-home message be?