# Linkages

# BARWON

Service Delivery Model for the Confused Elderly

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89006

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## PHILOSOPHY

- Recognition that the needs of aged people should be met in their own homes wherever possible and be cost effective, in preference to institutionalised care.
- Acceptance that care services should place the least restriction on the lives of those being cared for.
- Greater emphasis on involving service users and their advocates in all aspects of service provision.
- Recognition of the importance of informal care, particularly the role of carers.

## PROJECT GOAL

To prevent premature or inappropriate entry into the residential care area, by older people within the project area suffering from memory loss and confusion.

### Project Objectives

*PRIORITY ONE*

Develop a programme to prevent inappropriate admission of target group into residential care.

STRATEGY:

1. Determine eligibility criteria for project
2. Produce referral format
3. Determine assessment procedure
4. Establish case planning, case management & review
5. Develop service co-ordination
6. Develop a system to identify service gaps and methods to overcome the same
7. Develop an information and media strategy to publicise Linkages' aims

TARGET 60 and over who suffer from memory loss and/or confusion

| | | |
|---|---|---|
| K.P.I. | 1. | Reduction of inappropriate admissions into either nursing homes or hostels |
| | 2. | Greater service co-ordination |
| | 3. | Development of flexible services to meet consumer needs |
| | 4. | Increase public awareness of services currently available. |
| | 5. | Items in local newpapers, posters etc. Launch of project |
| WHO DOES IT? | | Co-ordinator<br>Committee |

*PRIORITY TWO*

| | | |
|---|---|---|
| OBJECTIVE | 1. | Ensure that project remains within the allocated budget |
| | 2. | Ensure that service providers are paid |
| | 3. | Ensure that financial monitoring forms are returned to CSV Head Office as required |
| STRATEGY | 1. | Monitor service expenditure |
| | 2. | Develop administrative systems to track co-ordination costs and unit expenses |
| TARGET | Budget | |
| K.P.I. | 1. | Budget is not exceeded |
| | 2. | Service providers are paid for service provision |
| | 3. | Financial monitoring forms are returned within the time frame |
| WHO DOES IT? | | Co-ordinator |

*PRIORITY THREE*

| | |
|---|---|
| OBJECTIVE | Training |
| STRATEGY | Provide access to training resources for both staff and carers |
| TARGET | Staff and Carers |
| K.P.I. | Degree of participation and interest by staff and carers |
| WHO DOES IT? | Co-ordinator |

Desirable Project Outcomes

Linkages should have the following outcomes for its clients:

- Recognise the value of a caring family.
- Help people avoid premature or inappropriate admission to long term residential care.
- Make access to the full range of services simple and easy.
- Assure individuals of continuing service.
- Determine care requirements on equal terms with the individual.
- Respond flexibly and rapidly to the changing care needs of the individual.

Service Delivery Options

1. Provide better information from the client perspective about what service packages are needed.
2. Improve cross-service referral.
3. Ensure better cross-service sharing of resources and reduced duplication i.e. avoiding multiple assessment.

Improved and more flexible responses fomr service providers.

Project Size: 100

# INTAKE AND ELIGIBILITY

## Client Analysis

As outlined in the Linkages programe guidelines, four levels of dependency have been proposed, with a flexible mix of consumers recommended as follows:

| LEVEL | % OF CONSUMERS as at Nov 1988 | % OF CONSUMERS suggested Mar 1989* |
|---|---|---|
| Least dependent | 20 | 5 |
| 2nd level dependency | 30 | 20 |
| 3rd level dependency | 45 | 30 |
| Most dependent | 5 | 45 |

The dependency level of each client will be assessed according to the levels of service required and the consequent costs.

*The suggested changes to the client percentages at each dependency level were made in the light of statistics for the project which indicated very small numbers at the lower level of dependency.

## Client Distribution

A suggested distribution of urban to outer rural municipalitites is 75% to 25%

| 75% LEVEL | 25% LEVEL |
|---|---|
| Geelong | Leigh |
| Geelong West | Barrabool |
| Corio | Bannockburn |
| Newtown | Otway |
| South Barwon | Colac City |
| Bellarine | Colac Shire |
| Queenscliff | Winchelsea |

Using the persons stated Dependency Level, numbers would look like:

| DEP. LEVEL | OLD % | NUMBERS | NEW % | NUMBERS |
|---|---|---|---|---|
| 1 | 20 | 15:5 | 5 | 4:1 |
| 2 | 30 | 23:7 | 20 | 15:5 |
| 3 | 45 | 34:11 | 30 | 23:7 |
| 4 | 5 | 4:1 | 45 | 34:11 |

Proposed Client Intake

| | | | |
|---|---|---|---|
| 1988 | October | 5 | 4:1 |
| | November | 15 | 11:4 |
| | December | 25 | 19:6 |
| 1989 | January | 30 | 22:8 |
| | February | 30 | 22:8 |
| | March | 45 | 34:11 |
| | April | 50 | 38:12 |
| | May | 60 | 45:15 |
| | June | 70 | 52:18 |
| | July | 85 | 64:21 |
| | August | 100 | 75:25 |

SUGGESTED PROPORTION OF LINKAGES CLIENTS FROM MUNICIPALITIES IN THE BARWON REGION (1986 Census)
*Using new percentages for each dependency level*

| MUNICIPALITY | Pop'n 60+ | % Pop'n 60+ | Dependency Levels(new %) CLIENT NUMBERS 1 | 2 | 3 | 4 | TOTAL CLIENTS |
|---|---|---|---|---|---|---|---|
| URBAN | | | | | | | |
| Bellarine | 5543 | 19.85 | 1 | 3 | 4 | 7 | 15 |
| Corio | 6625 | 23.73 | 1 | 3 | 5 | 8 | 17 |
| Geelong | 3141 | 11.25 | - | 2 | 3 | 4 | 9 |
| Geelong West | 3416 | 12.23 | 1 | 2 | 3 | 4 | 10 |
| Newtown | 2138 | 7.65 | - | 1 | 2 | 3 | 6 |
| Queenscliff | 1092 | 3.91 | - | 1 | 1 | 1 | 3 |
| South Barwon | 5960 | 21.35 | 1 | 3 | 5 | 7 | 16 |
| Sub-total | 27915 | 100.00 | 4 | 15 | 23 | 34 | 76 |
| RURAL | | | | | | | |
| Bannockburn | 397 | 6.69 | - | - | 1 | 1 | 2 |
| Barrabool | 1097 | 18.51 | - | 1 | 1 | 2 | 4 |
| Leigh | 208 | 3.50 | - | - | - | - | - |
| Colac City | 1987 | 33.53 | 1 | 1 | 2 | 4 | 8 |
| Colac Shire | 828 | 13.97 | - | 1 | 1 | 2 | 4 |
| Otway | 619 | 10.44 | - | 1 | 1 | 1 | 3 |
| Winchelsea | 790 | 13.33 | - | 1 | 1 | 1 | 3 |
| Sub-total | 5926 | 100.00 | 1 | 5 | 7 | 11 | 24 |
| GRAND TOTALS | 33841 | - | 5 | 20 | 30 | 45 | 100 |

## Client Admission to Project

Before committing the project to an ongoing involvement with a prospective client, the Co-ordinator should satisfy himself that without support at home, the client is likely to go to a hostel or nursing home before he/she really needs such an intensive level of care.

Priority should be given to people for whom basic support is most likely to make the greatest difference in preventing premature or inappropriate institutional care. This means that people with the most intensive needs are not automatically given the highest priority.

## Eligibility

The project is open to older people within the Barwon Region who are suffering from memory loss or confusion, whom without assistance are likely to be admitted into either a hostel or nursing home before that level of care is necessary.

Age: Older people are defined as 60 years and over

## Exclusion Criteria

* Older people whose preferred option is to go into residential care to receive the intensive levels of service they may require;
* Where the costs to maintain the person within the community are greater than those found in the residential area;
* Older people whose continued support at home may seriously exacerbate a carer's health problems.

NOTE:- Given the target population of this project it is essential that an external advocacy body review the project's rationale for client exclusion.

# CASE MANAGEMENT & THE ROLE OF THE CASE MANAGER

Function

Case Management's aim is to integrate the range of services required by the consumer to enable service delivery to better meet the clients needs.

Basic to this approach is the preparation of an initial assessment of the clients needs. From such an assessment the Case Manager should be able to develop a "Care Plan" that outlines the service requirements of the consumer, specifies the probable duration of the service provision, frequency and type of services to be provided.

Goals of Case Management

- Act as a focal point for all community based services;
- ensure that the client has access to the range of services appropriate to their need and in the sequence which will be most beneficial to them;
- ensure that any changes in the clients situation are identified and that appropriate remedial action is taken;
- prevent any unnecessary duplication of service;
- document gaps in services to enable future planning to rectify these.

The Case Manager has a responsibility to develop a broad overview of services currently available to assist the target group.

After the initial assessment has been completed and a lead agency appointed, the Case Manager is responsible to develop a Care Plan within the allocated time span (extensions to this date are subject to negotiation with the Linkages Co-ordinator).

The Care Plan should contain:

- description of problem,
- goals to be achieved,
- agencies and people responsible for service provision.

[See section Development of a Care Plan in CARE PLANNING PROCESSES & STRUCTURES]

## CARE PLANNING PROCESSES AND STRUCTURES

A most fundamental issue for the Linkages Project is that processes established for assessment, care planning, management and review place emphasis upon the needs of older people and their carers and facilitate easier access to the numerous range of services available.

The Care Planning process refers to a range of activities related to the specification of the support required by an individual and the strategies to be implemented to provide that support. These activities or elements of the Care Planning process are:

Information Collection;

Analysis of information and development of possible plans;

Consultation with those affected by the planning;

Decision making;

Monitoring;

and Review.

Care Planning is the decision-making about the consumer by the body established for this purpose, for example, a case conference committee.

A care plan is an action statement about how the goals in respect of a particular consumer are to be achieved.

Care planning principles enunciate the values and directions which decisions made in respect of individuals as part of the care planning process, should be in accordance with.

### Purpose of Care Planning Meetings

The outcome of the formalised decision-making process is a care plan. The Care Planning Meeting is the structure through which these decisions are made.

These decisions include:

- the desired outcomes for the older person and his/her carer(s);
- the changes required to achieve these outcomes;
- the tasks or activities that will facilitate these changes;
- the services required to carry out these tasks, and the quantity required;

- the determination of fees for services required;
- the appointment of a Case Manager to co-ordinate the delivery of services to the consumer;
- the review date;

Having established the services and quantity of service required by the consumer, the Project Co-ordinator will need to calculate the cost of these services. Care plan decisions concerning services required trigger the authorization by the Project Co-ordinator for the allocation of grants.

Care planning meetings should be re-convened if major changes to the care plan are required, and which vary the allocated grant levels.

Development of the Care Plan

The development of the individualized care plan should be a co-operative process between the Case Manager, the client and/or carer and family members in terms of the client's needs and the family's functioning as a whole. The Case Manager will consult with other specialized areas i.e. General Practitioner, Nurse etc. to ensure appropriate care planning co-ordination. Every precaution must be made to protect client confidentiality. Only necessary information should be communicated to agencies involved in the care plan. Activities, and or services to be provided to the client should be framed around minimal intrusion into the persons life i.e. least restrictive intervention.

In each of these areas the following key questions should be asked so that appropriate long term goals and strategies can be developed:

*How appropriate are the persons present circumstances?

*Does the person need support in this area of life activity?

*How could this be provided in the most appropriate and least restrictive manner?

*What strategy should we use to bring this about?

*Who is most appropriate to do this?

It must be stressed that selection of goals should be governed by the identified needs of the client and not limited to that which can only be provided by present resources. The advantages of the "Care Plan" is the identification of the wide range of services needed by clients which cannot currently be provided.

## Operationalisation of the Care Plan

The Case Manager contacts any agency to whom the client has been referred for service as soon as possible after the Care Plan Meeting, to ensure that services have begun.

The Case Manager acts as a central point to facilitate communication between other agencies. This is essential as Case Management is about a "planned approach" for serving clients.

## Review and Update of Care Plan

Case review should be an ongoing process however, at quarterly intervals (or more frequently depending on the individual) the Case Manager should undertake a detailed re-assessment of the current care plan.

An external review of the care plan will be undertaken by the Linkages Co-ordinator on a six monthly basis.

## Case Closure/Service Termination

A clients case may be closed for one of the following reasons:

- Change of placement;
- Client has moved out of service area;
- Client has died;
- Services are no longer needed;
- Family or other persons intervening;
- Other.

## SUMMARY OF CARE PLANNING

Care Plans often fail because they are overly optimistic or pessimistic. Demanding too much of the client aggravates existing symptoms and may cause his/her withdrawal, or may hold out false hope to family and friends. Expecting too little may lead to helpless or hopless behaviour.

Keep an open mind, and celebrate with client and family small victories.

-key to effective care:-

'hope and flexibility'
'take one day at a time and go with the flow'

Developing, monitoring and evaluating care plans demands creativity, patience and judgement from all levels of staff, as well as from family. These plans MUST be constantly revised with changes in the clients self care capacity or as other illnesses develop. Families of care givers should participate in care planning, to the extent they are interested and capable i.e. actual participation in team conferences.

Once a care plan is developed it must be well understood and followed by all levels of staff, family and visitors.

Care Plan's should be developed over a period of time so a multi-disciplined approach can be adopted - to encourage consistent approaches, each client, caregiver, family and staff person should be encouraged to contribute suggestions and observations on the clients response to the plan. A good care plan recognises the family as a client and includes an assessment of the family's needs and capacities as well as the direct client.

Care plans should be specific - more specific than "encourage independent functioning". The plan should specifically list what the client can do for herself/himself, what she can do with some assistance, and which activities require total assistance. By utilising these methods we are able to document any real changes in the individual.

Care plans should set individual priorities. The plan should encourage all external staff to tolerate any especially meaningful client or family routines or preferences. Eg. person may have a special security object - let the person wear her special hat to bed if thats what she wishes to do.

Teach staff/family/carers how to prevent, divert or distract a client from potential difficulty rather than arguing, convincing or explaining.'Model' or demonstrate helpful strategies - It's best to take nothing for granted in developing care plans.

Professionals should not take over too early - it is better to do 'with' than 'for' (as long as possible), even if it takes longer or is not done perfectly.

Protection from frustration, embarrassment, or risk must be based on observations OVER TIME (client centred).

All phases of care planning should be personalised or individualised to each client routine, Care plans should suggest consistent approaches by carers, family and staff, using recommendations from carer, family and staff.

Assessing for service requirements within Linkages is not diagnostic but rather is concerned with determining on an equal basis with the client:

- what forms of assistance will make the difference in helping him/her to confidently remain living at home;

- what forms of assistance are family and other informal carers able and willing to provide if given appropriate support.

*As an important focus is on ensuring the client/carer is confident with his/her living and support arrangements, the assessment needs to primarily deal with what the client identifies as being "the help that would make the difference".

FORMULA:

1 What does the client want

2 What does the client currently have

3 What is required

1 - 2 = 3

## REFERRAL FLOW CHART

| Stage | Action |
| --- | --- |
| REFERRAL TO PROJECT | |
| PROJECT CO-ORDINATOR | Assess quickly whether person is eligible. |
| ASSESSMENT PROCESS | Refer to Geriatric Assessment Team for assessment (via General Practitioner).<br>Input from local services involved with client. |
| DEVELOPMENT OF CARE PLAN | Completion of Care Plan Form by current major service provider or other appropriate person. |
| CARE PLAN MEETING | Organised by Co-ordinator.<br>Attended by representatives from major service providers currently or likely to be involved.<br>Optimum to be held within three weeks of referraL.<br><br>TASKS:<br>1. Identify services, quantity required & who should provide service. Agencies present take responsibility to provide services required.<br>2. Calculate cost of services and fees.<br>3. Appoint Case Manager based on who is likely to provide most service and who has had most previous contact, most likely to be Local Government or District Nursing. May be from ethnic or aboriginal or non-govt organis-ations.In difficult cases where a complex range of services is required or where the person's condition is likely to be very unstable, the GAT might need to take on Case Management.<br>4. Set appropriate review date. |

5. Assist Case Manager with location of services in cases where unusual services are required.

6. Any service required but unavailable should be recorded and passed on to Co-ordinator.

NOTE:- Care plan decisions concerning services required should be authorized by the Co-ordinator. Major changes will need to go back to a CPM for review.

| | |
|---|---|
| IMPLEMENTATION OF CARE PLAN | Case Manager is responsible.<br>Organise services not negotiated at Care Plan Meeting.<br>Liaise with other services working with client.<br>Monitor progress and if change in level of service required, initiate action if minor, or go back to Care Plan Meeting if major. In urgent situations can be authorized by Co-ordinator. |
| REVIEW | Six monthly |

# THE CASE RECORD

## Purpose

To locate in one area information pertaining to the client covering:

A. Client Assessment

B. Care Plan

C. Client Authorization Release

D. Case Notes

E. Review Forms

F. List of agencies involved in case

## Case Record Standards

Client records must be kept in a locked file within the agency that has case management.

Clients and carers must be informed of the purpose for collecting information and how it will be used and disseminated. Clients are to be informed that information is required to assist in service provision and will be treated in a confidential manner. This information should be available for review by the client/carer/guardian to determine accuracy, relevance, etc. of information.

NOTE:- Client/carer/legal guardian has the right to review the case record. Before this occurs the Case Manager should ensure that the file is up to date.

One copy of any/all case records can be given to the carer or guardian. Other services providing reports to Linkages should understand this information clause. However, before any medical/psychological reports are either released to carers etc. or viewed by the same, the authors of the reports must be contacted first.

## Retention of Case Records

At the close of the case, the case record is to be returned to the Linkages Office for registry filing.

## Guidelines for Recording Case Notes

Case notes illustrate the activity required to carry out the care plan. The reader of these notes should be able to ascertain the current case direction and its appropriateness.

Case Record is broken down into two areas:

1) **Contact Summary**
   Date of contact; Type of contact i.e. was it phone, office or home visit; and who was the Service of contact.

2) **Ongoing Case Record**
   i.e. Case notes

EXAMPLE OF CASE NOTES:

**Contact Summary**

| Date of Contact | Type | Source |
|---|---|---|
| 20-1-88 | Phone call | Case Manager |
| 22-1-88 | Home visit | Case Manager |
| 24-1-88 | Phone call | Case Manager |

**Discussion Notes**

Telephone call received from Mr. Jones re current living problems.

Services presently involved are Home Care, Meals on Wheels and District Nursing.

Services which are required and need to be arranged are: transportation to Health Centre; referral to Senior Citizens Centre.

It was clear from home visit that Mrs. Jones requires external socialization as due to Mr. Jones illness, she has bee confined within the home.

**Outcome**

Home care to continue.
Confirmed Health Centre appointment and arranged transport.
Contacted Senior Citizens Centre and organised for Mrs.X to meet Mrs. Jones and introduce her to others.

Case Manager:xxxxxx Date:xxxxxx

## APPEAL MECHANISMS

All organisations and consumers of the services must be informed of their Case Manager and the method of information collection and review. Further, it must be made clear to them, both verbally and in writing, that being involved with Linkages will require:

- a full assessment of their needs;
- liaison between services providing assistance (eg. Home Care, General Practitioner, District Nursing)
- appointment of one worker to act as Case Manager;
- development of a case plan that will meet client's individual needs.

Clients and carers and/or guardians should understand that any concerns that they have can be raised directly to the relevant agency. If this does not resolve the issue then the Case Manager would play an active role in problem resolution. If the issue has not been satisfactorily resolved, or if the persons concerns are beyond the capacity of the organisation, then the Case Manager would refer the matter to the Linkages Co-ordinator for resolution.

NOTE:- For a detailed description on the keeping of client records, recording etc. see section headed THE CASE RECORD.

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