

# **POA2: Training and trialing in the Northern Metropolitan Region**



**National Ageing Research Institute**

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## 1. Background and training schedule

The need to introduce a consistent approach to determining priority for HACC services was identified by the seven Local Government HACC agencies in the Northern Metropolitan Region (NMR) of Victoria. To meet this need they decided to fund the National Ageing Research Institute (NARI) to train assessment staff in the use of a Priority of Access (POA) tool developed for use in the Western Metropolitan Region (WMR).

The tool was developed in consultation with local government management and assessment staff in the WMR<sup>1</sup>. During its development the tool was trialed by three Local Governments in the WMR. After development, trial and modification of the tool, a training program was developed<sup>2</sup>. This training program included an initial 3 hour training program that included an introduction to the tool and how it was developed. The training also included how to complete the tool using two case studies. Following this training, staff trialed using the tool for two months and were then invited to return for a follow-up session to discuss any issues they had while using the tool. Any staff queries were discussed and clarified and suggestions for improving the tool were invited. Following these follow-up sessions weightings were added to half of the items and other small modifications were made. This led to the revised version 'POA2'.

POA2 is a double-sided score based tool that covers 14 factors that are likely to impact on risk and urgency for accessing HACC services. Seven of the items have been determined as having a greater impact on risk and are therefore given a higher score than the remaining seven items. These 'weighted' factors include; domestic and personal care activities of daily living, cognitive impairment, behavioural issues, carer availability and status and nutrition. The remaining seven items include communication, self rated health, vision, hearing, falls risk, social interaction and environmental hazards. Where possible, items correspond directly with items from the Service Coordination Tools (SCoT) and therefore only require some transcribing from the SCoT tools. Some items, however, are not addressed on the SCoT tools but were considered important for assessing priority. These included; carer status, communication, social interaction and environmental hazards.

The training program to be undertaken in the NMR was to be a revised version of the training undertaken in the WMR (revised to reflect most recent modifications to the tool). Consistent with the training program in the WMR staff will be invited to an initial 3 hour training program, followed by a two month period to trial the tool and a follow-up session to raise issues and make any suggestions for alterations. The training objectives, program outline and case studies used are included as Appendices to this report.

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<sup>1</sup> National Ageing Research Institute (2002). Development of a priority of access tool for WMR Local Government HACC providers. Parkville, Western Metropolitan Region, Department of Human Services.

<sup>2</sup> National Ageing Research Institute (2003). Priority of Access tool training for WMR Local Government HACC services. Parkville, Western Metropolitan Region, Department of Human Services.

Training in the WMR found that staff who had routinely been using the SCoT tools before POA training, were able to grasp the POA tool much more easily than those who were not familiar with the SCoT tools. It was, therefore, recommended that staff in the NMR were routinely using the SCoT tools before being trained in use of the POA2.

Three initial training sessions and two follow-up sessions were held on the dates as shown in Table 1. In total 40 staff attended the three initial training sessions and 16 staff attended the two follow-up sessions. No staff from Nillumbik or Moreland attended either the initial or follow-up training sessions. Moreland was in the process of implementing the SCoT electronically on laptops and felt that it was too early to begin training for using the POA2. Although fewer staff attended the follow-up sessions, the five Local Governments represented at the initial training were also present at the follow-up sessions.

**Table 1: Training program timetable**

<b>16<sup>th</sup> September</b>	<b>15<sup>th</sup> October</b>	<b>5<sup>TH</sup> November</b>
Hume Council 9.30 – 12.30  Hume (6) Darebin (13) Whittlesea (1)	Banyule City Council 9.30 - 12.30  Banyule (7) Nillumbik (0) Whittlesea (2) Hume (2)	Moreland Council, Coburg offices 9.30 –12.30  Darebin (2) Whittlesea (4) Yarra (3)
Feedback mtg Tues, Nov 18 <sup>th</sup> , 9.30 – 10.30 Hume Council  Hume (2) Darebin (3)		Feedback mtg Tues Dec 16 <sup>th</sup> <i>(for participants attending 15<sup>th</sup> Oct and 5<sup>th</sup> Nov).</i> 9.30 – 10.30 Banyule Council  Banyule (4) Whittlesea (4) Yarra (3)

The key focus of this report is to provide the feedback from staff from the follow up sessions and the trial period between the initial training and follow-up session. The last chapter provides a summary of the changes recommended before full implementation in the Northern Metropolitan Region.

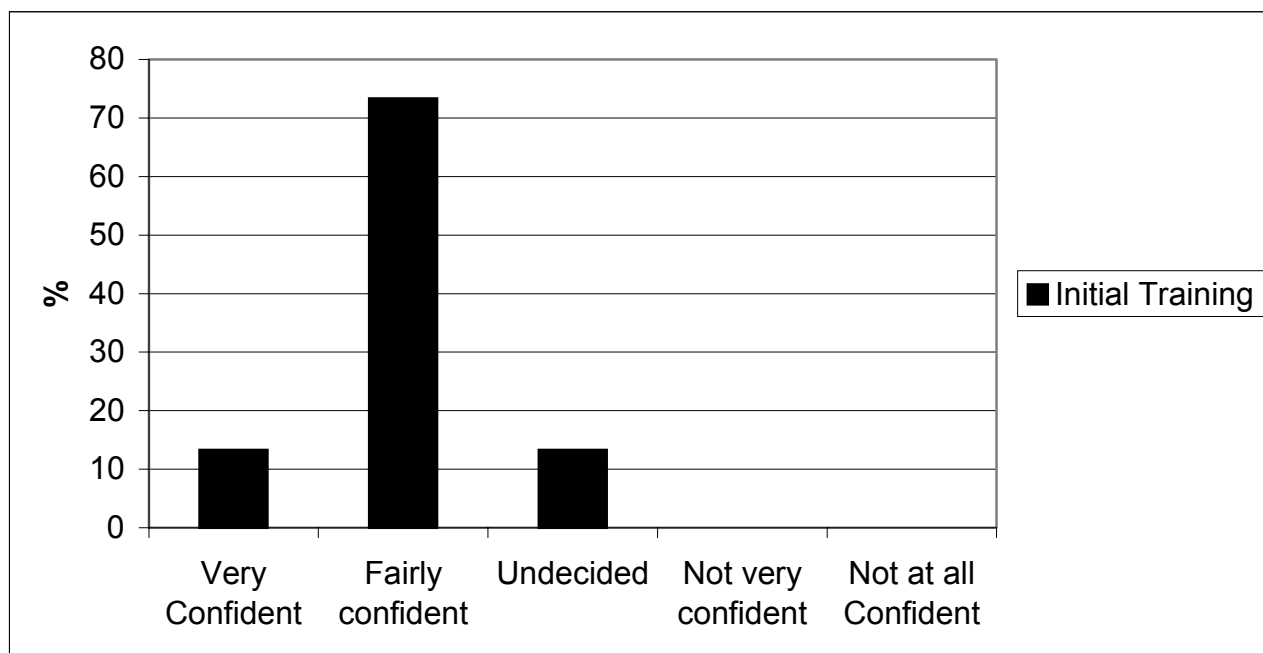
## 2. Summary of Evaluation forms

This chapter provides a summary of the feedback obtained from participants who attended training in use of the Priority of Access tool (POA2) in the Northern Metropolitan Region. Sessions were held on 16<sup>th</sup> September (20 participants), 15<sup>th</sup> October (11 participants) and 5<sup>th</sup> November (9 participants). Of the 40 participants attending the training, evaluation forms were received from 30 participants. The 30 evaluation forms have been compiled to provide the following summary.

**Table 2: Percentage of responses regarding aspects of the training session (n=30)**

	<b>% Poor</b>	<b>% Fair</b>	<b>% Good</b>	<b>% Excellent</b>
Introduction: Why a tool?	0	16.7	70	10
Development of the tool	3.3	10	73.3	10
Reviewing the questions	0	6.7	80	10
Case Studies	0	6.7	66.7	26.7
Presenter	0	0	76.7	20
Slide presentation	3.3	10	60	23.3
Resource kit	0	0	70	30
Venue and Catering	6.7	13.3	60	20

**Figure 1: Confidence using the tool after initial training.**



## 2.1 Comments

In response to the question regarding what would improve confidence in using the tool, 14 participants indicated that practice and routine use in the field would improve their confidence. Key suggestions/comments regarding the tool included:

- Acknowledging that HACC providers, ie LGA operate quite differently. Exploring ways in which POA tool can be incorporated taking account of differences which may exist between LGAs
- Clearer definition regarding assessing priorities for carers
- Good! Looking forward to trialing tool.
- Maybe a little more needed on when tool is to be completed and findings in Western region.
- Still very focused on Aged clients NOT younger/disabled clients. Improved focus on carer status etc. compared to previous tools.
- The focus on carers in the POA assist with Planned Activity assessments.

### 3. Feedback Meetings

#### 3.1. Minutes of the Feedback Meeting held at the Banyule Council on 16<sup>th</sup> Dec 2003.

##### Attendees:

NARI: Kirsten Black, Joan Nankervis

City of Banyule: Karen Baldwin, Tanya Herbstrelt, Janet Trupp, Nadia Massaroth,

City of Whittlesea: Tania Marshall, Leanne Shingles, Annette McDonald, Steve Ward,

City of Yarra: Nga To, Irene Sergakis, Lisa Chamouras

##### General Comments:

Overall themes that emerged in the discussion included:

- Assessment staff found it easier to use the POA2 tool if they had familiarity with the SCOTs'. The POA2 tool could be completed quickly (in one or two minutes) once people had had some practice using it.
- People acknowledged the benefits of using the POA2 tool in achieving consistency across Councils in prioritising clients for services, enabling comparison of levels of demand across the Region.
- The main limitation of the POA2 tool was its use with children with disabilities, which is an acknowledged limitation of the SCOTs'. The question was raised as to whether it would be appropriate to introduce a new tool across the Region which staff perceived did not satisfactorily reflect indicators that are relevant to children with disabilities. The question was also raised as to whether you could expect one tool to incorporate all indicators that are relevant to older people as well as children with disabilities.

**Table 3: Specific comments on each indicator:**

<b>Weighted Indicators</b>	
Domestic ADLs	With familiarity it became easy to complete. Limitations using it with children with disabilities. Weighting seemed appropriate.
Self Care ADLs & incontinence	Limitations using this screen with young children. May need to consider inclusion of a statement on POA2 tool that refers to need to consider age appropriateness of questions included in self care screen.
Cognition	Discussion regarding inclusion of a medium category. However meeting concluded that it would be difficult to identify a method where assessment staff could consistently categorise clients as having high, medium or low level priority. Agreed to leave weightings as they are.

<b>Weighted Indicators</b>	
Behaviour	Often related to a person's level of cognitive impairment.
Carer Availability	Concern expressed by Banyule staff that the weightings for carer availability and status can mean that a person with low needs but without a carer could be rated as a medium priority when assessing staff may judge them to be a low priority. An example given was a person who may require home care services to assist with some ADLs' (scores 4), does not have a carer (scores 8), only needs to gain one extra point to move into the medium priority category. Agreed that the Carer Status indicator would be revised to "how well is the client/carer coping" and revision made to comments in the three columns accordingly. Therefore if there is no carer and the client is coping adequately then a low score would follow.
Carer Status	
Nutrition Status	It emerged through the discussion that Councils vary in their use of the Nutritional Risk screening tool on the Health Behaviours Profile. In some Councils' the assessment staff use the screening tool as part of their standard assessment practice. In other Councils the tool is used at the assessment officers discretion. However completion of this indicator on the POA2 tool is reliant on Councils completing the nutritional risk-screening tool.

<b>Non-weighted Indicators</b>	
	<i>Meeting agreed that that no weightings were required to the indicators currently classified as non-weighted.</i>
Communication	Agreed that the tool needed to be revised to clarify that a persons communication needs were to be assessed in the context of their current environment. Otherwise no other changes were recommended.
Self rated health	No changes recommended
Sensory-Vision	No changes recommended
Sensory-Hearing	No changes recommended

<b><i>Non-weighted Indicators</i></b>	
Falls Risk	No changes recommended
Social interactions	No changes recommended
Environmental Hazards	No changes recommended. Most who attended use information from their OH&S assessment tools to address this item as there is no item on the SCOTs' on environmental hazards.
Other (Discretionary 2 points).	This has been a useful means to deal with people who may be borderline and who assessment staff may judge to be a higher priority. Factors considered in applying these additional 2 points have included: homelessness, "at risk" housing circumstances, significant numbers of other siblings (in the case of carers of young children with disabilities).

### 3.2. Minutes of the Feedback Meeting held at the Hume Council on 18<sup>th</sup> November

#### Attendees:

Kirsten Black (NARI)

Joan Nankervis (NARI)

City of Hume: Jan Lambeth, Christy Andronihos

City of Darebin: Sue Grant, Betty Kalambakis, Veronica Goulas

#### General Comments

**Hume** currently uses clinical judgement to determine levels of priority as opposed to a score based system. Hume has the ability to provide services to people normally regarded as low priority. Their priority system is instituted when there is a waiting list. Overall Hume staff found that the POA2 tool rated people at a level lower than staff would normally deem appropriate.

**Darebin:** Staff at Darebin Council found however that the POA2 tool rated people at a higher level relative to the rating that people would have received using the tool developed by Darebin Council. This example highlights the inconsistencies between Councils in their determination of a person's priority for services.

Representatives from Darebin expressed some frustration with the POA2 tool finding it more cumbersome than the tool that has been in use at their Council for some time. However staff at Darebin Council commenced the trial of the POA2 tool shortly after they had begun using the SCOTs'.

**Table 4: Specific comments on each indicator**

<b>Weighted Indicators</b>	
Domestic ADLs	<p>With familiarity it became simple to complete. Limitations using it with children with disabilities. As the questions included in the functional screen on the SCOT are not appropriate to young children, assessors are unclear whose functional needs they are assessing – the child's or the carer's.</p> <p>Staff from Hume found that clients who required home care services only would often score a low priority when Council, would normally judge them to be a medium priority.</p>
Self Care ADLs & incontinence	No changes recommended
Cognition	Cognitive indicator still seems to be the factor that will push up the score to get a high under this tool.

<b>Weighted Indicators</b>	
Behaviour	Rarely completed – “not appropriate” to assessment. Has been leaving it blank. Hume also leaving it blank unless the behaviours are obvious.
Carer Availability Carer Status	<p>Darebin. Believes these two questions are not adequate enough to convey carer stress. Using their existing tool each person (the client and the carer) are asked questions and scored separately. If a client has a low score and the carer has a high score then the household is rated a high priority for services.</p> <p>Darebin also use a separate tool for children with disabilities.</p> <p>Hume staff noted that where carer issues are present the overall score is significantly increased by up to 8 points and may place someone into a category that would be higher than expected.</p>
Nutrition Status	<p>The Nutritional Risk screening tool was regarded by some as requiring more information than would normally be collected in an assessment. Some attendees commented that if the person seems “nutritionally okay” they do not use the screening tool. They may ask questions related to those in the nutritional screening tool but do not score (and are therefore unable to address this indicator on the POA tool).</p> <p>Nutritional risk is not included in the tool used by Darebin staff.</p>

<b>Non-weighted Indicators</b>	
	Staff attending agreed overall that the non –weighted indicators did not need to be considered for weighting.
Communication	No changes recommended
Self rated health	Inclusion of this indicator has required people to think of this question in a more structured way than they have in the past. One issue raised was how you may ask this question or treat this indicator when a person has dementia or other cognitive impairment.

<b><i>Non-weighted Indicators</i></b>	
Sensory-Vision	No changes recommended
Sensory-Hearing	No changes recommended
Falls Risk	Falls risk is not an indicator on the existing Darebin tool. Other indicators included in the POA but not included in the tool developed by the City of Darebin are: nutritional risk, behaviour and self rated health.
Social interactions	No changes recommended
Environmental Hazards	No changes recommended

## 4. Findings from POA trial in NMR

Data was obtained from staff from 4 of the participating Local Governments. During the trial period data was recorded for 43 client assessments. The data recorded by assessment staff included the score and priority level determined using the POA2, their clinical judgement about the priority level they considered the client to be, reason for adding two bonus points and finally, assessors' suggestions about discrepancies between their priority level and the POA2 priority level. The data is summarised below. Please note that although this data provides some useful preliminary insights, it is a small sample of assessments and therefore limits our ability to make any robust conclusions about the feasibility of the tool.

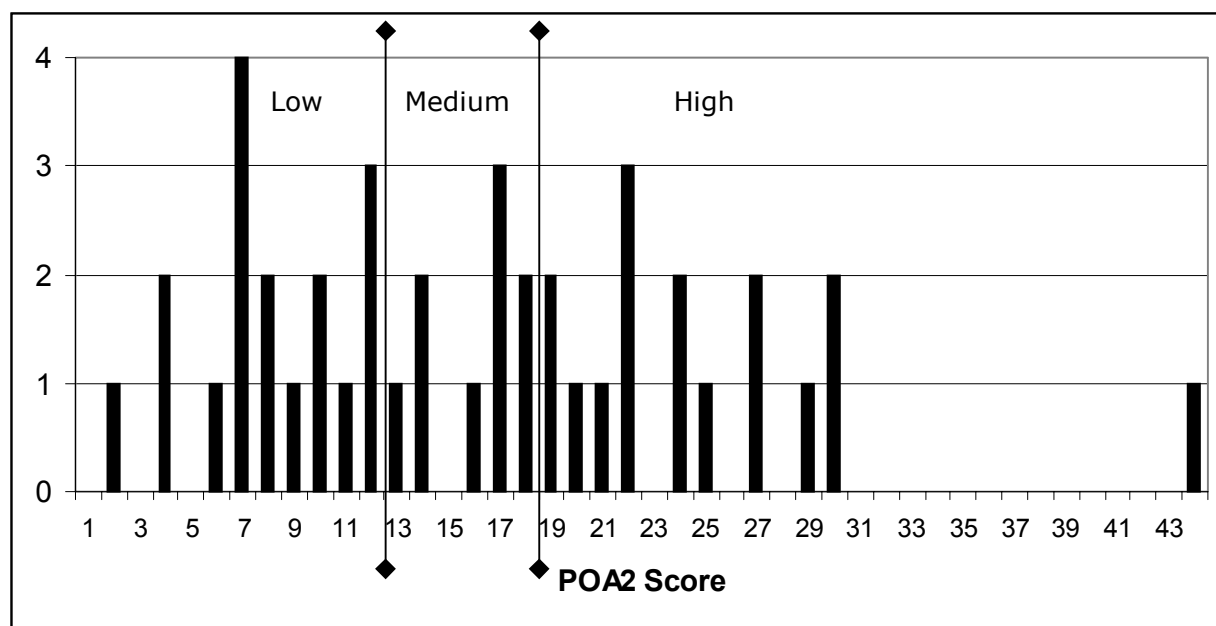
Figure 2 below shows the range of scores obtained during the trial. The cutoffs for high, medium and low are marked on the Figure and are:

Low priority = 0-12

Routine/Medium priority = 13-18

Urgent/High priority = 19+

**Figure 2: POA2 scores during NMR trial (n=43)**



Scores ranged from 2 to 44 (maximum possible), although only one client scored 44. With the exception of this client the highest score was 30. Seventeen clients (39.5%) were assessed as high and low priority with the remaining 9 (21%) assessed as a medium priority. This range of scores suggests that there may be too small a score range for the medium priority. This has altered from the original POA tool where the majority of clients fell in the medium priority level in the WMR. This may indicate a difference in profiles of clients in the West compared with the Northern Metropolitan region, but is more likely to simply reflect the change in scoring system with the addition of weightings for key priority factors.

Table 5 provides a comparison of assessors' judgements of priority cross tabulated with the POA2 priority level.

**Table 5: Comparison of POA2 priority level and assessor's judgement**

		POA2 tool score			Total
		High	Medium	Low	
Assessors judgement	High	<b>9</b>			9
	High/Medium	1	1		2
	Medium	7	<b>4</b>	6	17
	Low		4	<b>11</b>	15
Total		17	9	17	43

The shaded boxes indicate where both the assessors and the POA2 tool's priority levels match. Overall, the POA2 priority level matched the assessor's judgement for 24 (56%) of the assessments. The reasons given by assessors for mismatches are shown in Table 6. There were no mismatches crossing two priority levels, i.e. assessor rating client as low priority and POA2 rating as high priority or vice versa.

**Table 6: Assessors' reasons for discrepancies between assessor's judgement and POA2 score**

	No. of clients	POA Score for discrepancies	Reasons for discrepancy stated by assessor
POA2 matched assessor judgement	24	NA	NA
POA2 tool gave high priority when assessor judged medium	7	19	Points added due to nutritional risk
		19	Depression/cancer treatment – presents 'well', articulate
		20	Was bordering on high in my opinion
		22	No reason provided
		24	Child with a disability. Bonus points for hospitalisation
		25	No reason provided
		30	Child with a disability. Bonus points for surgery and hospitalisation
POA2 tool gave medium priority when assessor judged low	4	14	Child with a disability- questions not appropriate
		17	No reason provided
		18	Child with a disability
		18	'No carer' increase POA rating otherwise slight difference. Bonus points given
POA2 tool gave low priority when assessor judged medium	6	4	To gain a high/med score client needs to be cognitive impaired or have a carer*
		6	To gain a high/med score client needs to be cognitive impaired or have a carer.* Bonus points given for social isolation
		9	Even though scored low would still offer services. Bonus points for depression
		11	Even though scored low would still offer services
		12	No reason provided
		12	Needs assistance with mobility. Uses stick but still unsteady (will not use frame)
		Assessor gave a medium/high score- can't match with POA2 tool	2
21 (high)	Although I've spoken to carer not clear of the impact of him. Could change score – still high though.		

\*See comments on following page regarding possible misinterpretation by assessor

Of the 19 discrepancies, reasons were not given for four. A further four discrepancies were due to assessment of younger children with disabilities. Interestingly, although some of the items were considered not appropriate for children, all four of the discrepancies lead to the POA2 giving a higher priority rating than the assessor did.

The questions regarding carers was cited as causing discrepancies for a number of assessments. One assessor noted that the lack of availability of a carer pushed the score up and ranked the client as a medium priority when their judgement was that the client was a low priority. It is not clear whether these questions have been misinterpreted by one staff member who indicated; "to gain a high/med score client needs to be cognitive impaired or have a carer" for two clients who scored 4 and 6. If these clients did not have a carer they would have automatically scored 8 points.

Despite this assessor's reference to needing cognitive impairment to score a medium or high priority, another assessor noted that one client scored a medium when they were potentially at risk with Alzheimer's Disease. However, the assessor also indicated that the client was a borderline medium/high priority. Another two clients were assessed as a low priority on the POA2 when the assessor reported that the clients needed access to some services.

Two clients had a POA2 score of 19, the lowest score for a high priority. For both of these clients the assessors indicated they believed the client was only a medium priority. Reasons for the higher ratings on the tool were cited as due to the consideration of nutritional risk and one client with cancer and depression who presented 'well' and was articulate. One client scored 20 on the POA2 tool. Again the assessor indicated that this client was probably a medium priority, although they were bordering a high priority.

Of the three clients who scored 12 on the POA2 tool, the highest score in the low priority range, two were deemed a medium priority by assessors and one was considered a low priority. One of the reasons given by the assessor for considering the client a medium rather than low priority was that the client needed assistance with mobility and was having some difficulties with stability.

#### **4.1 Key issues needing to be addressed**

The above data suggests that there may need to be further alterations to the cutoffs for a medium priority. Clients scoring 19 and 20 (the low end of the high priority score range) were considered medium priority by assessors. Also, those scoring 12, the highest score for a low priority, were generally considered a medium priority by assessors.

Apart from score ranges a few other issues were raised that lead to discrepancies between the assessors' judgements and the POA2 priority level. The POA2 tool was considered inappropriate for children with a disability and generally gave them a higher priority rating than the assessor. There was also issues raised about the carer questions and whether lack of availability of a carer pushed scores up too high.

## **5. Recommendations for modifying the tool**

Feedback from staff at feedback sessions and findings from the trial use of the tool suggest 4 minor modifications be made to the POA2. These revisions will lead to revised POA3 version

The revised tool and guidelines will be included as attachments to the final report.

### **5.1 Changes suggested**

The following changes have been incorporated into the Priority of Access tool leading to the third version of the tool: POA3.

#### **5.1.1 Changes to cutoffs**

The trial of the tool provides some justification for expanding the medium priority cutoff from 13-18 to include scores of 12 and 19.

#### **5.1.2 Changes to carer questions**

Revise carer status indicator to reflect "how well the client or carer is coping". Therefore if there is no carer and the client is coping adequately then a low score would follow for this indicator. Three columns to be altered accordingly. The fact that there is some risk due to no available carer will be picked up in carer availability question.

#### **5.1.3 Communication**

Wording to be altered to clarify that a person's communication needs were to be assessed in the context of their current environment.

#### **5.1.4 Self-Rated Health**

Need to add to guidelines how to complete this question when client is unable to answer this question due to severe cognitive impairment. Guidelines will indicate to leave this question blank and use bonus points if client with cognitive impairment also has other major health concerns.

### **5.2 Suitability for children with disabilities**

In feedback sessions and through the trial, staff indicated that some of the questions were not suitable for children with disabilities. Limited data from the trial provides some indication that the tool provides children with a higher priority level than judged by the assessor. The question that caused greatest concern related to the domestic ADL question that reflects answers from the 5 item domestic screen on the SCoT. Young children are not expected to be able to travel independently, handle money and medications or do all of the housework. Concerns were also raised in relation to self care tasks and what children were usually able to do for their age.

Items such as carer status, cognitive impairment, behaviour, communication, social interaction, vision, hearing, environmental hazards and the bonus points were generally considered acceptable questions for this age group. Although there were

some indication by staff that a different set of indicators would be more appropriate for young children, no other indicators were suggested by staff.

This issue was also raised during the development of the tool and has been raised in the HACC service system on many occasions. It raises the question as to whether a separate priority of access tool should be used for these clients. Further discussion in the NMR is required to determine whether an alternative tool is to be developed for children or whether POA2 be modified further to be more appropriate for young children.

# Appendices

1. NMR POA2 Training Objectives and Program Outline
2. Case Studies used in training

## Priority of Access Training Program: For NMR Local Government HACCC services

### Key Objectives of the program

- To understand the value of a consistent approach to assessing priority
- To be able to confidently complete the Priority of Access tool in your work

<b>Time</b>	<b>Program Outline</b>	<b>Mins</b>
9.30	<b>Welcome</b> <ul style="list-style-type: none"> <li>• Introductions</li> <li>• Session overview</li> <li>• Contents of Resource Kit</li> </ul>	15
9.45	<b>Introduction: Why a Tool for determining priority?</b> <ul style="list-style-type: none"> <li>• Priority of Access and defining need</li> <li>• Benefits of using a measurement tool</li> </ul>	5
10.00	<b>Developing the POA tool</b> <ul style="list-style-type: none"> <li>• Requirements of a POA tool</li> <li>• What a POA tool does not do</li> <li>• Literature evidence</li> <li>• Core elements</li> </ul>	20
10.10	<b>Morning Tea</b>	10
10.20	<b>Reviewing the questions</b> <ul style="list-style-type: none"> <li>• POA tool overview</li> <li>• Who it is used for</li> <li>• Review of questions</li> <li>• Scoring</li> <li>• Overview of tool pilot and findings</li> </ul>	50
11.10	<b>Case Studies</b> <ul style="list-style-type: none"> <li>• Karen and Jason</li> <li>• Mrs B</li> </ul>	50
12.00	<b>Questions and discussion</b>	15
12.15	<b>Implementing the tool</b> <ul style="list-style-type: none"> <li>• Benefits of the tool</li> <li>• Providing feedback from trial period – using the feedback sheet.</li> <li>• Date of feedback meeting</li> <li>• Summary</li> </ul>	10
12.25	<b>Evaluation sheets</b>	5
12.30	<b>Close</b>	

## Case Study 1

### **Karen and Jason**

Karen comes to see you asking for some help with her son. She is 5 months pregnant and she says she is totally stressed out. She lives with her husband and three sons aged 7, 5 and 3. The 7-year-old, Jason, has profound intellectual and physical disabilities. He has spent some time in a community residential unit but the family prefer to have him at home.

Jason is unable to speak and is confined to a wheelchair. He has a back brace to keep his spine upright. He can keep his head upright and is able to drink fluids through a straw. He can also pick up objects and put them in his mouth. He can eat finger food that has been placed on a tray in front of him independently. Apart from feeding himself in this way, he is completely dependent in all activities of daily living including personal care. He appears to have good vision and hearing. Jason attends a mainstream primary school where he has a full-time integration aide.

This year James, Jason's younger brother has started going to school and Peter, the youngest is at 3-year old kinder. One of the difficulties that Karen is having is that when Karen is occupied with something else, Peter, the youngest child has been placing toys and other objects on Jason's tray which Jason mistakes for food and puts in his mouth. Karen is worried that he will choke.

Karen's husband Troy runs his own panel-beating business and tends to work long hours. Karen is seeking help now because her mother, who used to help her out, has gone to visit her sister who lives interstate who has just had her first baby. Karen is finding that by the time she attends to Jason in the morning and gets the other two boys ready for the day she is exhausted. Troy does help out with Jason in the morning but he has to be at work by 8am. Karen feels she needs some help at the beginning and end of each day to get the three boys up and ready and to cook dinner and prepare them for bed at night.

## Priority of Access Tool for WMR Local Government HACC Providers - Training

# Case Study 2

### **MRS D**

#### MEDICAL HISTORY

Mrs. D is an 81 year old woman discharged home from hospital following a fall resulting in a fractured right hip requiring a hip replacement - 3 weeks ago. Osteoarthritis affecting knees. Weight loss past 12 months. No prior history of falls. Wears bifocal glasses and has mild hearing loss but no aids. Previous history of depression and known to 'get a little down when she cant do things for herself or when she is 'stuck in the house'

#### SOCIAL SITUATION

Lives alone in own home. Widowed 8 years ago. Has three children. All married. One daughter lives close by and is very supportive. She rarely sees the other 2 daughters. Previously attended weekly church craft group which she would like to go back to but is not sure if she can. Has little contact with neighbours. No other community involvement.

#### PREVIOUS LEVEL OF FUNCTIONING

Independent in all personal care tasks. Conducted own cooking, and light cleaning. Home Help visited once per fortnight for heavy cleaning. Gardener assisted with lawns. Shopped with daughter weekly who also assisted with finances and transport to appointments. Did not drive or use public transport, but has a taxi concession card.

#### CURRENT LEVEL OF FUNCTIONING:

#### *ACTIVITIES OF DAILY LIVING*

Independent in eating and grooming. Requires set up and moderate assistance with lower body dressing, and bathing. Independent toileting using an over toilet frame. Uses a commode at night time due to fear of falling when walking in the dark. Remains continent. Performance managing self care tasks is limited by fatigue at times.

In domestic tasks she is able to plan and prepare a light meal and hot drink i.e. breakfast and uses a kitchen trolley to carry items around the home. Lacks strength and endurance for heavier tasks. Can't manage the laundry. Manages own medication. Unable to manage any community activities even with assistance at this stage.

#### *PHYSICAL FUNCTIONING*

Independently mobile 50m with a Pick Up Frame (PUF). Manages the front steps with rail support. Cant manage the back access as the stairs are unlevel. Able to get on/

off all chairs at home. Has marked fear of falling since admission and is unable to walk outdoors.

#### *COGNITIVE STATUS*

Orientated. No signs of memory loss or confusion and is able to manage medications and finances (with transport assistance).

#### HOME ENVIRONMENT

Front access 3 steps with rail. Access through back door has been blocked off to avoid use of unlevel steps. Shower over bath. Separate toilet off enclosed rear porch. Has rail on bath wall, and Personal Care Alarm installed. A home assessment was completed by her hospital O.T. A raised bath board, kingston chair, commode and overtoilet frame in addition to various small aides were provided.

Mrs. D's daughter is currently having a baby and is unable to resume previous assistance with shopping and transportation to appointments.