Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

# National Guidelines & Procedures for Standardised Implementation of the Home Care Packages Scheme

*October 2010*
*V1*

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| **Document developed by**<br>National Task Group HCP & HH<br>Members listed in Appendix XIII | | | |
| **Document approved by**<br>ISD Management Team<br>& DOHC | | | |
| **Approval date** | October 2010 | **Responsibility for implementation** | Each RDO & LHM & all health sector employees |
| **Revision date** | From October 2012 | **Responsibility for review and audit** | Assistant National Director, National Office, Services for Older People |

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## 1.0 Policy Statement

### 1.1 General

A key component of the Government policy is that the use of community and home based care should be maximised and should support the important role of family and informal carer in order to maintain older people at home for as long as possible. The Home Care Packages Scheme (HCP Scheme) was introduced by Government and implemented across the Health Service Executive (HSE) in 2006 to support this policy.

In 2006 the HSE drew up a framework and guidelines for the standardised implementation of the Scheme. The framework and guidelines were subsequently the subject of detailed discussions between the HSE and Department of Health & Children (DoHC). The 2006 Guidelines have been reviewed in the context of developments in the intervening years.

The "National Guidelines & Procedures for the Standardised Implementation of the Home Care Packages Scheme" ("The Guidelines") incorporate recommendations from the National Economic Social Forum (NESF) Report 38[1] (Appendix I) and from the DoHC commissioned Evaluation Report[2](Appendix II). Recommendations from the DoHC Evaluation Report are referenced in the Guidelines as follows.

**Recommendations of DoHC Evaluation Report 2009- Referenced to Draft HCP Guidelines 2010**

**Governance Arrangements**

**1:** Strengthen the linkage with the acute sector at national HSE and LHO level in the governance arrangements for Home Care Packages ï *Reference 6.2 Draft HCP Guidelines 2010*

**2.** Establish an operational delivery forum to share good practice and support the implementation of a standardised approach to Home Care Package delivery (see Recommendation 4 below) ï *Ref 6.1.2 Draft HCP Guidelines 2010*

**3.** Develop a national HSE approach to procurement of all services related to Home Care Packages. *Ref6.4 Draft HCP Guidelines 2010*

**Operational Delivery**

**4.** Implement a standardised approach to Home Care Package delivery through the immediate roll-out of the national guidelines, to encompass: *Reference overall Draft HCP Guidelines 2010*

- A national definition of 'mainstream' and 'enhanced' services - *Reference 5.1 & 7.2.2 Stage 3a Draft HCP Guidelines 2010*
- Guidance on classification of short-term and long-term HCPs - *Reference 7.2.2 Stage 3c Draft HCP Guidelines 2010*

[1] NESF, Implementation of the Home Care Package Scheme, 2009
[2] DoHC, Evaluation of Home Care Packages, 2009

- A national HSE approach to the deployment of cash grants - *Reference 7.2.4 Draft HCP Guidelines 2010*
- Standard literature and awareness information on the scheme for the general public *Reference 7.1 Draft HCP Guidelines 2010*
- Standard literature and awareness information on the scheme for HCP recipients - *Reference 7.1.1 Draft HCP Guidelines 2010*
- Standardised approach to means assessment - *Reference 7.1.1 Draft HCP Guidelines 2010*
- Principles for joint working with the acute sector, other parts of PCCC & alternative providers *Reference 6.0 Draft HCP Guidelines 2010*
- Standardised care needs assessment tool, including the informal care profile - *Reference 7.1.2 & 7.2.2 Draft HCP Guidelines 2010*
- Standard Home Care Package file/record of recipient profile, services and events - *Reference 7.2.1 Draft HCP Guidelines 2010*
- Standardised approach to budgeting for each Home Care Package - *Reference 7.2.2 Stage 4a Draft HCP Guidelines 2010*
- Standardised care plan and schedule of services - *Reference 7.2.2 Stage 3 Draft HCP Guidelines 2010*
- Standardised approach to review - *Reference 7.3 Draft HCP Guidelines 2010*
- Standardised approach to capturing outcomes and benefits *Reference 7.3 Draft HCP Guidelines 2010*
- Standardised monitoring and supervisory system ï *Reference 7.3 Draft HCP Guidelines 2010* (Monitoring & Supervision also being addressed in context of Home Care Quality Guidelines)
- Standardised complaints process ï *Reference 7.3 Draft HCP Guidelines 2010*

3 • Standardised set of governance principles for decision-making and accountability at LHO level with regard to Home Care Package delivery ï *Reference 7.3 Draft HCP Guidelines 2010*

- Standardised guidelines to support acute and PCCC decision-makers in allocating Home Care Packages based on local health system and population need ï *Reference 6.1 Draft HCP Guidelines 2010*

**5.** Undertake a value for money assessment of Home Care Package delivery in 2011 ï *Reference 7.3.2 Draft HCP Guidelines 2010*

**6.** Develop and implement a standard ICT-based approach to managing Home Care Package information. This may require an interim solution in anticipation of enhanced national HSE ICT systems. ï *Reference 7.3.2 Draft HCP Guidelines 2010 (and on-going work of Task Group in this regard)*

**7.** Develop and implement (based on existing LHO good practice) standard tools for capturing and reporting Home Care Package management information (in particular financial data). This may require an interim solution in anticipation of enhanced national HSE PCCC management information systems. ï *Reference 7.3.2 & 7.2.2 stage 4b Draft HCP Guidelines 2010*

**Performance Management**

**8**. Develop comprehensive monthly management information on Home Care Packages. As a minimum this should meet the data requirements set out by the Department of Health and Children. ï *Reference 7.3.2 Draft HCP Guidelines 2010*

**9**. Develop and implement standardised guidelines on the monitoring and review of the quality and delivery of Home Care Packages at a recipient, LHO and HSE level ï *Reference 7.3 Draft HCP Guidelines 2010*.

**Funding**

**10.** Develop comprehensive monthly *financial* management information on Home Care Packages as part of Recommendation 7 above. ï *Reference 7.3.2 & 7.2.2 Stage 4b Draft HCP Guidelines 2010*

- Implement immediate monitoring of the average weekly value of Home Care Packages. As classifications of Home Care Package are developed, these should be reflected in financial monitoring and used to develop indicative weekly values for Home Care Packages.
- Develop and implement guidelines to ensure consistent attribution of cost to budget.

It is the policy of the HSE that these Guidelines are utilised by all staff to support the implementation of the Home Care Packages Scheme uniformly across the HSE. The Scheme is resource limited and will be operated in line with the limits set out in the Annual Service Plan

### 1.2 Policy Objectives of Home Care Packages Scheme

The objectives of the HCP Scheme are to

- Facilitate timely discharge of older people from acute hospitals
- Reduce inappropriate admission of older people to acute care or residential care
- Reduce pressures on A&E departments
- Support older people to continue to live, or return to live, in their own community
- Support carers so that they might be able to continue to provide care for older people

The Scheme will be as flexible as possible within the confines of the legislative and policy objectives context in which Home Care Packages (HCPs) are provided. Within this context also HCPs should be responsive to the assessed needs of the individual and informal carers and will improve equity of service throughout the LHOs.

**However, the extent of the support available through the HCP Scheme is subject to the limit of the resources allocated each year to the HSE for this particular Scheme.** Therefore, at times, individual applicants who have been approved for a HCP may be placed on a waiting list for the Scheme following a risk assessment of their needs (see Section 7.2.5 for further details).

## 2.0 Purpose

The purpose of the Guidelines is to provide management and staff operating the HCP Scheme with a clear understanding of the purpose and objectives of the scheme and detailed guidance and procedures to be followed in implementing the scheme.

Adherence to the Guidelines will help to ensure that each application for the Scheme will be processed, and assessed, in a consistent way across the HSE taking account of the limit of the resources allocated to each of the four administrative regions and the resource limitations of each Local Health Office within the regions.

## 3.0 Scope

The Guidelines relate to the Home Care Package Scheme only. They are for use by all staff dealing with the HCP Scheme.

## 4.0 Legislation / other related policies

The Guidelines should be read in conjunction with other policies, guidelines, and procedures documents, particularly

- Health Act 1947 to 2007
- Government Policy on services for older people set out in "Towards 2016"
- Data Protection Act, 1988
- Freedom of Information Act, 1997- 2003
- HSE Service Plan 2010 and subsequent years
- Regional Performance Contracts 2010 and subsequent years
- HSE Quality & Risk Framework 2009
- Framework for the Corporate and Financial Governance of the Health Service Executive 2009
- HSE Code of Integrated Discharge Planning 2008
- 'Your Service, Your Say' The Policy and Procedures for the Management of Consumer Feedback to include Comments, Compliments and Complaints in the HSE
- HSE Guidelines for the Home Help Service (Under development 2010)
- HSE Home Care Quality Guidelines Implementation Plan (Under development 2010)
- HSE National Financial Regulations
- HSE Data Guidelines for HCP Scheme (Under development 2010)
- Long Term Care Report, January 2008

## 5.0 Glossary of Terms and Definitions (Alphabetical Order)

**Care Needs Assessment -** A Care Needs Assessment identifies a client's dependencies and care needs in order to ensure that appropriate care is provided in an appropriate setting. The assessment will be carried out by appropriate health care professionals as determined by the HSE. The assessment will include consideration of the following (not in order of priority):

- Ability to carry out the activities of daily living, e.g. Personal hygiene, mobility, continence management, meal preparation and essential environmental care.
- the medical, health and personal social services being provided to or available both at the time of the carrying out of the assessment and generally
- the family and community support available, and
- client wishes and preferences

The assessment may include an assessment of physical ability to attend to activities of daily living and/or cognitive assessment by a healthcare professional. Assessments to be undertaken having obtained patient consent

**Care Plan** - The Care Plan will set out the agreed care outcomes and actions to be undertaken by all services, supports and care staff, taking account of the assessed care needs of the applicant. The Care Plan will apply to both formal and informal care. It takes account of the older person's opinions. Where appropriate the views of the carer will also be considered.

**Common Summary Assessment Report (CSAR) -** A CSAR combines assessment information from various sources, creating a single, permanent and transferable report of the information relevant to a decision on an individual's care needs at a given point in time.

**Complaint -** A complaint made about any action of the Executive, or a Service Provider that, it is claimed, does not accord with fair or sound administrative practice, and adversely affects the person by whom, or on whose behalf, the complaint is made (Health Act, 2004).

**Complex Case -** A case requiring a co-ordinated response from a number of different healthcare professionals or external agencies & a range of additional support services beyond the type & amount required by other members of a population.The applicants present with multiple & complex needs that span both health & social care arenas & may include individuals with behavioural difficulties, emotional problems, mental illnesses or medical needs that may put

an applicant at risk or may present a risk to others including healthcare workers.

**Home Care Package** - A Home Care Package (HCP) consists of community services and supports which may be provided to assist an older person, depending on their individual assessed care needs, to return home from hospital or residential care or to remain at home. A HCP refers to the **enhanced level of community services and supports** above the normal levels available from mainstream community services. HCPs do not replace existing services.

The actual HCP provided to any individual may include paramedical, nursing, respite and/or home help and/or other services depending on the assessed care needs of the individual applicant. **Enhanced level of community services** is any additional level of services, over and above mainstream level of service, which is provided to support the assessed needs of the applicant (Refer also to Section 7.2.2 Stage 3a of the Guidelines).

**Home Help Service** provides personal and/or essential domestic care to dependent people to support them to live at home. It should support and complement the informal care already been provided.

**Informal Care (Informal Carer) –** "assistance given on an unpaid basis to one or more family members, relatives, friends or neighbours, who have difficulties in looking after themselves or in undertaking daily activities because of disability, age or long-standing illness" (Cullen et al, 2004: 16). Informal Carer is the person providing this informal care.

**Interim Home Care Package** A HCP put in place for a short period (normally up to maximum of 5 days) where standard procedures cannot be completed immediately and the HCP is required to facilitate

- discharge from hospital or
- maintenance of a person at home who because of an urgent change of circumstances (e.g carer suddenly unavailable) would otherwise have to attend A&E or be admitted to hospital

**Mainstream Community Service -** Mainstream community service is the level of service that might reasonably be expected to be delivered to a client from the core budgets allocated to specific services e.g home help service, nursing etc. This subject is referred to in more detail in Section 7.2.2 Stage 3a of these Guidelines.

**Multi-disciplinary Team (MDT)**
An MDT is a group of health care workers who are members of different disciplines, each providing specific services to patients.

**Schedule of Services -** The Schedule of Services sets out in writing, all services and supports that will be provided over 24 hours/7 days, to support the assessed needs of the individual older person in order for him/her to return to, or remain at home. Each Schedule is to include details of both formal and informal care and must take account of the older person's opinions. Where appropriate the views of the carer will also be considered.

## 6.0 Management of Scheme, Governance & Procurement

### 6.1 Management of the Scheme

#### 6.1.1 Roles & Responsibilities

In regard to health and social care services, four (4) regional management teams are in place, headed by Regional Directors of Operations.

Each **Regional Director of Operations (RDO)** is fully accountable and responsible for all local health and social care services in their respective region. RDOs are fully responsible for all service delivery and reconfiguration/integration of hospital/community services within their geographic regions and within the agreed Annual Service Plan and Regional Performance Contracts. They are also responsible for meeting service, quality, finance, human resources, and Value for Money targets. The Regional Directors have the authority to make decisions locally, consistent with nationally defined policies, frameworks, performance targets, standards and resources.

Resources allocated for the HCP scheme will be distributed across the system in a way that takes account of the following key principles:

- The local health system and existing resources
- Population need
- Current Older Population
- Projected growth in older population
- Existing community based services & supports including home help service
- Equity of access
- Acute hospital service pressures
- Service pressures generally
- Long term residential care bed capacity

**Local Health Office Managers**, reporting to the RDOs, currently have responsibility within their own areas for overall service delivery including the delivery of HCPs in line with the National Guidelines. This management structure may alter as new management structures are currently being considered, in which case, any new arrangement will incorporate responsibility for HCPs into the revised approach.

Where LHO areas are referred to throughout these Guidelines it is to be taken to refer to existing and any future arrangements that evolve. **LHO Managers have full responsibility within their own area and through their management structures to ensure that the Guidelines are fully and consistently implemented.**

Critical to the successful implementation, monitoring and evaluation of HCPs will be the assignment of overall responsibility for the HCP Scheme and the implementation of the National Guidelines, to **Senior Managers** e.g General Manager or other. Within this responsibility, a HCP Manager or Managers (who may combine this responsibility with other duties as determined within the area) may be assigned responsibility for the day to day operation of the scheme reporting to the relevant senior manager. The title HCP Manager is a generic term used in the Guidelines to describe the person(s) who is/are responsible for the operation of the scheme on a day to day basis. The actual title of the individual(s) will vary from area to area in line with existing arrangements and incorporates all of the existing and any future arrangements that may be made within the RDO area.

The **HCP Manager(s)**, while accountable to the senior manager in the LHO Area, is responsible for the day to day allocation of the HCP resources to

- ensure the efficient and effective use of the available resources assigned to the scheme
- maximise the impact of these resources in the achievement of the objectives of the scheme including facilitation of timely discharges from acute hospitals;
- facilitate contact with, and between, community services and acute hospital services in relation to HCPs, in majority of cases as direct liaison contact.
- where possible reduce inappropriate admissions through the provision of a HCP;
- reduce pressure on A&E Departments where appropriate through the provision of a HCP
- support older people to live in their own community by providing a HCP in appropriate cases
- employ appropriate performance management/monitoring to ensure that resources allocated are fully expended but not exceeded

The HCP Manager will need also to arrange for monitoring information to be recorded in an appropriate manner and submitted through the agreed processes to enable accurate reporting and evaluation and to ensure that relevant expenditure is properly coded to the HCP budget allocation.

An Implementation Plan, setting out the approach to how the Guidelines will be rolled out across the HSE, is included in the Guidelines. The Implementation Plan sets out the timelines for roll out and the key people responsible for same.

**All HSE staff and staff** employed in agencies receiving HCP funding from the HSE must operate the HCP Scheme in accordance with the Guidelines. All Line Managers and all senior managers are responsible for ensuring the operation of, and compliance with the Guidelines in their respective areas in accordance with the implementation plan.

The **Office of the Assistant National Director Services for Older People** will take a lead role in reviewing and updating the National Guidelines at appropriate intervals to ensure a consistent approach to the operation of the scheme continues to be documented. The Office of the AND will also take a lead role in the Best Practice Group which is to be established (Section 6.1.2). The Office of the AND will also take a lead in monitoring the operation of the Guidelines in terms of consist application, effectiveness and economical use of resources allocated for the Scheme.

### 6.1.2 Sharing Best Practice across the HSE

Senior/HCP managers (3 representatives from each Region) and a nominated area specialist SOP will partake in a national operational delivery / "Best Practice Group" which will be established in order to support implementation of the Guidelines in a standardised way across the system, to share good practice and to consider and recommend, to the National Office for Services for Older People, revisions/ clarifications that may be required. The chair of the Group will be selected from within the group, rotating on an annual basis. The group will be supported by a nominated National Specialist for Services for Older People.

Meetings, which should in the main be held by teleconference, should initially be held monthly while the Guidelines are being rolled out. Thereafter quarterly meetings may be sufficient. The Chair will be responsible for ensuring consensus is arrived at, recorded and disseminated. Where consensus is not achieved the issue is to be referred to the Office of the AND for decision in consultation with senior operational managers as appropriate.
The need for this Group to continue will be reviewed during 2012.

## 6.2 Linkages with Acute Hospitals

The HCP Scheme is administered within community services. However, it is critical to the success of the Scheme that linkages between community services and the acute sector, at national and

LHO level, are strong in order to ensure that the objectives of the Scheme are achieved. There are a number of approaches required to achieve this linkage.

At **National Level**, the Task Group established to finalise these Guidelines and to support implementation within their respective regions, included nominees from each of the four administrative regions representing the acute hospital sector and community services (Membership Appendix X). In this way, inputs to the Guidelines from across both acute and community services were assured.

At **LHO level**, the HCP Manager will need to establish close links and robust working relationships with acute hospital personnel. It is recommended that each LHO have a local team in place with representatives from both the acute and PCCC directorates to provide overall governance for the scheme within the LHO area, in line with the HSE Quality & Risk Framework (2009). This could be a function of Integrated Care Teams where they are in place.

This group should have a role in reviewing decisions made by the HCP Manager to ensure a robust decision making process exists. HCP Managers will manage the scheme in a fair way incorporating the needs of acute hospital and community based clients in accordance with the Guidelines. As Primary Care Teams and Networks are developed clear lines of responsibility and accountability for the scheme at operational level in each area will need to be determined. In this regard the National Discharge Planning process is one example of how discharge processes can be strengthened and HCPs are an important resource to enable people to transfer from hospital to community safely and successfully.

## 6.3 Governance

Governance of this Scheme within the HSE is set within the context of the overall framework for Governance of the HSE as set out in the Framework for the Corporate and Financial Governance of the Health Service Executive.

In addition the principles for decision making and accountability in relation to the HCP Scheme can be grouped under the following headings:

1. Legal compliance – compliance with all legal requirements and with the HSE Annual Service Plan and regional performance contracts;
2. Respect for views of clients, colleagues and service providers; client dignity; confidentiality; transparency; maintenance and safe-keeping of accurate records;

3. Efficient and Effective Performance - compliance with national guidelines to ensure achievement of stated objectives of the scheme; regular review of individual HCPs to ensure they continue to support the needs of the client; regular review of operation, efficiency & effectiveness of the scheme at senior management level within each Region and at national level. Strong financial oversight - for funding allocated to the HCP Scheme by maintaining complete, current and accurate financial and activity records in compliance with the nationally agreed requirements; Clearly defined budget allocation and activity targets linked to RDO Performance Contracts
4. Compliance with the HSE National Financial Regulations
5. The RDO will ensure that each LHO has in place appropriate arrangements in relation the HCP scheme at operational level.
6. Monitor Quality, Safety & Risk – appropriate accountability and oversight arrangements are in place to support the provision of assurances to HCP recipients, the public in general, senior management, the CEO of the HSE and to the HSE Board that the Scheme is being operated as intended.

## 6.4 Procurement

HSE will, at intervals, undertake a national procurement process and national tender for the supply by non-HSE providers of enhanced levels of home care services funded through the HCP Scheme. Enhanced levels of home care services in this context incorporates home help type services funded from the HCP allocation which is over and above those services provided directly by, or on behalf of, the HSE from the mainstream Home Help budget or by the HSE directly from the HCP allocation.

The national procurement process for the Scheme will adhere to procedures and requirements set out by the Procurement Directorate and will involve a representative of the Procurement Directorate.

Where mainstream services, other than home help type services, have been maximised, services of other professionals e.g. nursing, physiotherapy, etc may need to be procured. In such cases services may need to be obtained through established arrangements with employment agencies having regard for established HSE Human resource and procurement processes and with due regard to circular HR01/2010.

## 7.0 Guidelines & Procedures

A critical requirement in the development and implementation of "National Guidelines for the standardised implementation of the Home Care Package Scheme" is that the approach would be implemented in a consistent manner across the health system. To achieve this, a suite of standard documentation has been developed to support the Guidelines i.e. standard procedures and documentation (including application/referral forms, Common Summary Assessment Report (CSAR), Schedule of Services, Care Plans, standard letters etc).
The Guidelines are also supported by an Implementation Plan to ensure that they are operationalised in a consistent way within an appropriate time frame.

In addition, the Guidelines will be reviewed, and the operation of the scheme in line with the Guidelines will be audited, at appropriate intervals to ensure that the operational approach continues to support the objectives of the Scheme and that it is being consistently implemented at operational level.

### 7.1 Access to a Home Care Package

#### 7.1.1 Information and Application

Any person may apply on the appropriate form (Appendix III) to be considered for a HCP. Where an applicant cannot complete the form him/herself an application/referral may be made on behalf of a client by a family member, friend, carer or healthcare worker. Information booklets and application forms will be widely available to applicants and to the general public. In addition information on the HCP Scheme will be made available on the HSE website www.hse.ie.

**Access**

DoHC policy in relation to HCPs states that, in the context of current legislation, "Access to HCPs should be based on need" and means testing should not be applied to HCPs. Accordingly

- There is no requirement that an applicant should have a medical card in order to apply to be considered for a HCP, though the vast majority of beneficiaries are likely to be medical card holders.
- There is no financial means test applicable to the Scheme
- No charges will be levied on applicants in respect of services provided through the Scheme.
- Contributions shall not be requested or accepted from recipients with respect to the provision of HCP services
- Applicants care needs will be assessed to determine their requirement for a HCP

- HCPs will be allocated based on assessed care need within the limit of the resources available for the Scheme. When resources are fully allocated at Local Health Office level and waiting lists are in operation a prioritisation mechanism for allocating resources (services & supports) to approved applicants will be implemented as set out in detail in section 7.2.5.

To comply with the policy objectives of the scheme (see Section 1.2) as set out by the DOHC the vast majority of beneficiaries of the Scheme will be older people i.e. aged 65 or over. However, there will be flexibility in relation to applications from persons approaching 65 years. In addition some people aged less than 65 years, for example a person who has developed early onset dementia (and where their assessed needs can be best met by Services for Older People), may also be considered as exceptional cases for the HCP Scheme. Applications from persons aged under 65 years will need to be approved by the General Manager.

### 7.1.2 Care Needs Assessment

In order to determine if a person who has applied for, or been referred for, a HCP needs a package, a Care Needs Assessment will be undertaken. The assessment, by health professionals as determined by the HSE, will recommend what services/supports, if any, are required over and above what is available from mainstream services. In order to allocate a package the care needs assessment must confirm that enhanced levels of service/support are recommended. If the care needs assessment indicates that additional services/supports through the HCP scheme are not appropriate or required the application for a HCP will be refused (see also Section 7.2.2 Stage 5)

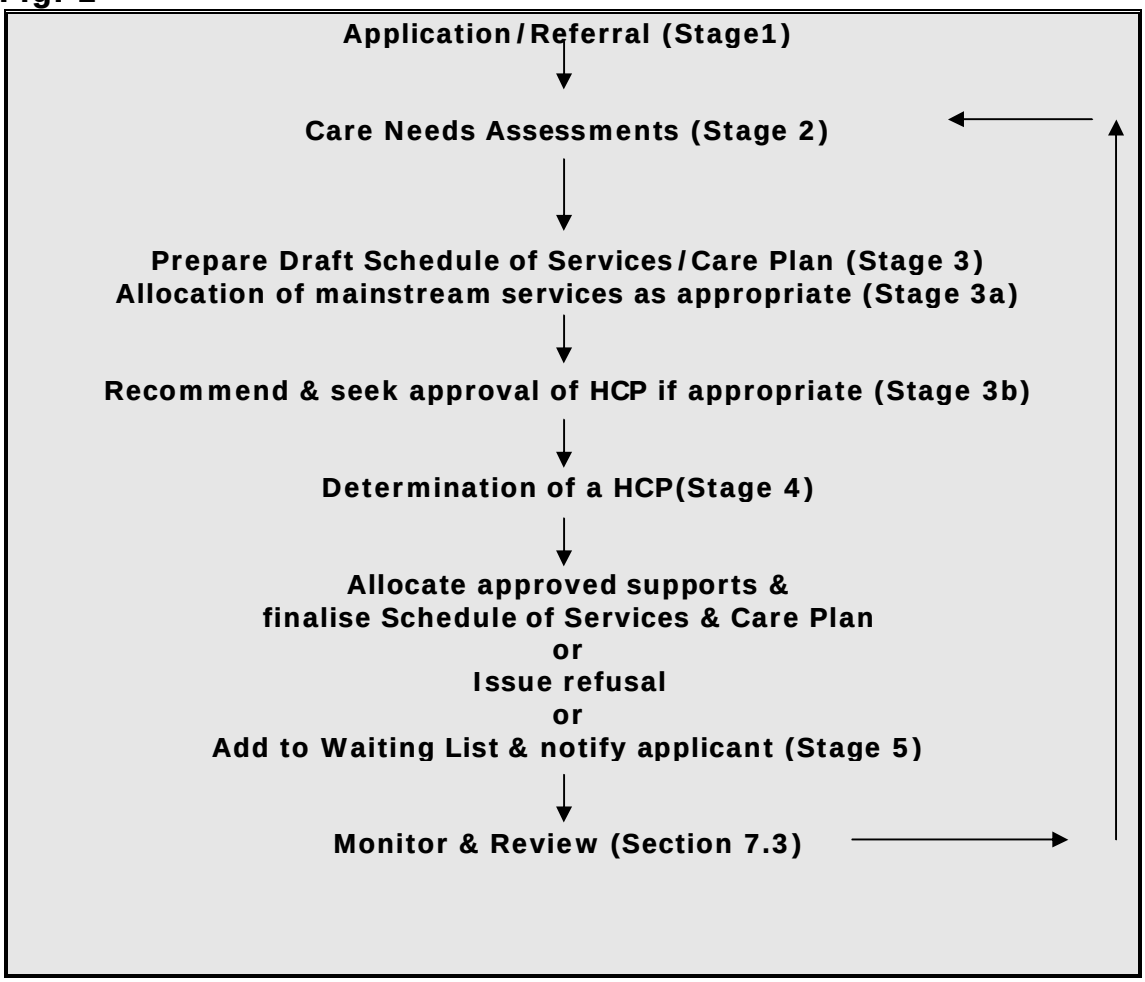
### 7.1.3 Resource Limit

The Scheme is resource limited and will be operated in line with the limits set out in the Annual Service Plan. The Service Plan sets out the agreed number of HCPs to be provided in any one year. The Regional Performance Contracts set out the annual service delivery targets for the region and for each local area.

## 7.2 Home Care Package Operational Processes & Procedures

The operation of the Scheme is set out diagrammatically in Fig 1 below. Processes and documentation supporting the operation of the scheme are described in more detail in this Section of the Guidelines.

**Fig. 1**




### 7.2.1 Application & Determination Process

The processes relating to managing applications and finalising a determination are set out in stages 1 to 5 below.

Stage 1: Application /Referral

Application for, or referral of, clients for a HCP must be made on the standard form (Appendix III). The form gathers the minimum data required in order to progress the application/referral, to ensure standard information is available in relation to each client and to record critical management information on utilisation of the Scheme. This application/ referral form must be completed for all new applicants once the Guidelines are implemented and for all existing HCP recipients at first review following implementation of the Guidelines.

Application/Referrals should be completed, to the extent that it is possible in each case, with the involvement & consent of the older person. Where the older person is unable to consent, their representative, acting in the best interests of the client, should be requested to give consent on their behalf. It should be noted on the HCP file that the consent on behalf of the client has been provided.

Applications/Referrals are accepted from all sources – self-referral, family or carer, general practitioner, PHN, hospital services staff or other health service personnel. On receipt of completed application/referral form the administrative processes set out in Table 1 are to be followed.

**Table 1 Procedures for Applications/Referrals on receipt**

| |
|---|
| **1. Applications/referral forms received** - date stamp, record data on ICT system or on interim database*, assign HCP reference number<br>**2. Issue acknowledgement** to client & referrer (Standard letter Appendix IV) within 5 working days of receipt of form & open individual HCP file<br>**3. Request care needs assessment** within 3 working days of date of receipt of application - to be returned to HCP Manager within 7 working days of request |

*interim database, pending national ICT solution being implemented, will be circulated separately

## Stage 2: Care Needs Assessment

The primary focus of service provision for older people is to maintain them at home for as long as possible.
In order to ensure that care at home is fully explored as an option and that appropriate care is provided in an appropriate setting an assessment of needs is required in respect of each application/ referral in order to develop an individualised, multi-disciplinary, person centred schedule of services and care plan (Appendix VI).

Process
HSE staff must have **consent** from the person/their representative prior to undertaking a care needs assessment – the applicant/ representative's consent is recorded on the application form. Staff must ensure that the consent is informed i.e. that people referred for an assessment understand what the assessment process involves, its purpose and their rights & responsibilities.

As part of the process, a person's **medical, physical, social & psychological needs** are assessed to determine the person's care needs and the type of services that would be most appropriate to support those needs. The assessment where indicated should consider the person's usual accommodation arrangement, access to transport and community supports. Where possible, in assessing a person and developing a care plan, the person's carer, family or other

representative should be involved, as they also play an integral part in developing the most suitable care plan. However, the person being assessed has a right to privacy and confidentiality, and should be asked if they want someone else to be involved in their assessment and discussion of care options.

The HSE supports the concept of **multi-disciplinary (MDT) working**. It also recognises that there is considerable variation nationally regarding the availability of staff. Therefore it is not possible to be prescriptive about who should complete a care needs assessment but best practice indicates input from a range of healthcare professionals. LHOs have an option to incorporate the decision making in relation to care needs assessments for HCPs into existing integrated structures (PCT clinical meetings; Local Placement Forum or hospital/community MDT meeting) or to establish a new structure.

A care needs assessment should be completed within 7 working days of the request from the HCP Manager. However in relation to hospital based clients a referral for a HCP should be timely and should be made within a reasonable time prior to the end of persons' phase of acute or rehabilitation care so as to reflect their current level of need. The outcome of the determination of the needs assessment should be notified, together with the decision relating to the application for the HCP, to the applicant within 5 working days of the decision regarding the HCP being made.

**Complex cases -** In cases requiring a co-ordinated response from a number of disciplines or agencies to support complex or multiple needs, the assessment should include, or have input from, a range of disciplines, skills & expertise sufficient to make an accurate & complete assessments of the person's care needs. This may involve input from existing primary care teams or other multidisciplinary teams and, where necessary, it should involve a linkage between acute & community services.

A meeting of relevant professionals to discuss complex cases should be convened to assist in the completion of the assessment report & drafting of the proposed schedule of services & care plan for the person requiring a HCP. Where a multi-disciplinary team exists, it is envisaged that one person will act as a coordinator to assist in the completion of the CSAR. The completed assessment report and supporting documents should be submitted to the HCP manager for determination of the application.

In some cases an applicant, whose care needs are far in excess of what can be supported through the HCP Scheme may insist on

continuing to live at home or return to home from residential care despite the clear risks involved in this care setting. In these cases the risks must be assessed and documented in the applicant's care plan. Such risk assessment should include frequency of care required, cognitive function, wound assessment if appropriate and moving & handling. The risks must also be discussed with the applicant & relevant family representatives in order to ensure that appropriate consideration has been given by the applicant and his/her family to other care options. The applicant and family will need to be clear that while supports may be provided that care in the home in the individual case carries risks that cannot be eliminated by the provision of community supports (Standard Letter Appendix IV).

In such cases appropriate supports may be approved within the limits of the HCP scheme to minimise the risks in so far as this is possible.

Care Needs Assessment Documentation

The HSE is in the process of drawing up a National Assessment Tool (or suite of tools) for the purposes of assessment of care needs and the Single Assessment Tool Working Group has been established to progress this work. In the meantime each area should continue to use existing assessment tools, to contribute to

- The completion of the **Common Summary Assessment Report (CSAR)** (Standard Format and Guide for completion) Appendix V
- The development of the schedule of services and care plan

**The absence of nationally agreed assessment tool(s) should not hinder the implementation of HCP Guidelines throughout the HSE.**

The CSAR for use in the HCP Scheme is an updated version of the original CSAR which was developed in the context of assessment of need for residential care under the Nursing Home Support Scheme (NHSS) in 2009. Additional pages have been designed to be attached to each CSAR to record the recommended levels of services from the HCP and to facilitate the recording of the determination of the application (included in Appendix V). The use of CSAR with additional sections appended, will ensure a consistent format for

- the outputs from various care needs assessments
- recommendations for HCPs
- determinations of HCPs

The CSAR has been designed so that any single professional who knows the patient well can complete it, but where an MDT is available

they should be involved in the completion as appropriate including specialist assessment where this is available. The goal is to capture the best information available as efficiently as possible. Apart from reports from named professions, the information sought on a CSAR form can be provided by a range of professional staff. For example, Barthel or cognitive assessments may be completed by a nurse, therapist or medical practitioner.

Each local area should therefore **document the local processes** for the completion of the CSAR and identify a link person to liaise between community & acute services, where appropriate, to ensure a comprehensive & timely completion of the needs assessment process & CSAR. This may be the HCP manager where such a structure exists but it should be a staff member from PCCC who can provide the link with the applicant's previous history/levels of service and future requirements for care.

The CSAR recommendation must indicate that the person is capable of living at home with supports and with identified supports in order for the application for a HCP to be progressed.

### Stage 3: Schedule of Services and Care Plan documents drafted

A schedule of services & care plan are to be drafted by the person(s) completing the CSAR. Where a number of professionals are involved one member of the MDT should act as key worker. The key worker co-ordinates completion of the CSAR and prepares the draft schedule of services & care plan.

The **Schedule of Services** sets out in writing, all services and supports available over 7 days, to support the assessed needs of the individual older person in order for him/her to return to, or remain at home. Each Schedule is to include details of both formal and informal care and must take account of the older person's opinions. The use of a standard format for the schedule of services is recommended by the DOHC Evaluation Report. Given the time constraints involved in drafting the Guidelines the Task Group has developed a standard format for Schedule of Services which is attached at Appendix VI. This version is to be used for all HCPs pending the further development of this or an alternative format in consultation with the National Primary Care Office in the context of the development of PCT standard documentation. In the intervening period the Best Practice Group should review the current document in the context of any suggested amendments that may be forthcoming.

A **Care Plan** will set out the agreed care outcomes & actions that will be undertaken by all services, supports and care staff taking account of the identified needs & opinions of the person. The Care Plan will apply to both formal and informal care. The use of a standard format for the Care Plan is recommended by the DOHC Evaluation Report. Given the time constraints involved in drafting the Guidelines the Task Group has developed a standard format for Care Plans which is attached at Appendix VI. This version is to be used for all HCPs pending the further development of this or an alternative format in consultation with the National Primary Care Office in the context of the development of PCT documentation. In the intervening period the Best Practice Forum should review the current document in the context of any suggested amendments that may be forthcoming.

The draft schedule of services and care plan, completed & submitted with the CSAR as part of the HCP application process, must **identify the mainstream and informal services and supports** already in place or available to be allocated, together with the additional or enhanced levels of services being recommended from the HCP. The draft is to be submitted with the completed CSAR to the HCP Manager for consideration in determining the outcome of the application for a HCP.

**The following Stage 3a clarifies what is to be regarded as mainstream services and what is to be regarded as enhanced levels of service in order to ensure that, as far as possible, all areas apply a similar approach.**

Stage 3a: Guidelines for Allocation of Mainstream Services

Each discipline involved in the provision of care must provide an appropriate level of service from **mainstream services** having regard to the

- demand for services,
- competing priority cases,
- level of resources available for the scheme and
- level of informal care available to the applicant (whether paid or unpaid).

It should be noted that an appropriate level of service may in fact be no service. The person(s) completing the recommendation for a HCP must ensure that mainstream services are maximised prior to recommending an enhanced level of service through the HCP Scheme.

Mainstream services include all services and supports funded from core budgets allocated for these services, which are provided either directly by the HSE, by arrangement with external providers or by a combination of both. **Mainstream services are not to be included in the cost of a HCP.**

In order to ensure a common understanding of what constitutes, and is recorded as, a HCP, and to ensure an equitable approach to the approval of HCPs across the HSE, mainstream services are defined below. Where a person requires more care than mainstream services can provide it is appropriate to refer the client for a HCP. **Only** where a client has applied for and been **approved** for a HCP can the additional services be costed as a HCP.

Home Help Service – First **5 hours** home help service received by the client per week are regarded as mainstream. Home help hours in excess of this mainstream level which are provided as part of an approved home care package are regarded as enhanced levels of service. The enhanced level of service approved i.e. above the mainstream are to be costed to the Scheme and counted as part of the activity of the Scheme.

**For Example**
*Mr. B's needs have been assessed and a total of 16 hours home help service is recommended.*
*Being High Dependency Mr B is referred for a HCP.*
*5 hours Home Help is approved from the mainstream service and the remaining 11 hours are approved from the HCP scheme.*
*The costs relating to 5 hours are coded as normal to the mainstream Home Help service with the remaining 11 hours coded to the HCP Scheme.*

Home Help Hours are to be allocated in line with national guidelines for the allocation of home help hours to clients.

The basis for 5 hours is that this would provide 1 hour of home help support each day (may be spread over two visits) for five days and is regarded as being a reasonable level for mainstream services for clients with lower levels of dependency. Clients who are more highly dependent, or complex cases, generally require home help hours above this level. (The 5 hours mainstream services may of course in reality be allocated over less than 5 days to meet the individual care needs of the applicant).

The overall budget for Home Help Services as set out in the Service Plan 2010 is expected to provide 11.98m home help hours. As part of the implementation of these Guidelines and the standardisation of what is regarded as mainstream services, it may be necessary to review over time the distribution of funding across Home Help Services and Home Care Packages. The level of demand for mainstream services by low dependency clients may result in resources being available for transfer to the HCP scheme to deal with

higher dependency cases. Any proposals to transfer budgets from the HCP Scheme to Home Help Service or other Service/Scheme and vice versa will need to have received appropriate approvals in the context of the Service Plan prior to being undertaken.

The classification of 5 hours as mainstream Home Help service will come into effect for applications approved from the implementation date of Guidelines in order to avoid possible confusion with regards current monitoring data.

Nursing Service - First **2 hours** per week are regarded as mainstream. Nursing hours provided in excess of this mainstream level and as part of an approved HCP are regarded as enhanced levels of service. These enhanced hours above the mainstream should be regarded as part of the wholetime equivalent hours funded through the HCP Scheme. Each LHO will need to identify and record the actual wtes provided for various nursing grades through the Scheme. The home care package nursing hours will need to be managed and monitored by the Director of Public Health Nursing (DPHN) and HCP Manager to ensure that the home care package funded hours are being allocated to clients, availed of by the HCP scheme and properly accounted for.

**For Example**
*Mr. B's needs have been assessed and a total of 6 nursing service per week is recommended.*
*Being High Dependency Mr B is referred for a HCP.*
*6 hours nursing is approved – 2 from mainstream and 4 from the HCP Scheme. 6 Hours will continue to be paid from mainstream as in this LHO area posts were approved and funded from the HCP allocation and included in the mainstream nursing complement.*
*The HCP Manager and DPHN will need to monitor the usage of these two posts in order to demonstrate that their equivalent hours are being utilised for HCP cases. In this case four of the six hours approved for Mr. B will count as part of the HCP funded posts.*

Physiotherapy & Occupational Therapy Services – In regard to physiotherapy services a person with low level needs might reasonably avail of services on an out patient basis on one occasion per week for about five weeks. This is regarded as mainstream.

A more dependent person with high needs would avail of more frequent services which could be as frequent as 2/3 times per week for 2/3 weeks. This is regarded as enhanced and may be approved by the HCP Manager as part of a HCP.

Occupational therapy service relate to urgency – lower levels of urgency where applicant could return home and wait for appliances are regarded as mainstream. Urgent higher dependency cases requiring assessment for appliances in order to return home and where additional input is required by OT services to facilitate this, would be regarded as enhanced levels of service and may be approved by a HCP Manager as part of a HCP.

In general therapy services provided in excess of this mainstream level as part of an approved HCP are regarded as enhanced and should be counted as part of the wholetime equivalent (wte) hours funded through the Scheme. Each LHO will need to identify & record the actual wtes provided for various therapies through the Scheme and manage the resource to ensure that the HCP funded hours (posts) are being allocated to HCP clients, availed of by the HCP scheme & properly accounted for within the HCP scheme. The HCP will need to maintain adequate records to demonstrate the utilisation of these resources.

Aids & Appliances - Normal processes in relation to mainstream provision must be fully explored and documented on the client's HCP file. Mainstream aids and appliances are regarded as any aids and/or appliances that are, or have been, traditionally available to support older people to remain at home or to return home. Based on an analysis of a range of cases over a three month period, it is considered that aids and appliances up to the value of €2,500 per client per annum should be regarded as mainstream. More expensive individual aids/appliances or a package of aids/appliances valued in excess of this level could be considered as part of a HCP. In such cases a HCP application must be completed and approved before the excess over €2,500 can be provided from the HCP Scheme. General Manager approval is required in all cases where Aids & Appliances are to be approved from HCP funding. This is to ensure that applicants are appropriately considered for mainstream support prior to considering a HCP.

Respite As a guide up to 2 weeks per annum is regarded as mainstream in terms of residential respite care. However each HCP Manager will need to take account of the availability of mainstream resources in the LHO area as the availability varies relative to the bed capacity (both public and private) and to budgetary resources to fund such respite arrangements from other initiatives. Where an existing arrangement for respite care has been operating for a client, involving more than 2 weeks per annum mainstream services, this should continue without any transfer of costs to the HCP scheme. This will ensure that existing arrangements are not inappropriately referred to

the HCP scheme. The HCP Manager may wish to obtain written confirmation of previous respite arrangements for the individual client in order to assess the appropriateness of providing respite through the HCP scheme.

In any case respite care provided in funded public beds must not be costed to the HCP scheme as they are already fully funded. Respite care that has been approved through the HCP scheme and provided at additional cost in a non-HSE nursing home should be costed to the HCP budget. Payment to registered nursing homes for residential respite care must not exceed the agreed cost of care as published annually in respect of the Nursing Home Support Scheme www.hse.ie.

General

Where mainstream services have been fully committed and it is therefore not possible to supply the above service levels from mainstream service provision the General Manager for the Area will have discretion to approve individual HCPs incorporating some or all of the mainstream elements identified above.

**For Example**

*Mr. B has applied for a HCP. His needs have been assessed and 16 hours home help service is required. The mainstream budget for home help services is fully committed to other clients. No mainstream home help hours are available for Mr. B.*

*HCP funding is available.*

*Mr. B cannot return home from hospital without this service. A HCP is approved for the full 16 hours home help service. There is no mainstream service in this case. The reasons for the decision in this case should be fully documented on file.*

*In summary the following situations will trigger the commencement of the application process for a HCP*

1. *Any case requiring more than 5 hours home help per week should be referred for consideration by the HCP Manager for a HCP with the agreement of the person receiving the care.*
2. *Any case requiring nursing care above 2 hrs per week should be referred for consideration by the HCP Manager as a HCP with the agreement of the client*
3. *Any case requiring physiotherapy /OT that involves a number of intensive visits/plans can be considered for a HCP as they are deemed as requiring enhanced care and may be referred to the HCP Manager for consideration as a HCP.*
4. *Aids and appliances valued in excess of €2,500 per client per annum may be regarded as enhanced and could be considered*

*as part of a HCP. General Manager's approval is required in all cases where Aids & Appliances are being considered as part of a HCP.*

5. *Over 2 weeks per annum is regarded as enhanced in terms of residential respite care, however each individual case will need to be examined on its merits. HCP Manager's approval required before any respite care can be considered to be a HCP or part of a HCP, and charged to HCP Scheme.*
6. *If mainstream budgets are exhausted the clients care can be fully met through HCP funding provided the reasons are documented on file and the GM approves same.*

Existing HCPs will need to be reviewed to consider their alignment with the guidelines – however revised cost coding of existing HCPs can only be undertaken if approved by the HCP Manager/General Manager within the available resources.

**In summary - Services/Supports cannot be coded to the HCP scheme without the prior approval of the HCP Manager/ General Manager as appropriate.**

Stage 3b: Guidelines for Assessment of Informal Care supported by Department of Social Protection

The HSE recognises the very significant care being provided by informal carers across the country.

**Informal Care** may be provided by family, friends, and/ or neighbours who undertake to support a person at home with or without reward. Such informal care should be factored into the supports available to the applicant for a HCP. Where informal care is supported by benefits/allowances paid through the Department of Social Protection particular consideration should be given to the intent of these benefits as set out by that Department in order to ensure that as far as possible the full range of resources available to support older people living at home are acknowledged and the resources available are distributed to benefit the greatest number of people. Where staff are aware that these benefits are not being availed of, the applicant and his/her representative should be advised to consider if these benefits/allowances would be an appropriate support in their circumstances.

**Carer's Benefit -** is a payment for people who have made social insurance contributions and who have recently left the workforce and are looking after somebody in need of full-time care and attention.

Carer's benefit can be paid for a total of 2 years for each person being cared for.

**Carer's Allowance** is a means-tested payment for carers who look after certain people in need of full-time care and attention on a full time basis. Two carers who are providing care on a part-time basis in an established pattern can be accommodated on the carer's allowance scheme.

The **Respite Care Grant** is an annual payment for full-time carers who look after certain people in need of full-time care and attention. The payment is made regardless of the carer's means but is subject to certain conditions. At the time of writing the grant is €1700 per annum per person cared for. This grant may be used by the carer in any way he/she wishes. Unlike Carer's Benefit and Carer's Allowance, it is not to be taken into account in the assessment of informal care for the purposes of determining the outcome of a HCP application. This approach is subject to review if the Department of Social Protection amends its requirements in relation to the Grant.

Stage 3c: Recommendation for HCP

Each professional involved in the care needs assessment will need to input appropriately, either as an individual input or as part of the MDT, to the **recommendation for enhanced levels of services and supports** from the HCP Scheme. The relevant section on the CSAR will need to be completed prior to submission to the HCP Manager for determination.

In line with Government policy, HCPs will be given to older people in the main, to address the following objectives (not in any order of importance)

- Facilitate their timely discharge from acute hospitals
- Reduce inappropriate admission to acute or long term residential care
- Reduce pressures on A&E departments
- Support older people to continue to live in their own community
- Support carers so that they might be able to continue to provide care

Discharges from acute hospitals to community services must be adequately notified to the appropriate community services staff in advance of discharge to ensure that the necessary supports and

services are in place and discharge home is not delayed. This is to be achieved through the improved discharge planning arrangements being implemented across the health system. (Code of Integrated Discharge Planning 2008)

The procedures to be followed relating to acquiring a completed needs assessment, and the schedule of services & care plan are summarised in table 2 below.

**Table 2 – Procedures relating to Needs Assessment, Schedule of Services/Care Plan**

**1.** Key person coordinating needs assessment notes date request received.
**2.** Refer to all appropriate professionals, MDT, for assessments.
**2.1** Appropriate assessment undertaken
**2.2** CSAR including recommendation for HCP completed
**2.3** Schedule of Services & Care Plan drafted
**3.** CSAR, draft Schedule of Services & Care Plan returned to HCP manager within 7 working days of receipt of request.
**4.** HCP Manager liaises with professionals who undertook assessments as appropriate.
**5.** Where the resources for the scheme are fully expended and a waiting list is in operation (7.2.5), or where complex cases are being considered for a HCP, an MDT meeting may be required to discuss the assessment, schedule of services care plan, and completion of Priority Rating Score.

Stage 4: Procedures for determination of an application for a HCP

The following section provides guidance in relation to what factors should be considered in determining the outcome of an application for a HCP.

Stage 4a - Consideration of Application

Following identification of the care needs and completion of recommendations the HCP Manager makes a determination in relation to the application.

The following will be amongst the factors that will need to be considered by the HCP Manager (see also Table 3 below):

- Appropriate care in the appropriate setting
- Limit of resources for the Scheme
- Estimated duration of proposed HCP
- Estimated weekly cost of the HCP & requirement for GM approval
- The outcome of the assessment of care needs and the recommendation made by the person(s) completing the CSAR
- Any report on the client and his/her needs provided by applicant's GP
- Applicants expressed wishes as recorded on CSAR

- Appropriateness of an Interim HCP
- Age of applicant – If under 65 years requires GM approval
- Alternative responses

*Appropriate Care in Appropriate Settings*

It is acknowledged that not all patients are suitable to continue to be cared for at home and therefore are not suitable for a HCP. For these people their care needs can only be met appropriately by admission to an acute hospital or to long stay residential care. Where care at home with supports is appropriate a HCP may be considered.

*Limit of resources for the Scheme*

The extent of the support available through the Scheme is subject to the limit of the resources allocated each year to the HSE for this particular scheme. Therefore at times individual applicants may not receive all of the services/supports recommended and may instead be allocated a portion of what is recommended or may not be allocated any additional services/supports immediately. In such cases the application will be placed on a waiting list held at Local Health Office level (Section 7.2.5 refers) following a risk assessment of the applicant's care needs. Where a waiting list is in operation the allocation of a HCP by the HCP Manager must follow the guideline set out in section 7.2.5.

Finance Guidelines outlining the approach to recording budget allocations, direct HCP pay and non-pay expenditure, assignment of related costs, ensuring value for money, financial reporting requirements, etc are attached at Appendix VI.

*Duration of a Home Care Package*

Home Care Packages are based on the assessed needs of the older person. There are therefore no upper or lower time limits for a HCP. However, review arrangements (See Section 7.3) must be put in place at the time of approval of the package to ensure that the individual's care needs continue to be supported in the most appropriate way in the most appropriate setting. Expected duration of a HCP may be a relevant consideration if the particular HCP is in excess of the values set out in this section.

In order to ensure a standard approach to recording of HCPs the following categories are to be used in relation to duration of a HCP and will be calculated by the ICT system based on start and finish dates input to the system. In the interim, classifications will be calculated on an excel database.

A **long term HCP** is one which is in place for a period of 30 days or longer and includes packages provided for
- On-going assistance with activities of daily living,
- On-going personal care needs,
- Medication management
- Persons who could not continue to or return to reside at home without such on-going supports & services.

A **short term HCP** is one that is in place for less than 30 days and includes packages provided for
- An applicant to return home from hospital where care needs can be reviewed within a short period in the home setting (see also Interim HCP below)
- Respite breaks to support carer
- Transition period while client is re-orientating from hospital or residential care to home care
- Short period while informal carer is ill or unavailable
- Supporting an older person to remain at home while recuperating from an illness or convalescing following acute hospital admission
- Supporting a terminally ill older person to remain at home

*Interim HCP*

It is generally acknowledged that older persons' assessed needs while in a hospital environment may vary significantly from needs assessed in their own home environment. Interim packages may be allocated therefore to facilitate, in particular, discharge home of

- Patients not previously known to the service
- Patients known to Community Services whose care needs are known to have increased but whose actual needs cannot be fully assessed while in a hospital setting
- Patient who only need transitional support to facilitate re-orientation to the home environment
- Emergency cases arising in the community e.g. sudden & unexpected carer unavailability where care needs assessment process cannot be completed immediately.

The initial levels of service/support approved for a short period, at the discretion of the HCP Manager, may be increased, decreased, withdrawn or remain the same following full review of the care needs in the home setting. As a guide it is recommended that interim HCPs are reviewed, and the services levels revised if necessary, normally within a maximum of 5 working days of the applicant returning home or the Interim HCP being commenced. Any extension of this time line is a matter for the HCP Manager but the reasons for extending should be documented on file.

The normal application form for a HCP should be completed and submitted in accordance with the procedures set out in this document. Contact should be made by telephone with the HCP Manager to indicate that an interim HCP may be required. The HCP Manager will assess the need for an interim arrangement.

In individual cases the interim HCP may be all that is required by the older person prior to care reverting to mainstream community services or with no subsequent involvement of mainstream community services.

Approval by the HCP Manager is required prior to the allocation of any Interim HCP. Interim HCPs are subject to the limit of the resources available for the scheme and the procedures set out in these Guidelines in relation to the management of resources and waiting lists set out in section 7.2.5 must be applied.

*Weekly value of a Home Care Package*

The weekly value relates to services approved from the HCP scheme only and does not include services provided through mainstream services budgets.

In individual cases where, for exceptional reasons, consideration is being given to supplying a home care package which exceeds the value of €525 per week (excluding aids/appliances) approval of general manager or equivalent will be required. As a guide therefore, a HCP consisting of more than 25 hours per week home help service or over 15 nursing hours per week will generally need to be approved by general manager or equivalent.

HCPs valued at over €850pw (excluding aids/appliances) will only be approved in very exceptional cases where all other care options including residential care have been fully explored and generally where such high value HCP is required for a very limited duration e.g. end stage terminal illness.

A standard cost calculator will be circulated to all areas to ensure that a similar approach to costing is in place across the system.

Where such very high intensity care is required, decisions on the provision of a HCP for an individual should take account of the relative costs of community based and residential care and the need to spread the available resources to the maximum benefit of the greatest number of applicants. Cognisance will also need to be taken of the appropriateness of community based care in such cases where 24 hour care is provided for in residential care settings supported by the Nursing Home Support Scheme.

*Stage 4b Determination regarding application for HCP – Approval or refusal*

The HCP manager will have considered all of the foregoing in determining the outcome of an application for a HCP.

**Routine (non-complex)** cases will be determined by the HCP Manager. Periodic review of randomly selected cases by the local governance group (as set out in section 6.2) will help to ensure that a consistent approach is being taken to HCP processing and decision making. It is suggested that a peer review of anonymised cases by governance groups from other areas to ensure consistency across areas be conducted one a year (at a minimum). MDT input is required for the care needs assessment and may be requested as part of the determination by the HCP Manager, but a full MDT meeting is not needed to support such applications.

**Complex or multiple need** cases should be supported by a multidisciplinary team where possible. MDT meetings, involving the HCP Manager, may consider new applications or reviews. This practice encourages a multi-disciplinary and multi-dimensional approach to assessment and decision making.

Where a HCP is required **urgently for a complex case**, the decision can be made by the HCP Manager in accordance with the Guidelines, but the decision should be reviewed no later than 21 working days by the relevant MDT or other agreed local structures. If an interim HCP is provided in respect of a complex case a review of the case should be carried out normally within working 5 days to ensure an appropriate care plan is implemented which may or may not include a HCP.

In cases where insufficient details are submitted, the HCP manager can seek additional information before making a determination in relation to any application. **Information regarding the determination** of the application is to be fed back to those involved in the application for a HCP.

Having considered all of the aspects of the application in line with these Guidelines the outcome of the determination must be set out in the appropriate format and signed by the relevant personnel. It is the responsibility of the HCP manager to ensure that in respect of each application accurate up to date records are maintained in relation to the scheme including an appropriate needs assessment and comprehensive individual files.

*Stage 5: Notification of Outcome of Application/Referral*

The outcome of the application for a HCP will be **notified verbally if application is urgent**. In all cases the outcome will issue **in writing** (Standard Letter Appendix IV) to the applicant (or his representative) and to the referrer (if different) within 5 working days of the decision being made. A time limit of 5 working days to confirm acceptance of the offer of the HCP (from date of offer – whether verbal or written) will apply. Verbal confirmation of acceptance of a HCP is sufficient – date of verbal notification & confirmation should be recorded on client file.

If an application is **approved and resources are available** the applicant and referrer are notified in writing (and if appropriate verbally), the schedule of services and care plan are finalised in consultation with the client and the services are operationalised.

If an application is **approved and resources are not available**, the applicant and referrer are notified in writing (and if appropriate verbally), and the applicant's details are added to the waiting list.

If application is **refused** the reasons are to be set out on file, the applicant and referrer notified in writing (and if appropriate verbally) with the reasons for the refusal and setting out the right of the applicant to appeal. An applicant whose care needs are being supported through existing or additional mainstream services will need to be advised accordingly (Standard Letter Appendix IV).

Once the outcome of the application for a HCP is determined the Schedule of Services and Care Plan is to be finalised & signed off by the key worker in partnership with the older person, their informal carer and all service providers. This applies even if application does not result in additional services being provided from the HCP scheme i.e. mainstream services only are being provided to support the care needs.

### 7.2.2 Standard Individual HCP File Content

Each client HCP file held by the HCP Manager must at a minimum contain the following

- Copy of completed Application /Referral form and Schedule for when case review will be undertaken
- Copy of completed initial CSAR, schedule of services & care plan (including any informal care being provided, and by whom) and any re-assessments, and updated schedules of services and care plans

- Level of dependency on initial assessment and on review – independent, low, medium, high, maximum as identified on CSAR.
- Copy of any correspondence regarding the HCP
- Completed determinations of application, including details of service approved through HCP and estimated costs;
- Length of time person is in receipt of HCP - start date , finish dates when HCP ceased and reason for ceasing;
- Record possible alternative response(s) that were considered prior to HCP approval – to assist with value for money reviews;
- Questionnaires and interviews with clients and their carers in relation to satisfaction with the HCP - undertaken as part of review
- As Waiting Lists are likely to emerge, Priority Ranking Score should be completed for all applicants

Hospital admissions and other significant events are to be recorded on care plan held at client level and by health staff. Such events are to be notified by front line staff to the HCP Manager for consideration in context of continuation of HCP.

### 7.2.3 Sources of Services/Supports

The HCP Scheme is administered by the Health Service Executive. However, services/supports approved under the scheme may be provided in a number of ways as follows. The categories assigned to the various types allows for a standard approach to recording and monitoring of HCP Scheme performance data across the HSE.

1. directly by the HSE **("Direct HCP")** (includes Aids and Appliances) or
2. by voluntary groups/organisations/private providers where service agreements are in place **("Indirect Home Care Package")** or
3. by special arrangement with voluntary groups/ organisations/ private providers, on an individual case basis, directly reimbursed by HSE **("Indirect Home Care Package")** where the provider is selected by the HCP Manager from the **Approved provider** list.
4. through a **combination** of the above **(Category "Direct", "Indirect" is assigned on the basis of whichever element of the Home Care Package is the greatest cost).**

The majority of HCPs will involve service delivery directly by the HSE (Direct HCP) or on behalf of the HSE by voluntary or private providers who already have a service level agreement in place (Indirect HCP). Indirect HCP Providers of **home support services**, through the HCP scheme, similar to the home help service, will need to meet certain criteria set down by HSE and be a **"approved provider".**

There will be indirect service providers who do not need to be recognised as a approved provider e.g. nursing homes registered with HIQA may provide residential respite care services as part of a HCP. Payment to indirect service providers should, except in exceptional circumstances be made by the HSE directly to the provider, in arrears, when clients have certified that the services have been received.

### Section 7.2.4: Home Care Cash Grant

Cash Grants have to date been a feature of the HCP Scheme in some LHO areas. The Task Group considered the various arguments for and against the continuation of this aspect of service delivery for HCPs. Having considered these arguments it was agreed by the Task Group that no further cash grants would be approved under the HCP scheme and that existing cash grants involving direct payments to clients or their representative, should be phased out. Existing Cash Grants should be reviewed as a priority and where possible alternative arrangements made by providing direct or indirect services as appropriate.

## Table 3 – Consideration by HCP Manager

**1.** HCP manager **considers** applications/referrals in line with the Guidelines
**2.** HCP manager may **discuss** case with relevant professionals, MDT to clarify issues
**3.** HCP Manager to **finalise** determination within 7 working days of receipt of completed recommendation.
**3a.** HCP manager sets out in detail the particular services/supports under HCP being **approved** if any and sign approval section of CSAR. **or**
**3b.** Set out reasons for **refusal** and signs refusal.
**4.** HCP exceeding €525 per week or if applicant is aged <65 years, set out recommendations, sign & seek GM's approval. If value exceeds €850pw particular detailed case to be set out for GM consideration & determination.
**5.** Insert **review** date & review intervals.
**6.** Arrange for letter of approval/refusal to issue to applicant within 5 working days of decision being made, & copy to relevant personnel (Standard Letter Appendix IV)
**7.** Record information on database & update individual HCP file.
**8.** If resources are not available to provide the recommended levels of service/support, add to waiting list (See 7.2.5) noting Priority Ranking Score; issue letter to client/referrer (Standard letter)
**9.** HCP Manager will make a verbal offer of a HCP which can be confirmed thereafter in writing (Standard letter) - Offer is time limited to 5 working days and indicate the actions required on the part of the applicant, if any, with specific time frames
**10.** HCP Manager may extend an offer but must document reasons for extension.
**11.** Refusal of a HCP will be noted on the applicant's file, confirmed in writing to applicant/referrer & no further offers will be made unless a new application is received and processed.

### 7.2.5 Management of Resources & Waiting List for HCP Scheme

Finance Guidelines outlining the approach to recording budget allocations, direct HCP pay and non-pay expenditure, assignment of related costs, ensuring value for money, financial reporting requirements, etc are attached at Appendix VII.

When an applicant for the Home Care Package Scheme has been determined as needing enhanced levels of community supports and the resources for the scheme are fully committed and no services/supports can be allocated, the applicant's details will be placed on a **waiting list for resources by reference to the date the application was received by the HSE**. One waiting list per LHO will exist.

Applicants must only be added to the waiting list when the following conditions apply:

- Care needs have been determined.
- Application for a HCP has been approved
- Risk Assessment has been undertaken leading to **Priority Ranking Score** (See Section below – Priority for HCP applications on waiting lists)

Each application being placed on the Waiting List will therefore have received consideration for Prioritisation. Applications/referrals must be processed even if it appears that resources are not immediately available.

Applicants will remain on the waiting list until:

- Service/support approved by the HCP Manager through the HCP have been supplied either through mainstream services or through HCP scheme (subject to review of the case if there is a significant delay in allocating services) or
- It is confirmed in writing by applicant, their representative or the referrer, that they no longer require a HCP or
- An offer of a HCP is refused by the applicant or
- Review of priority ranking undertaken to confirm or amend score
- Other relevant event e.g. applicant deceased or admitted to residential care etc.

Regular reviews of Prioritisation will be conducted at intervals as determined by the health professional conducting assessment and/or HCP manager.

## Priority & Offers of HCPs to applicants on waiting lists

As the scheme was established to be as flexible as possible to support older people, and the health system, it is acknowledged that from time to time particular individual cases of exceptional or urgent needs will arise. In order to deal with the most urgent cases in the first instance all applications will need to be prioritised.

### 7.2.5.1 Priority Ranking System

In order to assess the degree of priority involved, a Risk assessment against 5 identified factors will be undertaken. Risk is to be measured in terms of likelihood and impact i.e. the likelihood of an event occurring combined with its impact (consequence). This approach is adopted from the HSE Risk Assessment Tool[3]

The methodology for measuring risk in this way plots a single ascribed value of likelihood against a single ascribed value of impact and therefore reduces risk to a single, easily comparable value. This process uses informed but subjective judgement in assigning the values for likelihood and impact.

Likelihood scoring is based on the expertise, knowledge and actual experience of the health professional scoring the likelihood. In assessing likelihood, it is important to consider the nature of the risk. The assessment of likelihood of a risk occurring is assigned a number from 1-5, with 1 indicating that there is a remote possibility of its occurring and 5 indicating that it is almost certain to occur.

**1. LIKELIHOOD SCORING**

| **Rare/Remote (1)** | | **Unlikely (2)** | | **Possible (3)** | | **Likely (4)** | | **Almost Certain (5)** | |
|---|---|---|---|---|---|---|---|---|---|
| Actual Frequency | Probability | Actual Frequency | Probability | Actual Frequency | Probability | Actual Frequency | Probability | Actual Frequency | Probability |
| Not currently a factor and not likely to occur in next 7 days | 1% | Not currently a factor but may occur within next 7 days | 10% | Currently a factor but not likely to require increased interventio n in next 3-4 days | 50% | Currently a factor and will require increased interventio n in next 3-4 days | 75% | Currently a factor and requires immediate increased interventio n or interventio n within 24/48 hours | 99% |

[3] Developing and Populating a Risk Register Best Practice Guidance, HSE 2009

To determine the impact of any harm should it occur, each risk factor has been assigned descriptors over 5 levels ranging from negligible to extreme harm. In scoring impact, the anticipated outcome of the risk is grade from 1-5, with 1 indicating a Negligible Impact and 5 indicating the most Extreme/serious Impact.

The ranking system of prioritisation factors is therefore developed, with each factor having a 0-25 risk rating, thereby producing an overall priority ranking to a score of between 0-100 (Risk Rating score for 4 factors combined – Factors 3 and 4 are mutually exclusive). Therefore all applicants on the Waiting list will be prioritised with an individual score ranging from those with least priority (0) to maximum Priority (100).

## Risk Assessment leading to Priority Ranking Score

5 factors have been identified in terms of identifying the degree of priority an individual applicant may have on a waiting list. The degree of risk should be assessed for each client across the factors and scored taking both the "Likelihood" and "Potential Harm" into account, producing an individual factor score and then leading to an overall Priority ranking Score.

The Priority Ranking Score sheet is displayed below. This table will need to be completed as part of the assessment of need and is included with the supplementary pages attached to CSAR.

## PRIORITY RANKING SCORE SHEET
## Circle the relevant score in each table

1. **Assessment of Risks within in the home environment and carer support.** This includes risks relating to the home environment such as the quality of housing, accessibility, heating, housing adaptations or capacity to adapt, availability of carer supports, capacity of individual to support themselves through formal or informal care arrangements, etc

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| | |
|---|---|
| **Score Zero if factor is not applicable** | **0** |

**2. Assessment of Risks to the Client.** This includes risks relating to the personal care of the client, medical and nursing care needs, mobility, hygiene, toileting, feeding, etc.

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| **Score Zero if factor is not applicable** | **0** |
|---|---|

**3. (or Factor 4. below) Assessment of Risk to client of entering A&E/ hospital admission**

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| **Score Zero if factor is not applicable** | **0** |
|---|---|

**4. (or Factor 3. above) Assessment of Risk remaining in hospital without additional support to return home**

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| **Score Zero if factor is not applicable** | **0** |
|---|---|

**5. Assessment of Palliative Care Needs**

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

**TOTAL PRIORITY RANKING SCORE = _____ (0-100)**
**(Total Priority Ranking Score is obtained by addition of 5 separate risk factor score as recorded above)**

The particular risks taken into account in scoring the priority ranking should be recorded in the appropriate section of the CSAR (Section 9)

When resources are fully committed, one waiting list per LHO will be established. In order to be placed on waiting list an assessment of prioritisation must be completed so that each person on the waiting list should have a priority ranking score (0-100).

Applicants on the Waiting List will generally be offered a HCP by reference to their chronological date on the waiting list. However, where applicants who are at risk are on the waiting list and in order that those applicants at greatest risk receive supports, HCPs will be offered on the basis of Priority Ranking Score – those who score highest will be taken from the waiting list ahead of persons who have scored lower.

Where two or more patients are marked as equal priority i.e. with same ranking score, the next available HCP will be allocated to the person with the longest waiting time, and chronological order will apply i.e. chronological order will apply to the group of equal priority applicants.

**Table 4 Procedures for Managing Waiting List for HCPs**

**1**. HCP Manager will manage waiting list - there will be a single HCP Waiting List per LHO area. This list will

- record applicants in order of the date the completed application was received by HSE (as per date stamp) and
- identify most urgent cases as per their priority ranking score.

**2**. If no priority applicants are waiting for a HCP the applicant next on the waiting list chronologically will be offered the next available HCP

**3**. If priority applicants are on the waiting list the applicant with the highest priority score will be offered the next available HCP.

**4.** Where a number of applicants have equal priority status, chronological order will apply to determine which of that group of applicants is to be offered the next available HCP.

**5.** HCP Manager will make a verbal offer of a HCP - confirmed after in writing. Offer will be time limited to 5 working days - indicate the actions required by the applicant

**6.** If applicant deemed unsuitable for HCP, the reasons must be considered and future status on the waiting list must be reviewed.

**7.** HCP Manager to ensure that ceased HCPs are notified in a timely manner. All service providers and client representatives must notify HCP Manager not later than one working day after HCP no longer required/ceased (up to 5 working days will be allowed where client is deceased).

**8.** Where an applicant is deemed unsuitable for a temporary reason e.g. acute illness, HCP Manager may extend offer or may, if the HCP cannot be taken up in a reasonable timeframe, allocate the HCP to the next person. The original applicant will then remain on the waiting list and may be offered a HCP on another occasion. If offer is again refused name is removed from waiting list and applicant must re-apply.

**9.** If applicant refuses offer of HCP, the refusal will be noted on the applicant's file, confirmed in writing to applicant/referrer, details removed from waiting list, no further offers will be made unless a new application is received and a care needs assessment completed.

### 7.2.6 Cessation of Home Care Package

A HCP will **cease** if

- the client is undergoing treatment in an acute hospital or
- the client is receiving residential respite care or
- the required monitoring arrangements are not being adhered to or
- the services/supports are no longer required by the client (as determined by HSE staff) or
- following review the enhanced levels of services/supports are no longer required by the client (as determined by HSE staff) and her/his care needs can be met by mainstream services
- the client is deceased

The client or his/her representative should advise the HCP Manager or their key contact within the HSE e.g. PHN, promptly of any such circumstances arising.

If a HCP is temporarily ceased while a client is hospitalised etc. it should be re-commenced, with HCP manager approval, without the necessity to re-apply. The actual re-commencement date will need to be determined by the HCP Manager. If care needs have altered a review may be scheduled.

Other than where applicant is deceased, a letter will issue to the applicant/referrer to confirm cessation of a HCP and the reasons for ceasing (Standard Letter Appendix IV). The cessation date and reason for cessation should be recorded on the ICT system and on the clients file.

## 7.3 Monitoring and Review

Monitoring of the HCP Scheme is required at a number of different levels.

### 7.3.1 Client level

HCPs will be subject to **regular review** by the relevant HSE staff e.g. public health nurse and/or other relevant health care professional(s). The appropriate interval for reviews will be determined by HCP manager on approval of the HCP and following each completed review. In any case each HCP will be formally reviewed at a minimum every 3 months but it is expected that the majority will be formally reviewed at much shorter intervals as determined by the HCP Manager and the health professional(s) involved in the case.

In addition to scheduled reviews any health professional or any care provider or the client or his representative can request a review if the clients needs change. A review request can be made by the client/representative by contacting the local PHN, other health professional involved in the care of the older person or by contacting the HCP manager (Contact details included in Public Information Leaflet).

The purpose of the review is to **reassess the older person's care needs** and to ensure that the HCP continues to support those needs. The review may lead to an increase, decrease, continuation or discontinuation of the HCP or referral to another service. The outcome of the review will be advised to the client and his/her representative in writing within 5 working days of determination (Standard Letter Appendix IV). Where a long term HCP is to be reduced or discontinued, the client and his/her representative should be given adequate notice of the withdrawal or reduction (10 working days), the reasons for same and the opportunity to appeal the decision.

Reviews are to be documented into the relevant sections of CSAR and signed off by the person(s) undertaking the review and copied to the HCP Manager. The review will follow the process as applies to new applicants set out in the Guidelines. Any recommendation for an alteration to the HCP must be clearly set out in Section 13 of the CSAR supplement page by the professional(s) undertaking the review and considered by the HCP Manager. No changes in the HCP can be implemented until approved by the HCP Manager.

The schedule of services & care plan must be updated to reflect the altered needs and any approved changes to services/supports.

As part of the review the client/family/carer will be asked to complete a questionnaire (standard format – to be finalised by Best Practice Group) which will provide feedback to the HCP manager in relation to the benefits/outcomes and any problems encountered with the individual package. This will assist in the development of the HCP for the individual and overall feedback is to be advised to the Best Practice Group for consideration in terms of proposed amendments or clarifications required to the National Guidelines.

### 7.3.2 Area, Region and National Level

The HSE must be in a position to provide on comprehensive data/ information on the range, distribution and cost of caring for older people in the community. In addition qualitative measures will need to be in place to ensure the best outcomes for the older people availing of HCPs.

An ICT–based solution to managing the detailed HCP Scheme information, and capturing and reporting management and performance information, is required. Work on this is requirement is being progressed during 2010 by the National Task Group on HCPs and Home Help Services. Any recommended solution will require approval through the nationally agreed processes.

When such a system is implemented it is intended that data collection & reporting will have the capacity to incorporate a comprehensive list of data by local area, by region and nationally (Appendix VII). Details of the exact structure and layout of reports will be agreed at a later stage. In the interim a significantly more limited range of information will be available on a quarterly basis – details set out in Appendix IX)

Questionnaires completed by clients/carers, complaints and appeals upheld will be examined and collated anonymously to provide feedback for the purposes of identifying outcomes, benefits to clients, and updating the Guidelines.

The DoHC Evaluation Report 2009 recommended that a Value for Money Review of the HCP Scheme would be undertaken in 2011. The above data, the implementation of the national guidelines, improved recording of financial information and the procurement of an ICT solution, will support the preparations for such an evaluation. It is intended that the VFM review would be undertaken after the Guidelines have been in operation for at least 12 months. On this basis the VFM review would be undertaken in 2012 at the earliest.

## 7.4 Complaints and Appeals

It is the right of Service Users to make a complaint where standards of care, treatment and practice are perceived to fall short of what is acceptable. In these circumstances, the complainant should have ease of access to an effective and fair system to deal with their complaint. The HSE, in accordance with Part 9 of the Health Act 2004 is committed to providing a system for the management of complaints that facilitates effective feedback from and communication to all service users.

Management of Complaints in the HSE

Part 9 of the Health Act 2004 outlines legislative requirements to be met by the HSE and relevant service providers in the management of complaints. The provisions of the Act were implemented with effect from 1st January 2007. The policy and procedures for the management of complaints in the HSE were finalised in line with the regulations. Over 800 Complaints Officers have been nominated throughout the HSE to handle complaints.

The approach to complaints management is set out in the process entitled "Your Service Your Say". Public information leaflets on "Your Service Your Say" are widely available from HSE facilities. Each staff member involved with Home Care Packages should ensure the availability of these leaflets to individual clients and their carers.

Persons in receipt of services from private providers funded by the HCP scheme - "approved providers" - will have access to the complaints procedure established by the individual provider. If this process does not yield a satisfactory conclusion an applicant may refer their complaint to the HSE to be dealt with under the HSE processes outlined above.

Appeals

In the event of an unfavourable decision in relation to HCP application or review, formal notification should be issued advising the applicant of his/her right of appeal and indicating where he/she should send the appeal. The formal notification is incorporated into the relevant standard letter in Appendix IV.

An appeal should set out the reasons why the applicant is not satisfied with the decision made in relation to the application for a HCP. An appeal must be submitted to the Appeals Officer within 20 days of receipt of the decision letter.

## 8.0 Implementation Plan

The Guidelines will be disseminated and implemented across the 4 regions following approval by Senior HSE Management and by the DoHC. The implementation of the approved Guidelines will be the responsibility of the RDOs and LHO managers within the Region supported by Area Specialists, HCP managers and the regions representatives on the National Task Group.

An implementation plan, including estimated resource implications, will be submitted with the National Guidelines to senior HSE management for approval. The following summarises the implementation plan – dates are subject to Guidelines being approved in September 2010:

National Task Group

- Completes draft Guidelines & submit for approval to senior HSE Management & DOHC – June 2010
- Following approval the members of the National Task Group will support the implementation of the Guidelines through preparation of training materials & presentations participation September/October 2010
- Guidelines to be in operation from 1st December 2010 for new applications.
- Reviews of existing HCPs to be undertaken and substantially completed by 31st December.

Briefing of Senior Managers – by end October 2010

- Guidelines and documentation circulated
- Regional Briefings for Senior Managers – October 2010
- HCP Managers assigned & trained

National Best Practice Group will be established to deal with queries, provide clarifications to HCP managers in regions and consider & recommend amendments to achieve best practice – November 2010

General Staff Training/Briefing

Briefing/training sessions will be conducted across the Region incorporating all appropriate staff in the PCCC and Hospitals services. Additional detailed training of specific staff will be required in relation to the ICT system in advance of ICT implementation.

Discharge Planning and HCPs

Briefings with Hospital Staff will form an important element of implementation of the National Guidelines. These briefings will also provide an opportunity to discuss arrangements for integrated

discharge planning. Timely communication between hospital staff and the community services staff is a key success factor in the Home Care Packages scheme and it will ultimately ensure appropriate care is provided in the most appropriate setting and in the most efficient manner – November 2010.

ICT System

The implementation of the Home Care ICT System will follow the ICT Project Management Methodology. The first and current phase of the project is the approval phase where approval for the project will be sought from within the HSE and then from the Department of Finance. Given the costs involved, the Dept. of Finance may carry out a Peer Review of the proposal, a process that may take several months.

Following approval, the second Initiation phase involves detailed project definition and sign-off, project planning and procurement. Having agreed contract with a supplier, the Implementation phase begins and this is where an ICT system is delivered to meet the project objectives. The main stages are system set-up, testing, training, go-live and rollout. In the final Close-Out phase the project transitions into operational mode and there are reviews the whole undertaking. The key stages are system support, project handover and post project review.

Following approval by the HSE and Dept. of Finance, the estimated duration of the project is 12-18 months.

Resource Requirements

Full implementation of the Guidelines will require the allocation of additional staffing and non-pay resources in order to fully support the consistent implementation of the guidelines across the system.

Pay:

Staff, over and above existing levels, will need to be assigned to support the scheme in terms of day to day management; rollout of and training on ICT system; ongoing administration of the ICT system; input of data, updating of individual client files etc. The additional requirements are currently being estimated. In advance of the ICT system being implemented there may be a need for additional staff to be assigned to the HCP scheme to facilitate the operation of the applications process and the issuing of formal acknowledgements, approvals etc. This requirement is being assessed.

Non-Pay:
The most significant resource requirement under this heading relates to the procurement of the ICT system. The final scope of the system will determine the extent of the requirement.

It is expected that no additional WTE or resources will be provided for in 2011 and therefore these must be prioritized within existing HSE resources.

## 9.0 Revision and Audit

The DOHC recommends that a Value for Money audit of the HCP Scheme is to be undertaken in 2012. The Guidelines will be reviewed following the audit to take account of any recommendations emerging.

Revision of the approved version of the Guidelines will be the responsibility of the Office of the Assistant National Director Services for Older People. Recommendations for amendments will be accepted from all stakeholders and the Best Practice Group established to support implementation of the Guidelines. Procedural amendments, clarifications and updates that do not require senior management / DoHC approval will be undertaken routinely and an updated version circulated as required.

If significant amendments, involving resource implications or policy changes, are being proposed, such changes will require senior HSE management approval and DoHC approval as appropriate.

In addition, the Guidelines will be fully reviewed after two years of operation.

Furthermore the Guidelines will be revised to take account of the development of PCTs as they are progressed.

## 10. References / bibliography

National Economic & Social Forum(2009). *Implementation of the Home Care Package Scheme Report 38* Dublin

Department of Health and Children (2009) *Evaluation of Home Care Packages* Dublin: Government Publications.

Cullen, K., Delaney, S. and Duff, P (2004) *Caring, Working and Public Policy* Dublin, The Equality Authority

HSE (2009), *Developing and Populating a Risk Register Best Practice Guidance*, HSE

## Section 11.0 Appendices

## Appendix I

**Recommendations of NESF Implementation of the Home Care Package Scheme Report 38 2009** (More detail on each recommendation is available in the Report which is available on the NESF website - http://www.nesf.ie)

**Strategy with agreed outcomes**

- Agree the number of HCPs to be supplied
- Agree standard eligibility criteria

**Accountability**

- Clarify the responsibility of different organisations and individuals, and incentivise it

**A focus on delivery**

- Devise detailed delivery plans
- Co-ordinate delivery more effectively
- Set standards for delivery, and monitor them
- Innovate in delivery – use IT, non-traditional providers, etc

**Links between outcomes and budget**

- Link budget and staff for HCPs to the needs of older people

**Understanding of organisational culture**

- Take organisational culture into account, so that there is a coherent link between policy design and policy implementation

**Measurement**

- Collect data on the likely need for HCPs
- Collect data on the inputs, outputs and outcomes of the HCP scheme
- Use this data to manage the scheme's performance

**End Appendix I**

## Appendix II

### Recommendations of DoHC Evaluation Report 2009

**Governance Arrangements**

**1:** Strengthen the linkage with the acute sector at national HSE and LHO level in the governance arrangements for Home Care Packages.

**2.** Establish an operational delivery forum to share good practice and support the implementation of a standardised approach to Home Care Package delivery (see Recommendation 4 below).

**3.** Develop a national HSE approach to procurement of all services related to Home Care Packages.

**Operational Delivery**

**4.** Implement a standardised approach to Home Care Package delivery through the immediate roll-out of the national guidelines, to encompass:

- A national definition of 'mainstream' and 'enhanced' services
- Guidance on classification of short-term and long-term HCPs
- A national HSE approach to the deployment of cash grants
- Standard literature and awareness information on the scheme for the general public
- Standard literature and awareness information on the scheme for HCP recipients
- Standardised approach to means assessment
- Principles for joint working with the acute sector, other parts of PCCC & alternative providers
- Standardised care needs assessment tool, including the informal care profile
- Standard Home Care Package file/record of recipient profile, services and events
- Standardised approach to budgeting for each Home Care Package
- Standardised care plan and schedule of services
- Standardised approach to review
- Standardised approach to capturing outcomes and benefits
- Standardised monitoring and supervisory system
- Standardised complaints process
- Standardised set of governance principles for decision-making and accountability at LHO level with regard to Home Care Package delivery
- Standardised guidelines to support acute and PCCC decision-makers in allocating Home Care Packages based on local health system and population need.

**5.** Undertake a value for money assessment of Home Care Package delivery in 2011.

**6.** Develop and implement a standard ICT-based approach to managing Home Care Package information. This may require an interim solution in anticipation of enhanced national HSE ICT systems.

**7.** Develop and implement (based on existing LHO good practice) standard tools for capturing and reporting Home Care Package management information (in particular financial data). This may require an interim solution in anticipation of enhanced national HSE PCCC management information systems.

**Performance Management**

**8**. Develop comprehensive monthly management information on Home Care Packages. As a minimum this should meet the data requirements set out by the Department of Health and Children.

**9**. Develop and implement standardised guidelines on the monitoring and review of the quality and delivery of Home Care Packages at a recipient, LHO and HSE level.

**Funding**

**10.** Develop comprehensive monthly *financial* management information on Home Care Packages as part of Recommendation 7 above.

- Implement immediate monitoring of the average weekly value of Home Care Packages. As classifications of Home Care Package are developed, these should be reflected in financial monitoring and used to develop indicative weekly values for Home Care Packages.
- Develop and implement guidelines to ensure consistent attribution of cost to budget.

**- End Appendix II –**

## Appendix III

**Application/Referral Form for Home Care Package Scheme**

**This application and an information leaflet are to be finalised with the Communications Directorate as is not for public use in its current format**

*Health Service Executive* *Form HCP 01*

*Home Care Packages Scheme*

*Information and Application/Referral Form – Sample Only – Not For Use*

*Use this form to apply for a Home Care Package. Completed forms should be returned to your HSE Home Care Packages office. Staff in that office can also help you to complete your application. Contact details for HSE Home Care Packages Scheme Offices are provided on the back page. Before completing this form you can read more detailed information on the scheme in the Home Care Packages Scheme Information Booklet.*

*Frequently Asked Questions*

- *What is the Home Care Packages Scheme?*

*A Home Care Package is a range of community services and supports, over and above what is ordinarily available from the HSE, which may be provided to assist a dependent older person to return to home from an acute hospital or from residential care, or to remain at home for longer. A Home Care Package refers to the enhanced/additional services and supports above the normal levels available from mainstream community services*

- *Who can apply for the scheme?*

*Any person who believes he/she requires additional services/supports to assist them to live at home may apply to be considered for a Home Care Package. As the scheme was established to support older people, applicants will generally be aged over 65 years and will usually be in receipt of community based services/ supports. In some limited exceptions persons aged less than 65 years may be considered for a Home Care Package. If the person requiring the supports is unable to apply an application may be made on his/her behalf.*

- *How does the application process work?*

*The application form should be completed and submitted to the relevant local office. A Care Needs Assessment will be undertaken which will identify what, if any, of your care needs are not being addressed, and how these might be best met. The HSE will consider the application and the needs assessment and will notify the applicant of the outcome of the application. It is recommended that before you apply for a HCP that you would discuss your needs with your local PHN who may be able to assist you.*

- *How does the application process work if I am in hospital or residential care?*

*If you are in hospital you should ask the person dealing with the plan for your discharge (this might be a nurse or a social worker) for an application form. This should be completed and returned to the relevant local office.*

❖ *What supports does the HSE offer through the Scheme?*

*Because the HSE is eager to support older people to remain at home for as long as possible when this is appropriate to your needs, Home Care Packages are flexible and provide a range of services and/or supports to support the assessed needs of the person. Services might include additional home help hours, nursing care, physiotherapy, respite care etc. Services may be provided directly by the HSE, by voluntary providers operating on behalf of the HSE or by private providers*

❖ *Is there an assessment of income?*

*No. Your application for the Home Care Package Scheme is assessed on your care needs as identified by health professionals*

❖ *Are there any charges for the services provide through a Home Care Package?*

*No, there are no charges for services and supports provided through the Home Care Package Scheme. However, if an applicant arranges services/supports above the levels provided by the HSE he/she will be liable for the cost of such services/supports.*

❖ *Who should fill in the form?*

*Where possible the person requiring the additional supports should complete the form him/herself. If this is not possible a spouse, relative, friend or health care professional can complete the form for you. He/She will need to explain on the appropriate section of the application form why they are applying and they will need to explain to you why they are applying for a HCP on your behalf.*

❖ *What do I need to include with my application form?*

*No documents are required with your application form.*

❖ *What happens if my circumstances change?*

*If your circumstances change in any way that affects your need for a Home Care Package you must notify the local office. A review of the Home Care Package may be undertaken including re-assessment of your care needs.*

❖ *I want to appeal a decision made in relation to my HCP application - what must I do?*

*The Appeals Service provides an internal, independent and impartial review of decisions taken by personnel of the HSE relating to applications by members of the public for specified services and entitlements, where applicants are dissatisfied with the outcome of their application. If you wish to appeal a decision you should write to the Appeals Officer for your area outlining the reasons for your appeal. Contact details of the appeals officer will be provided if the outcome of a decision is unfavourable or can be obtained from your local office or from the HSE website – www.HSE.ie*

❖ *If I want to make a comment or complaint about the service what must I do?*

*We want to give you the best possible care and treatment. There may be times, however, when you think we could do better. And sometimes you may even want to tell us about something we have done well. You have rights when it comes to your health including:*

- *the right to have your say and be listened to*
- *the right to complain if you are not happy about something we have done.*

*We want you to tell us if you have a comment, compliment or complaint about your health care. In order to help you to do so the following options are available to you:*

- *Talk to any member of HSE staff, service manager or complaints officer by contacting your local health office*
- *Complete and submit the HSE's 'Your Service, Your Say' comment card. Staff can help you put your complaint in writing, if you require assistance.*
- *E-mail yoursay@hse.ie with your feedback.*
- *Send a letter or fax to any HSE location. Staff can help you put your complaint in writing, if you require assistance.*
- *Ring us: LoCall 1890 424 555: Your call will be answered by a staff member from HSE Consumer Affairs*

*If some, or all, of your Home Care Package services are being provided by a private service provider and you are unhappy with the service they are providing you should make your complaint to the service provider in the first instance. If you wish you may then refer your complaint to the HSE using any one of the approaches outlined above.*

*Office Use Only*
*Date Received_____-Ref No_____*

# *Home Care Packages Scheme Application Form*

**This application and an information leaflet are to be finalised with the Communications Directorate as is not for public use in its current format**

## *Part 1 Applicant Details – Please use BLOCK CAPITALS*

**Personal Details**

*Name of Applicant*

*Home Address*

*Current Address (if different from above e.g living with relative, in a Hospital/nursing home)*

*If in hospital/nursing home please state date of admission & Medical Record Number if known:*

*Date of Birth*

*Daytime Phone Number* *Mobile or alternative phone no.*

*Gender*

*Email address*

*Do you hold a medical card?* *Please supply the number:*

**Relevant Contacts**

*GP Name, Address, Phone Number*

*PHN Name, Address, Phone Number*

*Family Contact Name & telephone Number _____*

*Relationship to applicant_____*

*Who will assist you with arrangements for your Home Care Package?*

*Name & telephone Number _____*

*Relationship to applicant_____*

Department of Social Welfare supports:

*Is Carers Allowance/ Carers Benefit/Respite Care Grant being paid to someone to care for you? Yes No*

*If yes please state - Type of payment(s) ……*

*Name of person receiving the payment ……*

*Address of person receiving payment ……*

*Contact telephone number of person receiving payment……*

*If not it may be that your carer should apply for one of these supports. More information is available from the Department of Social & Family Affairs.*

*Part 2 – Application for Home Care Package*

*As part of this application I understand that the HSE will make arrangements for a Care Needs Assessment to be undertaken. Any organisation with information relevant to the applicants care needs may provide the HSE with this information. The content of the Care Needs Assessment report may be provided to, or shared with, relevant health professionals, if required.*
*The signature below indicates consent to this access.*

*The HSE will treat all information and personal data provided to them as confidential. The HSE will only disclose information or personal data to other people or bodies according to the law.*

*I am aware that I must report to the HSE, within 10 working days, any changes in my circumstances which may affect my entitlement to a Home Care Package.*
*I hereby confirm that I have read and understood the foregoing. I wish to apply for Home Care Package under the Home Care Package Scheme. I understand that if my care needs can be met from mainstream services without the need for a HCP then this application will be taken as an application for appropriate mainstream services.*
*I have read the statement above and I say that the information given by me on this form is correct to the best of my knowledge and belief.*

*Signed: _____*

*Date: _____*

*Part 3: To be completed only where the person who may need a Home Care Package is unable to sign this application.*

*I, _____ hereby wish to apply for/refer for a Home Care Package for _____ who it appears may need a Home Care Package and is unable to make the application on his/her own behalf. I have informed him/her that this application is being made.*

*Signed:* *Name in Block Letters:*

*Date:* *Contact Details: Phone Number*

*If this application/referral is being made by anyone other than the client or his/her representative please tick the appropriate box below*

| **1. SOURCE OF REFERRAL (PLEASE TICK):** | | | | | |
|---|---|---|---|---|---|
| Community Hospital | | Acute Hospital | | GP | |
| Mental Health | | Community | | Nursing Home | |
| Name of Location | | | | | |
| Date of Referral | | | | | |

**To comply with data protection legislation the HSE wishes to advise that information supplied in this form will be recorded on a computer system**

| *When you have completed application please submit it to the office in your area:* | | | |
|---|---|---|---|
| *Local Health Office* | *Contact Name* | *Contact Address* | *Contact Telephone and Email* |
| *Carlow/Kilkenny* | | | |
| *Cavan/Monaghan* | | | |
| *Clare* | | | |
| *Cork – South Lee* | | | |
| *Cork – North Lee* | | | |
| *Cork – North Cork* | | | |
| *Cork – West Cork* | | | |
| *Donegal* | | | |
| *Dublin North Central* | | | |
| *Dublin North* | | | |
| *Dublin North West* | | | |
| *Dublin South East* | | | |
| *Dublin South City* | | | |
| *Dublin South West* | | | |
| *Dublin West* | | | |
| *Dun Laoghaire* | | | |
| *Galway* | | | |
| *Kerry* | | | |
| *Kildare/West Wicklow* | | | |
| *Laois/Offaly* | | | |
| *Limerick* | | | |
| *Longford/Westmeath* | | | |
| *Louth* | | | |
| *Mayo* | | | |
| *Meath* | | | |
| *Roscommon* | | | |
| *Sligo/Leitrim* | | | |
| *Tipperary North & East Limerick* | | | |
| *Tipperary - South* | | | |
| *Waterford* | | | |
| *Wexford* | | | |
| *Wicklow* | | | |

**Appendix IV – Standard Letters**

**Subject to adjustment as Scheme is implemented**

**Ref: HCP Request For Care Needs Assessment**

**HCP Office details**

**HCP Ref:**

**Date**

**Contact for Needs Assessment**

**Address**

**Re: Name,**

**Application for Home Care Package Scheme or Review of a Home Care Package**

Dear Name,

**(Office use- Select relevant text & Delete any items that do not apply)**

**The above named has applied for a Home Care Package. A copy of the completed application is attached herewith.**

Or The above named has applied for a review of their Home Care Package. A copy of the request is attached herewith

Or A review of the Home Care Package allocated to the above named/ clients named on the attached listing is due on .....(insert date)/ dates set out.

I should appreciate if you would arrange to have a care needs assessment undertaken and a CSAR completed, in respect of the above named applicant. The completed CSAR form should be returned to me no later than 7 days from the above date in order that the application/review may be processed speedily.

Should you have any queries, please contact this office.

Yours sincerely,

_____

**Name**
**HCP Manager**

**Ref: HCP Acknowledgement of application or request for review**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Application for Home Care Package Scheme or Review of a Home Care Package**

**Dear Name,**

**(Office use- Select relevant text & Delete any items that do not apply)**

**I wish to acknowledge receipt of your application for the Home Care Package Scheme, completed on your behalf by..... (delete if not appropriate). Your application is being processed and further correspondence will issue to you in due course.**

**or**

**I wish to acknowledge receipt of request for a review of your Home Care Package. Your request is being processed and further correspondence will issue to you in due course. I should appreciate if you would arrange to complete the attached questionnaire which is part of the review and return it to me by.....Your answers will help us to understand what parts of the Home Care Package Scheme work well, or not so well.**

Should you have any queries, please contact this office.
Yours sincerely,

_____

**Name**
**HCP Manager**
C.c. Referrer & PHN

**Ref: HCP Decision Letter - Approval**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Application for a Home Care Package**

**Dear Name,**

**(Office use- Select relevant text & Delete any items that do not apply)**

I refer to your recent application a Home Care Package. Following assessment of your care needs, I wish to inform you that you have been approved for a Home Care Package. A copy of the Care Needs Assessment Summary Report (CSAR) is attached for your information.

The services and supports that you will receive from the HCP Scheme are:

1.
2.
3.

These services are in addition to the services you are already receiving.

Attached to this letter you will find a document called "Schedule of Services". This sets out all the services and supports which you will receive to support you to remain at home including those provided through the Home Care Package Scheme. It also sets out who will provide the services e.g HSE, voluntary provider, private service provider.

**(Delete if not applicable)** As you have been approved for residential respite care in a registered nursing home you will need to sign the form below after you have availed of the respite care. You can give this form to the nursing home proprietor who will sent it to us when he requests payment and we can arrange the payment to the nursing home on your behalf. You can avail of this respite care in any registered nursing home of your choice. The maximum weekly

rate that the HSE will pay for this care is set out in the cost of care document attached (also available on the HSE website www.hse.ie)

A copy of your care plan will also be provided to you. Your care plan sets out in detail the assistance we have assessed that you need and how we expect this to benefit you. You will need to retain the schedule of services and care plan in your own home so that you and all those providing care and/or support will know what is agreed and what ways they are to assist you.

**Review**

Your home care package is subject to review by relevant professionals from time to time. This review will help to ensure that your care needs continue to be supported and that care at home remains appropriate. The review will also take account of your views on how you think the home care package is supporting you and how you think it could be improved. A review may result in an increase, decrease or no change in the level and range of services/supports provided or to a discontinuation of individual services/supports or the entire home care package. Your home care package will be reviewed on or before_____(Insert date)

If your needs change before this date you may request a review by contacting your local Public Health Nurse or by contacting this office.

If you have any queries in relation to your Home Care Package, please do not hesitate to contact me. If at some stage the HCP is no longer required contact should be made with this office so that the package can be ceased.

Yours sincerely,

_____

**Name**
**HCP Manager**

C.c. Referrer (exclude completed CSAR) & to PHN

----------**Detach Here**----------

**Ref. Number**
**Name** **Address**

**I confirm that I have received __ week(s) respite care in _____Nursing Home.**

**Signed:**_____

**Nursing home proprietor to attach this signed section when requesting payment from the HSE.**

**Ref: HCP Decision Letter – Outcome of review**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Review of Home Care Package**

Dear Name,

**(Office use- Select relevant text & Delete any items that do not apply)**

I refer to the recent review of your Home Care Package.

A- No Change

Following a review of your care needs, I wish to inform you that you continue to be approved for a Home Care Package. A copy of the reviewed Care Needs Assessment Summary Report (CSAR) is attached for your information. There is no change in the services/ supports that you will receive through the Home Care Package Scheme as your current arrangements continue to support your assessed needs. (proceed to section D&F)

B-HCP Ceased

Following a review of your care needs, I wish to inform you that you are no longer approved for a Home Care Package as the case needs assessment indicates that you no longer require the services provided through the Home Care Package Scheme. A copy of the reviewed Care Needs Assessment Summary Report (CSAR) is attached for your information. It is proposed to withdraw the services provided through the Home Care Package Scheme with effect from .....(insert date). The services being withdrawn are as follows:

1.
2.
3.

If you wish to appeal this decision you should contact this office immediately. If you do not contact me I will assume you are satisfied

with this decision and arrangements will be made to cease the Home Care Package from the above date. (Proceed to section E & F)

C-HCP Increased/Decreased

Following a review of your care needs, I wish to inform you that you continue to be approved for services through the Home Care Package Scheme. A copy of the reviewed Care Needs Assessment Summary Report (CSAR) is attached for your information. As your needs have increased/decreased the services/ supports that you will receive through the Home Care Package have been increased/decreased to ensure that the Home Care Package continues to support your assessed needs. Arrangements are now being put in place to provide the following levels of service from the Home Care Package Scheme

1.
2.
3. (Proceed to section D,E (if relevant) & F)

D-

Attached to this letter you will find a "Schedule of Services". This sets out all the services and supports which you will receive to support you to remain at home including those provided through the Home Care Package Scheme. It also sets out who will provide the services e.g HSE, voluntary provider, private service provider.

A copy of your care plan will also be provided to you. Your care plan sets out in detail the assistance we have assessed that you need and how we expect this to benefit you.

You will need to retain the schedule of services and care plan in your own home so that you and all those providing care and/or support will know what is agreed and what ways they are to assist you.

E- Where service levels are ceased or reduced post review

You may appeal this decision and can do so by writing to:
**Insert Appeals Officer name and contact details**

Your appeal should set out the reasons why you are not satisfied with the decision made in relation to your application for Home Care Package. If you wish to submit an appeal you should do so within 20 days of receipt of this letter.

F -

**Next Review**

Your home care package will be reviewed again on or before _____ (Insert date). If your needs change before this date you

may request a review by contacting your local Public Health Nurse or by contacting this office.

If you have any queries in relation to your Home Care Package please do not hesitate to contact me.

Yours sincerely,

_____

**Name**
**HCP Manager**

**C.c. Referrer & PHN**

**Ref: HCP Decision Letter- No funding available**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Application for Home Care Package Scheme**

Dear Name,

Thank you for your recent application for a Home Care Package. Following assessment of your care needs, it has been determined that you meet the criteria and have been approved for a Home Care Package. A copy of the Care Needs Assessment Summary Report (CSAR) is attached for your information.

However, as there is a set amount of funding available to provide a specific number of Home Care Packages in _____ LHO Area and as that resource is fully allocated to other applicants we are not in a position to provide the additional services/supports at this time. We have placed your name on the waiting list and we will contact you again when funding becomes available.

Yours sincerely,

_____

**Name**
**HCP Manager**

**C.c. Referrer & PHN**

**Ref: HCP Decision Letter - Approval with conditions (high risk)**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Application for Home Care Package Scheme**

Dear Name,

I refer to your recent application a Home Care Package. Following assessment of your care needs, I wish to inform you that you have been approved for a Home Care Package. A copy of the Care Needs Assessment Summary Report (CSAR) is attached for your information. You will be aware, from your assessment, that there are a number of care needs in your case, which indicate that you are in a high risk category in remaining in your home.

While options regarding possible alternative care arrangements have been fully discussed with you, you have decided to avail of the Home Care Package to support you to continue living at home. You must be aware however, that your needs cannot be fully met, and the risks cannot be fully eliminated by the provision of this Home Care Package. **You will need to sign the form below and return to your local office to indicate you understand and accept this.**

While the Home Care Package is being allocated to you there is a limit to the resources available. You should note that the continuing provision of a Home Care Package depends on you continuing to meet the criteria and it is also dependent on the resources available to the HSE. The HSE may not be able to continue to provide a Home Care Package if there is a change in your condition, if the assessment criteria change, or if the HSE does not have sufficient available funding in the future.

A Home Care Package cannot provide 24 hour care, and is not an appropriate alternative to residential care in all cases. The existing

Home Care Package allocation may be unable to sustain you living in the community and you may have to consider alternative care arrangements. We will be available to assist you as you consider these options in due course.

Attached to this letter you will find a document called "Schedule of Services". This sets out the services and supports which you will receive as part of your Home Care Package and who will provide the services e.g HSE, voluntary provider, private service provider. A copy of your care plan will also be provided to you. Your care plan sets out in detail the assistance that we can provide to support your needs and how we expect this to benefit you. You will need to retain the schedule of services and care plan in your own home so that you and all those providing care and/or support will know what is agreed and what ways they are to assist you.

**Review**
Your home care package is subject to review by relevant professionals from time to time. This review will help to ensure that your care needs continue to be met and that care at home remains appropriate. The review will also take account of your views on how you think the home care package is supporting you and how you think it could be improved. A review may result in an increase, decrease or no change in the level and range of services/supports provided or to a discontinuation of individual services/supports or the entire home care package. Your home care package will be reviewed by _____(Insert date)

If you have any queries in relation to your Home Care Package allocation, please do not hesitate to contact me.

Yours sincerely,

_____

**Name**
**HCP Manager**

**C.c. Referrer & PHN**

**----------Detach Here----------**

**Ref. Number**
**Name** **Address**

**I confirm that have read and accept the contents of the letter of .....concerning my Home Care Package.**

**Signed:**_____

**Ref: HCP Decision Letter - Refusal & Appeal**

**HCP Office details**

**HCP Ref:**

**Date**

**Applicant Name**

**Address**

**Re: Name,**

**Application for Home Care Package Scheme**

Dear Name,

I refer to your recent application for a Home Care Package. I regret to inform you that on the basis of the information available to the HSE your application for a Home Care Package is refused at this time.

Your application was refused because.....
*Your needs assessment indicated .....*
A copy of the Care Needs Assessment Summary Report (CSAR) is attached for your information.

You may appeal this decision and can do so by writing to:

**Appeals Officer**

Your appeal should set out the reasons why you are not satisfied with the decision made in relation to your application for Home Care Package. If you wish to submit an appeal you should do so within 20 days of receipt of this letter.

If you have any queries in relation to your Home Care Package application, please do not hesitate to contact me.

Yours sincerely,

_____

**Name**
**HCP Manager**

**C.c. Referrer (& PHN)**

**- End Appendix IV -**

## Appendix V – Refer to Intranet for Current Version

# COMMON SUMMARY ASSESSMENT REPORT

Please complete all sections clearly in block capitals. Read guidance notes before completing

**Assessment process and purpose has been explained to applicant and consent obtained:** ☐

| **1. SOURCE OF REFERRAL (PLEASE TICK):** | | | | | |
|---|---|---|---|---|---|
| Community Hospital | | Acute Hospital | | GP | |
| Mental Health | | Community | | Nursing Home | |
| Name of Location | | | | | |
| Date of Referral | | | | | |

| **2. PERSONAL DETAILS:** | | **PPS no. of person who may need care** | | **No:** | |
|---|---|---|---|---|---|
| First Name: | | Surname(s): | | Preferred Name: | |
| Current Address: | | Past Address (if relevant): | | Tel No(s). | |
| | | | | Date of Birth (DD/MM/YYYY) | |
| Medical Card No: | | Hospital Number: | | | |

**3. PERSONAL CIRCUMSTANCES:**

| Marital Status: | Single | | Married | | Widowed | | Separated | | Divorced | | Other | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Living: | Alone | | With Spouse | | With partner | | With family | | With carer | | With Other | |

Housing situation (see guidance document):

Who is principal carer and what level of support do they provide? (Please include contact details):

| Assessment of Carer's needs completed? | Yes | | No | | (Please attach if available) |
|---|---|---|---|---|---|

Identify any family members, neighbours, friends who provide support:

| Contact Person/Specified Person(contact details address/phone/mobile): | | | Relationship to applicant? | |
|---|---|---|---|---|

| GP: | | Contact Details: | | PHN &/or CMHN | | Contact Details: | |
|---|---|---|---|---|---|---|---|

**4. WHAT OPTIONS OF CARE HAVE BEEN DISCUSSED WITH THIS PERSON AND WHAT IS HIS/HER PREFERRED OPTION?**

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

**5. RECORD OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (SEE GUIDANCE DOCUMENT BEFORE COMPLETING):**

| SERVICE (Tick) | Home Help/Support | | Day Care | | Respite | | Meals Supply | | Laundry | | **Aids and Appliances** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hours/Times p/w or relevant time or if refused services | | | | | | | | | | | | |
| SERVICE (Tick) | PHN/CMHN | | Family support/Private Carer | | | | Therapy or other discipline | | Day Hospital | | Services Refused | |
| Hours/Times p/w or relevant time or if refused services | | | | | | | | | | | | |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

**6. CURRENT DIAGNOSIS AND MEDICAL/MENTAL HEALTH SUMMARY: ( please include only relevant conditions)**

| Completed by: | NAME | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

**7. CURRENT MEDICATIONS (NOT FOR PURPOSE OF DISPENSING)**

| Name of Drug | Dosage | Frequency | Name of Drug | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

**8. ASSESSMENTS**

| **8 (A) BARTHEL INDEX** | **DATE** | | **SCORE** | **SCORE** | **SCORE** |
|---|---|---|---|---|---|
| Mobility | Immobile (0) Wheelchair independent (1) Walks with help (2) Independent (3) | | | | |
| Transfer | Unable (0) Major Help (1) Minor Help (2) Independent (3) | | | | |
| Stairs | Unable(0) Needs Help (1) Independent up and down (2) | | | | |
| Bowels | Incontinent(0) Occasional accident (1) Continent (2) | | | | |

| | | | | |
|---|---|---|---|---|
| Bladder | Incontinent(0) Occasional accident (1) Continent (2) | | | |
| Toilet use | Dependent (0) Needs some help (1) Independent (2) | | | |
| Bathing | Dependent (0) Independent (1) | | | |
| Grooming | Needs help (0) Independent (1) | | | |
| Dressing | Unable to help (0) Needs help (1) Independent (2) | | | |
| Feeding | Unable to feed themselves (0) Needs some help (1) Independent (2) | | | |
| Independent (20) Low Dependency (16-19)<br>Medium Dependency (11-15 )<br>**Total**<br>High Dependency (6-10) Maximum Dependency( 0-5) | | | | |

| **8 (B) COMMUNICATION** | Tick |
|---|---|
| No problems | |
| Retains most information and can indicate needs verbally | |
| Difficulty speaking but retains information and indicates needs non-verbally | |
| Can speak but cannot indicate needs or retain information | |
| No effective means of communication | |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

| **8 (C) OTHER ASSESSMENTS** | | | |
|---|---|---|---|
| TYPE | SUMMARY (PRINT NAME, ROLE, DATE AND SIGN, OR APPEND SIGNED REPORT) | | |
| Cognitive assessment (Specify) | Date: | | Outcome: |
| Pressure sore risk assessment | | | |
| Falls risk assessment | | | |
| Nutritional | | | |
| Other (specify) | | | |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

| **8 (D) Please include details of the person's mental health status (please attach any supporting documentation if available):** |
|---|
| |
| **8 (E) Additional comments e.g. Employment, Recreational or Social Needs (attach supporting documentation):** |
| |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

| **9. PLEASE IDENTIFY ANY OTHER SIGNIFICANT MEDICAL/SOCIAL/ RISK FACTORS THAT SHOULD BE CONSIDERED AS PART OF THE CARE NEEDS ASSESSEMENT :** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |

| **10. HEALTH PROFESSIONAL REPORTS**. (Please attach if relevant. Tick to indicate a report is appended) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Nursing | | Dietician | | Occupational Therapy | | Speech and Language | | Other | |
| Physiotherapy | | Psychology | | Podiatry | | Social Work | | | |

| **Section 11. Specialist Assessment: Best practice recommends that all older people should have either a consultant geriatrician assessment or consultant old age psychiatry assessment prior to a decision being made about their future care needs** | | | | |
|---|---|---|---|---|
| Geriatric Medicine | Completed | | Date: | |
| Old Age Psychiatry | Completed | | Date: | |
| Rehabilitation Consultant | Completed | | Date: | |
| Neurologist | Completed | | Date: | |
| Other(Specify) | Completed | | Date: | |
| **Specialist Comment: (or append report)** | | | | |

| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
|---|---|---|---|---|---|---|---|---|

| **This section should be completed by the person co-ordinating the completion of the CSAR** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |

| **12. This section should be completed by the multidisciplinary decision making team (MDT)** | | | | | | |
|---|---|---|---|---|---|---|
| It is the recommendation of this multidisciplinary decision making team that this person's overall needs are currently best met: (Please tick): | | | | | | |
| Within a Long Term Residential Care Setting | | | | | | |
| Sheltered Housing | | | | | | |
| Other (Specify) | | | | | | |
| At Home with Community Supports (please complete SERVICES RECOMMMENDED below, and HCP recommendation if applicable) | | | | | | |
| Likelihood of change in personal circumstances | Low Risk | | Medium Risk | | High Risk | |

| PLEASE INCLUDE THE RECOMMENDED SERVICE | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Please tick if referral has been sent** | Home Help/Support | | Day Care | | Respite | | Meals Supply | | Laundry | | Aids/Appliances | |
| Comment(s) | | | | | | | | | | | | |
| SERVICE (Tick) | PHN/CMHN | | Therapy or other discipline | | | | Day Hospital | | Other (Specify) | | Other (Specify) | |
| Comment(s) | | | | | | | | | | | | |

| Section 12: Confirmation of Decision regarding Long Term Residential Care/ Recommendation regarding alternative approaches to care | | | | | | | |
|---|---|---|---|---|---|---|---|
| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |
| Completed by: | NAME (PRINT) | | Role | | Date | | Signature | |

## Home Care Packages Scheme – CSAR Supplementary Sections

**The following Sections 13, 14 & 15 must be completed where the CSAR is being used as part of the determination of an application or referral for a Home Care Package**

## Section 13. Recommended Community Supports and Services funded from HCP Scheme

**to be completed by the persons undertaking the care needs assessment/key worker.**
**(Days/times of service delivery - set out in Schedule of Services/Care Plan)**

| Service/ Support | Recommended Service Levels per week | Mainstream Services (insert total of current & additional available) | Recommended from HCP Scheme | Signature of person recommending HCP subject to resource approval by HCP Manager |
|---|---|---|---|---|
| **Home Help** (In line with HH Guidelines) | | | | A N *O*THER |
| **Physiotherapy** | | | | |
| **Occupational Therapy** | | | | |
| **Speech & Language Therapy** | | | | |
| **Nursing** | | | | A N *O*THER |
| **Day Care** | | | | |
| **Respite Care** | | | | A N *O*THER |
| **Aids & Appliances** | | | | |
| **Other: Specify** | | | | |
| | | | | |
| | | | | |

## Section 14 - PRIORITY RANKING SCORE SHEET –
**Circle the relevant score in each table**

### 1. Assessment of Risks within in the home environment

- includes risks relating to home environment e.g. quality of housing, accessibility, heating, housing adaptations/capacity to adapt, availability of carer supports, capacity of individual to support themselves through formal or informal care arrangements etc.

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| Score Zero if factor is not applicable | 0 |
|---|---|

### 2. Assessment of Risks to the Client

- includes risks relating to personal care of the client, medical and nursing care needs, mobility, hygiene, toileting, feeding, etc.

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| Score Zero if factor is not applicable | 0 |
|---|---|

### 3. (or Factor 4 below) Assessment of Risk to client of entering A&E/ hospital admission

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| Score Zero if factor is not applicable | 0 |
|---|---|

**4. (or Factor 3 above)Assessment of Risk remaining in hospital without additional support to return home**

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

| | |
|---|---|
| **Score Zero if factor is not applicable** | **0** |

**5. Assessment of Palliative Care Needs**

Risk Matrix Score =

| RISK MATRIX | Negligible (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
|---|---|---|---|---|---|
| Almost Certain (5) | 5 | 10 | 15 | 20 | 25 |
| Likely (4) | 4 | 8 | 12 | 16 | 20 |
| Possible (3) | 3 | 6 | 9 | 12 | 15 |
| Unlikely (2) | 2 | 4 | 6 | 8 | 10 |
| Rare/Remote (1) | 1 | 2 | 3 | 4 | 5 |

**TOTAL PRIORITY RANKING SCORE = _____ (0-100)**
**(Total Priority Ranking Score is obtained by addition of 5 separate risk factor score as recorded above)**

**Actual Risks considered in the above prioritisation score are to be listed on Section 9 of CSAR.**

**Section 15: Decision in relation to above application for a HCP - To be completed by the HCP Manager**

**1. Checklist / Factors Considered:** Factors taken into account in determining outcome of application – copies of relevant supporting documentation to be retained in individual HCP file. Please tick all factors that have been considered

☐ Client/Referrer completed form
☐ Appropriate care in appropriate setting
☐ Limit of Resources available for scheme
☐ Estimated duration of proposed HCP
☐ Appropriateness of Interim HCP
☐ Estimated weekly cost of HCP & requirement for GM approval (If > €525 pw, GM approval required; If >€650 alternative care to be fully explored) – insert estimated cost of this package here - €_____ (Use cost calculator and print copy for file)
☐ Care Needs Assessment/Schedule of Services/Care Plan/Recommendations of professionals/MDT/Priority Ranking Score
☐ GP Letter – Copy on file – Yes No
☐ Applicants expressed wishes as recorded on CSAR
☐ Age of applicant (If <65 years General Manager approval required)
☐ Alternative responses to application/referral – State most likely alternative response if HCP not provided (required for VFM evaluation)

**Comments:**

_____
_____
_____
_____
_____
_____

☐**Objective** being met by HCP – **Tick principal & secondary objective being met by the HCP – insert 1 & 2 respectively**

.....Facilitate discharge of applicant from _____hospital (insert name of hospital)
.....Reduce inappropriate admissions of older person to acute or residential care
.....Reduce pressures on A&E departments
.....Support older person to continue to live, or return to live, at home
.....Support carers to continue to provide care for older person
.....Other – Please specify _____

**2. Decision** ☐ HCP Approved – allocate services/supports & set review date
☐ Interim HCP Approved - allocate services/supports & set review date
☐ HCP Approved but resources not available - add to waiting list (date application received)
☐ HCP Refused – reasons set out below

**If approved set out below the specific services / supports <u>approved from HCP Scheme</u> (do not reflect mainstream services in this section) and review date. If not approved set out here reasons for refusal: (Use additional sheets if necessary) – attach copy of HCP costing – use HCP cost calculator.**

_____
_____
_____

**1. Home Help Service**: Hours approved from HCP (if any) _____ per pw - Home Help Hours to be provided as follows (include any specific additional details

relating to this approval e.g. if the hours are provided at weekends, as twilight hours, details of provider if known etc)

_____
_____
_____

Classification of HCP service approved: ☐ Direct ☐ Indirect

**2. Nursing Services**: Hours approved from HCP (if any) _____ pw - Nursing Hours to be provided as follows (include any specific additional details relating to this approval e.g. if the hours are provided at weekends, as twilight hours etc)

_____
_____
_____

Classification of HCP service approved: ☐ Direct ☐ Indirect

**3. Therapy Services**: Hours approved from HCP (if any) _____ pw - Therapy Hours to be provided as follows (include any specific additional details relating to this approval e.g. if the hours are provided at home, or in clinic setting etc)

_____
_____
_____

Classification of HCP service approved: ☐ Direct ☐ Indirect

**4. Other Services/Supports**: Approved from HCP if any e.g day care, respite etc _____ to be provided as follows (include any specific additional details relating to this approval)

_____
_____

Classification of HCP service approved: ☐ Direct ☐ Indirect

5**. Aids/Appliances**: Aids/appliances approved from HCP (if any) (GM approval required)

_____
_____

Overall classification of the HCP – based on whether direct or indirect is the greater cost element.

Overall Classification of HCP service approved: ☐ Direct ☐ Indirect

**Start Date:** **Review Date:** **Finish Date if known:**

**The review date for an <u>interim HCP</u> will be within 5 working days of commencement.**

**Approved/Refused/Recommended by:** _____

**HCP Manager** **Date**

**Where relevant - Approved/Refused by** _____

**General Manager** **Date**

**Letter re outcome issued to applicant** _____ **Insert date**
**Letter re outcome issued to referrer** _____ **Insert date**

**If resources are not available immediately**

**Identify priority category for waiting list - See Section 7.2.5 in Guidelines**
**Insert most up to date Priority Ranking Score _____**

**Added to waiting list by date application received_____ (Insert date) and Priority Ranking Score attached.**

# COMMON SUMMARY ASSESSMENT REPORT

**(CSAR: Post Legislation)**

# GUIDANCE DOCUMENT

**<u>This Guidance document was written for the Nursing Home Support Scheme but may be applied when the CSAR is being used to recommend home based care.</u>**

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

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

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

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

# Values and Principles

- Admission to Long Term Residential Care is a significant life decision

- People should not be admitted to long term residential care against their wishes, irrespective of the views of carers and others or of the likely safety of remaining in the community

- The decision-making process should include the older person to the fullest extent possible

- The needs and preferences, if ascertainable, of the individual are the primary consideration when determining whether continuing care is appropriate

- The decision should only be taken when all other care options have been exhausted

- Placement must be appropriate

- To ensure appropriate placement, it is vital that each person has a comprehensive assessment

- Arrangements for the provision of on-going care should be fair and seen to be fair

- People have a right to sufficient and appropriate information on the range of services available to them with in order to make an informed choice about whether they wish to enter long term residential care

**General Points of information:**

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

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

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

**Who should complete a CSAR?**

- The HSE supports the concept of multi-disciplinary (MDT) working. It also recognises that there is considerable variation nationally regarding the availability of staff. Therefore it is not possible to be prescriptive about who should complete a CSAR.

- Each local area/ agency should therefore devise and document their processes for the completion of the report. The goal is to capture the best information available as efficiently as possible. The CSAR has been designed so that any single professional who knows the patient well can complete it, but where an MDT is available they should be involved in the completion. Apart from reports from named professions, the information sought on a CSAR form can be provided by a range of staff. For example, Barthel or cognitive assessments may be completed by a nurse, therapist or medical practitioner.

- Where a Multi-disciplinary team exists, it is envisaged that one person will act as a coordinator for the completion of the form.

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

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

- Ensure that the relevant MDT members have contributed to the completion of the form, as required by local policy
- Sign the form to confirm:
  - that the relevant MDT members have been involved
  - that any information on the form (apart from contributions signed by other professionals) is accurate
  - that the CSAR presents an accurate profile of the care needs of the patient, as of the date of signing.

**Professional contributions to the CSAR**

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

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

**Can the CSAR be modified to meet local needs?**

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

**Section 1: Source of referral**

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

**Section 2: Personal Details**

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

**Section 3: Personal Circumstances**

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

**Contact Person, Specified Person and Care Representatives**

Where the applicant is able to manage their own application, they may choose to nominate a contact person. The HSE will still send confidential information to the applicant, but will address queries to the contact person. The applicant must personally sign any agreements with the HSE.
Where the applicant is not able to manage their application, a 'Specified Person' may act on their behalf. The HSE must be clear as to the identity of the Specified Person and their relationship to the applicant. In certain circumstances, the HSE may decline to deal with a person seeking to act as a Specified Person.
Where an applicant applies for Ancillary State Support but is not able to enter into a financial agreement, a Care Representative has to be appointed by the Circuit Court to deal with aspects related to the legal charge.
In some cases, the Specified Person and the Care Rep. may be separate individuals.

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

- Does the person live in: town, village, or isolated rural area?
- What distance is the applicant from the nearest neighbour etc?
- House type e.g. bungalow, 2 storey etc, location of bedroom and bathroom

- Home Condition: good/fair/poor (poor windows etc)
- Sanitary facilities to include indoor/outdoor toilet, shower/bath
- Is there heating in the house? An electricity supply?
- Running water, hot or cold water available?
- Outline any access issues that will influence mobility, ability of transport to access location
- Please identify the presence of any environmental hazards e.g. steps

**Prinicpal carer**

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

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

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

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

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

## Section 5 Report of current community/home support services

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

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

**5. REPORT OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (SEE GUIDANCE NOTE BEFORE COMPLETING)**

| SERVICE (Tick) | Home Help/Support | √ | Day Care | √ | Respite | √ | Meals Supply | √ | Laundry | X | Day Hospital | X |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hours/Times p/w or relevant time or if refused services | **15 hrs p.w.** | | **3/7** | | **Every 6 weeks for 2 weeks** | | **5/7** | | **N/A** | | **N/A** | |
| SERVICE (Tick) | PHN/CMHN | √ | Family support/Private Carer | X | Therapy or other discipline | X | Other (Spec.) | X | Services Refused | √ | | |
| Hours/Times p/w or relevant time or if refused services | **PHN visits 3/7** | | **None** | | **N/A** | | | | **Boarding Out** | | | |

**N/A: Not applicable**

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

## Section 6 Current diagnosis and Medical/Mental Health summary

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

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

**Section 7 Current medication**
The information documented in this section is to be used as part of the assessment process and not for the administration of medication. For patients in hospital, this section may be completed once key medication has been prescribed as medication frequently changes with the patient's condition. Alternatively, a list of medications on discharge may be appended to the CSAR.

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

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

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

**Section 8: Assessments**

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

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

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

8A Guidelines for the use of Barthel

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

- Usually the performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.

- Unconscious patients should score "0" throughout, even if not yet incontinent.

- Middle categories imply that patient supplies over 50% of the effort.

- Use of aids to be independent is allowed

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

8(B) Please indicate the individual's ability to communicate and retain information.

8(C) A cognitive assessment, appropriate to the patient's age and medical status, *is required. Please also report* any other risk/assessments completed if relevant, e.g. pressure sore, falls, nutritional etc.

8(D) Mental Health Status: please include in free text relevant details and attach any supporting assessments or documentation which assists the application.

8(E) If the individual has specific employment, recreational or social needs, please enter these into section 8 or provide a separate report. It is envisaged that this aspects may particularly apply to adult applicants.

## Section 9. Medical / social / other risk factors

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

Examples:

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

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

1. People with **critical interval needs** are the most dependent, requiring assistance on a frequent and unpredictable basis. People with critical interval needs are **unable** to carry out certain activities of daily living **unaided**, such as:
    - Getting in and out of bed or a chair
    - Getting to and using the toilet
    - Controlling bladder or bowel movements
    - Demonstrating inappropriate/anti-social/violent or risky behaviour due to severe mental impairment
    - Being disoriented for time, person and place and being liable to wander if left unattended
    - Being acutely ill and needing constant nursing attention
2. People with **short interval needs** also need assistance several times a day but at longer, usually predictable intervals.
3. People with **long interval needs** are more independent, requiring assistance with several activities but usually less than once in twenty-four hours, and predictably.

## Section10. Health Professional Reports

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

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

## Section 11. Specialist Assessment

The HSE is working towards best practice. All older people seeking HSE support for continuing care should have a clinical assessment by either a Consultant Geriatrician or a Consultant in Psychiatry of Old Age and associated members of the MDT prior to the decision being made. This assessment should be specifically to address the appropriateness of the proposed admission into long term residential care.
Adults seeking care may be assessed by other professions, including neurology or rehabilitation.
All those undertaking specialist assessment may a comment that long term residential care is or is not required, or may append a report

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

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

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

### Material Alteration in Personal Circumstances

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

### Services Recommended

This section may be useful for strategic planning purposes in identifying future service developments. It should be completed whether or not residential care is recommended i.e. to identify the type of services that may negate the need for long term residential care

### Section 12 sign-off

This should be signed by the chairperson of the multidisciplinary decision making team in your area, or all of the members of the team, depending on local practice.
Signatories to this section are taking responsibility for verifying that, in their judgement and/or that of the professionals involved, the patient does or does not require residential care at the date of signing.
If care is required, the decision as to where that care should be provided is a completely separate decision process.

**- End Appendix V -**

## Appendix VI

## Schedule of Services - SAMPLE

| Schedule of Home Care Services & Supports | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Client Name** | | | **Date of Birth** | | | | |
| **Address** | | | | | | | |
| **PPSN** | | | | | | | |
| | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **Midnight-8.00am** | | | | | | | |
| **8.00 - 9.00am** | | | | | | | |
| **9.00 - 10.00am** | | | | | | | |
| **10.00-11.00am** | | | | | | | |
| **11.00 - 12.00** | | | | | | | |
| **12.00 -1.00 pm** | | | | | | | |
| **1.00 - 2.00 pm** | | | | | | | |
| **2.00 - 3.00pm** | | | | | | | |
| **3.00 - 4.00pm** | | | | | | | |
| **4.00 - 5.00pm** | | | | | | | |
| **5.00 - 6.00pm** | | | | | | | |
| **6.00 - 7.00pm** | | | | | | | |
| **7.00 - 8.00pm** | | | | | | | |
| **8.00 - 9.00pm** | | | | | | | |
| **9.00 - 10.00pm** | | | | | | | |
| **10.00-12.00pm** | | | | | | | |
| **Other Services** | | | | | | | |
| **Aids & Appliances provided** | | | | | | | |
| **Service Provider Contact Details – List all providers** | | | | | | | |
| **Carer Contact Details** | | | | | | | |
| **HSE Nurse Contact Details** | | | | | | | |
| **Schedule Prepared Date** | | | | | | | |
| **Prepared by** | | | | | | | |
| **To be Reviewed Date** | | | | | | | |

**Insert appropriate code beside service as follows:**
**D = direct service provision by HSE**
**I = Indirect service provision by voluntary or private approved provider.**
**Include names of service providers in space provided.**

# Sample Care Plan

| Home Care Packages | Sample Draft Home Care Plan | Form Ref HCP 2 |
|---|---|---|
| **Name:** | **Preferred Name:** | **Date of Birth:** |
| **Address** | **Contact Number:** | **Date Care Plan Completed:** |
| **GP:** | **GP Contact Number:** | **Date Plan Reviewed & replaced:** |
| **Medical Card Number:** | **PPSN:** | |

**Care Alerts: e.g. Allergies e.g Gluten, Drug reactions, Falls risk: Please highlight in red:**

## Communication:

**Care Needs:** **For action by:**

**Goal: To maintain of enhance current levels of communication**

| **Vision** | | **Hearing** | |
|---|---|---|---|
| **Aids** | • None • Glasses •Magnifying glass<br>• Clean & fit glasses daily<br>• Able to clean and fit own glasses | **Aids** | • None • Hearing aids R L • Adjust volume daily<br>• Check batteries and clean aids daily |
| **Actions** | • Place objects in range of vision<br>• Read documents aloud<br>• Assist to write<br>• Assist to use telephone | **Actions** | • Gain attention before speaking<br>• Speak loudly, clearly and directly<br>• Minimise background noise<br>• Allow extra time for response<br>• Give step by step instructions |
| **Other** | | | |
| **Eye Care Required** | | **Ear Care Required** | |
| **Speech & Language** | | | |
| **Language/s spoken**<br>**Speech Disorder/s:** | | | |
| **Other** | | **Personal Preferences:** | |

## Mobility

**Care Needs:** **For Action by:**

**Goal: Client will maintain current level of mobility**

| **Walking** | | | |
|---|---|---|---|
| **Aids** | Walking Stick Zimmer frame<br>Wheelchair Wheeled walker | **Status summary** | • 1 to assist 2 to assist<br>• Hip replacement Knee replacement Amputee |
| **Other**<br>Provide direction<br>Supervise movement<br>Encourage to maintain mobility | | **Aids** Bed rail Slide sheet Hoist Standing hoist<br>**Other e.g. stairs:**<br>1. Unable 2. Needs Help 3. Independent up & down | |

## Toileting & Continence

**Care Needs:** **For action by:**

**Goal: To promote continence or maintain at current level**

**Continence**

| | | | |
|---|---|---|---|
| **Bladder Management** | Toilet – Times<br>Other | **Bowel Management** | High Fibre Diet<br>Encourage fluid intake<br>Bowel Chart<br>Other |
| **Continence Aids**: | Day: | Night: | |

**Toileting**

| | |
|---|---|
| **Toileting Aids** | Commode urinal bed pan |
| **Toileting regime:** | |
| **Personal Preferences:** | |

## Showering, Dressing and Grooming

**Care Needs:** **For action by:**

**Goal:** Adequate personal hygiene will be maintained

**Shower & Washing**

| | |
|---|---|
| Preferred Day/Time Frequency | Shower Bath Bed Sponge Other<br>Adjust water temperature Encourage to optimise self care<br>Other |
| **Transfer Showering Aids** | Walk to Shower Wheelchair Other -<br>Shower chair Other |
| **Toiletries** | Normal soap Soap substitute – Specify Deodorant Aqueous Cream Moisturiser (am pm)<br>Other |
| **Hair Care** | Wash in shower Wash in Bath Preferred Days Other e.g Day Care Centre, Hairdresser |

**Grooming**

| | |
|---|---|
| **Hair Care** | Facial hair – Wet shave Dry Shave Frequency Products |
| **Nail/Foot Care** | |
| **Teeth**<br><br>**Dentures** | Some ( upper lower) All None<br>Cleaning routine: Independent Supervise Some assistance/prompt Fully assist<br>Cleaning routine: |

**Dressing And Undressing**

| | |
|---|---|
| Dressing assistance | Bra Buttons Belt Zip Stockings Socks Jewellery Make-up Shoes Laces Other<br>Assist with selecting clothing Other |
| **Personal Preferences** | |

| Pressure Area and Skin Care | |
|---|---|
| **Care Needs:** | |
| **Goal: To maintain skin integrity and prevent development of pressure areas** | |
| **Pressure Relief Aids** | |
| **Pressure Area Regime Skin Care** | |
| **Other** | e.g refer to Specialised Wound Care Plan |

| Eating & Drinking | | | | | |
|---|---|---|---|---|---|
| **Care Needs:** | | | | **For action by:** | |
| **Goal:** To ensure that clients receives adequate nutritional intake to meeting assessed need | | | | | |
| **Eating** | | | | | |
| **Preferred place to eat** | Dining Room | Kitchen Table | Bedroom | Other | |
| **Type of diet Special Diet** | | | | | |
| **Special Instructions** | | | | | |
| **Aids** | Modified crockery | Modified Cutlery | Bowl | Lipped Plate | Clothing Protector |
| | Other | | | | |
| **Drinking** | | | | | |
| **Aids** | Modified Cup | Clothing Protector | | | |
| **Thickened Fluids** | Consistency – Type of Thickener to be used | | | | |

| Sleeping And Rest Routine | | | | | |
|---|---|---|---|---|---|
| **Care Needs:** | | | | **For action by:** | |
| **Goal:** Client sleeping and rest requirements are met | | | | | |
| | Usual Rise time | Usual Time to Bed | Rest Time | | |
| | Preferred Sleeping Position | Pillows Required | Bedding Preferences | | |
| **Sleep Aids** | Massage | Music | Hot Drink | | |
| | Other | | | | |
| **Room** | Light on | Door Open | Door Closed | Bed Rail/Protector | Other |
| **Night-time patterns Other Preferences** | Night Wear | Toilet | Other | | |
| **Night Checks** | Hourly | Every Two Hours | Other | | |

| Medications | | | | |
|---|---|---|---|---|
| **Current Medications** | Eye Drops | Ear Drops | Other – See Itemised Listing and Administration Schedule | |
| | 1. Independent | 2. Needs some help: | Supervise or Some assistance/prompt | 3. Dependent: Fully assist |
| | Pre-packed | Measure | Self-Administer | |
| **Blood Sugar Level Testing** | | | | |

| Social Needs/Activities | | | | |
|---|---|---|---|---|
| **Care Needs:** | | | **For action by:** | |
| **Goal: Clients social, emotional and psychological needs are met as required** | | | | |
| **Frequency of visits/Contact by Family/Friends** | | | | |
| **Religion Beliefs/Practices Cultural Needs** | attends Place of Worship – Detail Time/Place<br>Other Religious Practices to be observed/supported | | | |
| **Hobbies/Interests** | | | | |
| **Social Group** | Day | Time | Contact Name & Number | Transport |
| **Day Care Service** | Day | Time | Contact Name & Number | Transport |
| **Preferred Activities/Games** | | | | |
| **Requirements** | | | | |

| Essential Environmental Needs: Please include details as appropriate: | | |
|---|---|---|
| **Requirements** | | **Frequency** |
| **Essential Cleaning** | | |
| **Essential Nutritional Needs** | | |
| **Other** | | |

| Specialised Care Plans | |
|---|---|
| **Refer to Specialised Care Plans for: Please tick as appropriate** | ☐ Medications<br>☐ Pain Management<br>☐ Wound Care<br>☐ Behaviour that challenges<br>☐ Other _____ |

| | | |
|---|---|---|
| **Date Care Plan Written:** | **Signature:** | **Print Name & Title:** |
| **Review Date:** | **Signature:** | **Print Name & Title:** |
| **Date Care Plan Reviewed:** | **Signature:** | **Print Name & Title:** |

## Appendix VII
## Accounting for Home Care Packages

Each LHO is responsible for accounting for both funding and expenditure in respect of Home Care Packages. There is an absolute requirement to be able to report to the DoHC on where and how funding has been allocated and spent. In this respect each former Health Board management accounts department has been advised to ensure that arrangements are in place to facilitate this. However it is also incumbent on each LHO to ensure that the coding structures in place are properly utilised at service level to achieve full transparency on this funding is achieved.

To achieve this visibility on HCP funding and consequent spend the following must be in place for each LHO;

- A separate cost-centre set up for each LHO called '*Home Care Packages*'

- All funding provided for HCP's identified and allocated to this cost-centre in each LHO across Income, Pay and Non-Pay headings

- Staff employed or part employed in HCP services to be appropriately charged to the HCP cost-centre. In recognising that different payroll systems operate in different this charging can either be by way of direct coding, cost-distribution or split costing.

- For simplicity where a WTE portion is allocated to HCP's in an LHO but the work is carried partially by all of a team it will suffice to charge that WTE portion of one (or more if necessary) designated staff member to HCP's

- Where staff occupy positions which were originally approved under HCP's they must not be charged to the HCP unless they are working in this service

- Where it is not possible to code certain payroll costs directly, monthly or quarterly journal adjustments should be entered which charge the portion of staff time spend on HCP's. This may be particularly relevant to directly employed Home Helps and the activity collected for data-set reporting should be useful as a basis for the journals

- All contracted out services to HCP providers and cash allowances where used, should be coded to the HCP cost-centre

- Any other direct costs such as aids/appliances, telephone, travel/subs, offices expenses, rent, heat/power/light etc to be coded to the new cost-centre or manually journalled each month/quarterly if necessary

- A journal adjustment should be entered to charge costs identified from 1st January to the date where this arrangement was not in place at the beginning of the year.

The local Management Accountant's office will advise on any queries in respect of the above.

## Appendix VIII

### Monitoring Information to be available when ICT System is implemented across the system

The information available to incorporate in the reports will include:

1. For all receiving home care services, no. of clients:
   1.1 at the start of the reporting period
   1.2 commenced during the reporting period
   1.3 ceased during the reporting period
   1.4 at the end of the reporting period
   1.5 benefiting[4] during the reporting period
2. For each age group[5], no. of clients:
   2.1 at the start of the reporting period
   2.2 commenced during the reporting period
   2.3 ceased during the reporting period
   2.4 at the end of the reporting period
   2.5 benefiting during the reporting period
3. For each home care service component (including direct home help, indirect private home help, indirect voluntary home help, respite care, nursing and therapy services)[6], no. of clients:
   3.1 at the start of the reporting period
   3.2 commenced during the reporting period
   3.3 ceased during the reporting period
   3.4 at the end of the reporting period
   3.5 benefiting during the reporting period
4. For each client care group[7], no. of clients:
   4.1 at the start of the reporting period
   4.2 commenced during the reporting period
   4.3 ceased during the reporting period
   4.4 at the end of the reporting period
   4.5 benefiting during the reporting period
5. For all receiving home care services:
   5.1 Average, min, max and total weekly cost[8]
   5.2 Average, min, max and total weekly time[9] provided

---

[4] Receiving a HCP at any time during the reporting period
[5] Age groups have to be agreed. Examples: under 65, 65-80, over 80.
[6] Granularity has yet to be agreed.
[7] Client care groups will include older people services, disability services, mental health services, children and family services and other services.
[8] Costs will be based on a configurable cost per hour for each service component, plus the cost of aids & appliances and any cash grant provided.
[9] Time may be measured in hours or WTEs.

5.3 Average, min and max duration[10] of the home care service

6. For each home care service classification[11]:
   6.1 Average, min, max and total weekly cost
   6.2 Average, min, max and total weekly time provided
   6.3 Average, min and max duration
7. For each home care service component:
   7.1 Average, min, max and total weekly cost
   7.2 Average, min, max and total weekly time provided
   7.3 Average, min, max and total weekly time of mainstream services provided
   7.4 Average, min, max and total weekly time of additional services provided
   7.5 Average, min and max duration
8. For each care group:
   8.1 Average, min, max and total weekly cost
   8.2 Average, min, max and total weekly time provided
   8.3 Average, min and max duration
9. For aids and appliances:
   9.1 Average, min, max and total weekly cost
10. For all applications, no. of clients:
   10.1 making an application
   10.2 who are eligible for the service
   10.3 who are assessed as requiring home care services
   10.4 from each referral source
   10.5 for each referral reason
11. For all who are assessed as requiring a home care services, no. of clients:
   11.1 by gender
   11.2 by age group
   11.3 by marital status
   11.4 by carer profile[12]
   11.5 by number of dependency factors
   11.6 by duration group[13]
   11.7 by cost group
12. For all who are assessed as requiring home care services:
   12.1 Average, min and max time from referral letter to decision letter[14]
13. For all who have been assessed and are waiting for home care services:
   13.1 Average, min, max and total weekly cost for recommended services

[10] Duration is measured in weeks.
[11] HCP classifications have to be agreed. Examples: Short term, long-term.
[12] Carer profiles have to be agreed. Examples: Cared for by partner, by family, by friend/neighbour.
[13] Duration groups have to be agreed. Examples: 0-4 weeks, 5-10 weeks, over 10 weeks.
[14] The decision letter indicates to the client whether the HCP has been approved, rejected or wait listed.

13.2 Average, min, max and total weekly time for recommended services

14. For all receiving home care services, no. of reviews:
    14.1 planned (due)
    14.2 overdue
    14.3 completed
    14.4 by review outcome[15]
15. For all ceased home care services, no. of clients
    15.1 By cessation reason

[15] Review outcome may include that the client has the same needs, increased needs, decreased needs or no needs.

## Appendix IX

## Monitoring Information which will be available prior to ICT System being implemented across the system

- **Number of people in receipt of a HCP**
  - Under 65 years
    By LHO area
    By Region
    National

  - 65 years and over
    By LHO area
    By Region
    National

- **Number of people in receipt of a HCP Cash Grant (this is a sub-set of previous heading. The numbers will be reducing as Cash Grants will no longer be approved under new Guidelines)**
  - Under 65 years
    By LHO area
    By Region
    National

  - 65 years and over
    By LHO area
    By Region
    National

- **Number of HCPs provided based on planning cost**
  - Under 65 years
    By LHO area
    By Region
    National

  - 65 years and over
    By LHO area
    By Region
    National

- **Number of new HCP recipients**
  - Under 65 years
    By LHO area
    By Region
    National

  - 65 years and over
    By LHO area
    By Region
    National

- **Expenditure on HCPs**

  - By LHO area
  - By Region
  - National

- **Average weekly cost of HCPs**

  - By LHO area
  - By Region
  - National

- **Waiting Lists –** Data to be recorded, and frequency, will be agreed with CPCP if waiting lists emerge.

## Appendix X Membership of the Working Group

| | | |
|---|---|---|
| **Chairman**<br>Michael Fitzgerald | A/LHM | Kerry LHO |
| **Project Manager(s)**<br>Geraldine Rigney<br>Natalie Vereker | <br>National Specialist<br>National Specialist | <br>Services for Older People<br>Services for Older People ï Joined May 2010 |
| **Members** | | |
| John Brennan | Head Social Worker | Mater Hospital |
| Brian Dunne | Senior Analyst | HSE |
| Michael Fahey | Manager | Services for Older People, Mayo LHO |
| Grace Fraher | General Manager | Wicklow LHO |
| James Gorman | Finance Manager | Laois/Offaly |
| Brenda Hannon | Area Specialist | Services for Older People, HSE Dublin Mid-Leinster |
| Frank Keane | Manager | Nenagh General Hosp |
| Maev Lennon | Case Manager | Dublin South City |
| John Linehan | A/Area Specialist | Services for Older People, HSE South |
| Eithne McAuliffe replaced by<br>Violet Hayes | Area Specialist<br><br>DPHN | Services for Older People, Kerry LHO<br><br>West Cork LHO |
| Patricia McEvoy | Manager | Services for Older People, Carlow Kilkenny LHO |
| Paschal Moynihan | Area Specialist | Services for Older People, HSE West |
| Geraldine Murphy | Manager | Services for Older People |
| Elaine P Ryan | | Meath LHO |
| Claire Sheehy | Analyst for Older Persons Care group | Corporate Planning & Corporate Performance (CPCP), |
| Cepta Smyth | Home Care Support Coordinator | Galway LHO |
| David Willow | Director of Allied Therapies | Tallaght Hospital |