CSAR

COMMON SUMMARY ASSESSMENT RECORD (FORM: CSAR/PV3a)

NHSS (2009)

GUIDANCE DOCUMENT

To assist practitioners in the completion of the Common Summary Assessment Report (CSAR).

Table of Contents

INTRODUCTION 3

VALUES AND PRINCIPLES 4

GENERAL POINTS OF INFORMATION 5

SHARING INFORMTION IN COMPLETION OF CSAR 6

COMPLETION OF THE CSAR 6

Section 1: Source of Referral 6

Section 2: Personal Details 6

Section 3: Personal Circumstances 6

Section 4: Options of Care discussed with person 8

Section 5: Current community/home support services 8

Section 6: Current Medical/Mental Health Diagnosis Summary 9

Section 7: Current Medications 9

Section 8: Assessments 9

Section 9: Additional Comments 10

Section 10 (a): Health Professional Reports 10

Section 10 (b): Specialist Assessment 11

Section 11: Recommendation MDT 11

Section 12: to be completed by Local Placement Forum (LPF) 11

INTRODUCTION

This Guidance Document is to assist practitioners in the completion of the Common Summary Assessment Report (CSAR).

The Nursing Home Support Scheme was enacted in October 2009.This scheme is the only to access to state financial support towards the cost of long-term residential care.

All applicants are required to complete an application form. Step 1 is an application for a Care Needs Assessment (see part 2 of the application form). This assessment will be undertaken by the Multidisciplinary Team (MDT) and the report compiled in the Common Summary Assessment Report (CSAR). An assessment of the person's needs is a legislative requirement under the NHSS Act 2009. The aim being to develop a national common assessment approach, primarily, but not exclusively, for older persons seeking access to long term residential care, in the public, voluntary or private sectors.

Admission into long term residential care is a significant life decision. Best practice requires older people to be assessed, specifically to determine whether: a) there are remedial factors which might avert admission to long term residential care; b) to provide recommendations to maximise health, by a Consultant Geriatrician or Consultant in Psychiatry of Old Age and c) to ascertain the applicant's wishes with regard to admission to residential care. 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.

While predominantly for the needs of older persons, anyone over 18 years may also apply for this scheme when residential long-term care is being considered.

As Health and social care professionals, we have a duty of care to ensure that people are provided with sufficient and appropriate information to enable them make an informed decision in relation to entering residential long term care; including discussing with the person the reasonably foreseeable pros and cons of long term residential care. The rights and wishes of the person are paramount in the decision making process.

It is generally envisaged that the health professional(s) with the most comprehensive knowledge of the applicant will be central to the CSAR Completion process.

VALUES AND PRINCIPLES

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

- **ALL APPLICANTS** have the right to self-determination and capacity to so do is assumed unless otherwise proven. People should not be admitted to long term residential care against their wishes, irrespective of the views of carers and others or of their 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

- A comprehensive person centred assessment is necessary to ensure the best outcome for the person and appropriate care environment.

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

- People have a right to be provided with sufficient and appropriate information on the range of services available to them, in order to make an informed choice on entering long term residential care.

GENERAL POINTS OF INFORMATION:

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

- Legislation requires that
  - Individuals seeking state support and ancillary state support towards the cost of their residential continuing care must have a care needs assessment report
  - Individuals must be provided with a copy of their care needs report following completion of the process
- Expert opinion on Older Persons is that care needs are best determined by multi-disciplinary assessment, involving a Consultant Geriatrician or Psychiatrist of Later Life, where available.
- A CSAR will combine assessment information from various sources, thereby creating a single, permanent and transferable record of the information relevant to a decision on an individual's care needs at a given point in time.
- An up-to-date CSAR will meet the requirements of the Integrated Discharge Planning code where a patient is being discharged to residential care.

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 devise and document their processes for the completion of the record. 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 professionals, 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, <u>it is required that one person will act as the coordinator for the completion of the form</u>.

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 (other than contributions signed by other professionals) is accurate
  - that the CSAR, in so far as is possible, 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. Local policy can determine the requirement for signing when CSAR is completed by one person.
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. The CSAR form was amended in October 2010 following a national audit.

SHARING INFORMATION IN COMPLETION OF CSAR

Informed consent to share information between professionals is presumed when one applies to have a Care Needs Assessment undertaken; to ensure the person is fully informed and aware of this, the CSAR includes for the provision of this consent to be restated and signed by the applicant. **The Specified Person may act on behalf of the applicant in relation to any matter under this Act where the applicant has reduced ability to make decisions** (i.e. diminished mental capacity or unable physically) **including but not limited to the giving of consent.**

COMPLETION OF THE CSAR

Section 1: Source of referral

- Please include the name of the location from which the referral originates or the name of the person who has made the referral.
- For audit purposes please identify the location of the applicant e.g. name of acute hospital, name of community hospital, name of community area

Section 2: Personal Details

- The PPS number must be included.
- If available please use the addressograph (personal details) to complete this section.
- The Home/Past Address is required when differing from that of the addressograph/current address.
- The hospital number may be known as the medical records number or patient control numbers in some areas.
- Preferred Name: the applicant may have a nickname or a pet name to differentiate them from other common names used in a geographical area.

Section 3: Personal Circumstances

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

Living Circumstances: required as it is important to the provide an “holistic” picture of the applicant.

3.2 Housing

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

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

3.3 Principle Carer

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

3.4 Contact Person

3.4.1 Nominated Contact Person; 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.

3.4.2 Specified person; 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. This person may act on behalf of the applicant in relation to any matter under this Act where the applicant has reduced ability to make decisions (i.e. diminished mental capacity or unable physically) including, but not limited to, any application, appeal, review or the giving of consent. The HSE must be satisfied that the specified person is acting in the best interests of the person.

Where the HSE is dealing with a Specified Person and an application is made for the nursing home loan then that specified person or another eligible person is required to be appointed as a Care Representative by the Circuit Court.

3.4.3 Care Representative: 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 different individuals.

A Care Representative is only required where a person has reduced capacity (i.e. **diminished mental capacity**) and wishes to apply for the Nursing Home Loan (Ancillary State Support) The person must apply to become a Care Representative and be appointed by the Circuit Court. Their role is to act on behalf of the person in respect of the Nursing Home Loan application. They can also act on behalf of the person as a "Specified Person" in relation to all other aspects of the NHSS. An

assessment of the applicant's capacity is required from two independent medical practitioners to establish whether they have capacity or not.

Section 4: Options of Care Discussed with Person

The underpinning principle of **ALL APPLICANTS** having the right to self-determination and capacity to so do is assumed unless otherwise proven.

- The needs and preferences, if ascertainable, of the applicant are the primary consideration when determining whether continuing care is appropriate and **must be sought and recorded**. The needs and preferences of the carer should also be given consideration.

- 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 or nominated/specified designated person..

- Where the person is unable to make an informed decision due to diminished mental capacity this should be recorded and the choice of the specified person sought and recorded.

- Examples of Care Options may include residential care in the public/ private sector, sheltered housing, returning 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)

Section 5 Current Community/Home Support Services

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

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

5. RECORD OF CURRENT COMMUNITY/HOME SUPPORT SERVICES (SEE GUIDANCE NOTE BEFORE COMPLETING)												
SERVICE (Tick)	Home Help/Support	√	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

Section 6 Current Medical/Mental Health Diagnosis Summary

Section 6 (a); Current details of the person's diagnosis and medical history are required. This section may be completed by relevant medical personnel or by the person completing the CSAR in line with local policy.

- It should be noted that legislation indicates that a copy of the CSAR be made available to the applicant. In certain rare circumstances, a medical decision may have been made that information on diagnosis should be withheld from a patient. The person(s) completing the CSAR should be cognisant of this when completing the CSAR form.

Section 6(b); Current details of the person's mental health status and history are required. This section may be completed by the relevant medical staff or by the person completing the CSAR as per local policy.
Additional information where relevant can be provided in a separate attached report (Section 11)

Section 7 Current Medications

The information documented in this section is to inform the assessment process and not for medication administration purposes. For people in hospital, this section may be completed once key medication(s) have 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 an additional blank A4 page to record additional information if required. Please use relevant headings clearly 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 their physical ability, cognitive status and other associated risk factors relevant to their individual health needs. Validated and reliable assessment tools appropriate to the applicant's age and medical status should be used.

It is important that the practitioner undertaking the Modified Barthel and the cognitive assessment have knowledge and experience on the use of the tools used.

It should also be noted that neither the Barthel or a cognitive assessment or any other assessment tools in isolation predict the need for long term residential care.

8(a) Guidelines for the use of the Modified Barthel Index

- To demonstrate the person's changing ability this may be completed and recorded on two separate occasions.
- The index should be used as a record of what the person can currently do.

- The main aim is to establish the person's 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.
- Use of aids to be independent is allowed

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

8(b) Communication; the ability of the person to communicate effectively and retain and make sense of information is a necessary requirement of the assessment process. Please tick one box only.

8(c) Cognitive Function; this should be assessed using a validated 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. The cognitive assessment should be appropriate to the patient's age and medical status.

8(d) The detection of risk through screening provides invaluable information in determining a person's care needs. Please record all risk/assessments completed NB: Pressure Ulcer Risk Assessment, Falls Risk Assessment, Nutritional Risk Assessment, Wandering Risk Assessment etc.

8(e) Medical/social/other risk factors; the purpose of this section is to capture any significant medical, nursing, allied health or social factors that indicate that this person's needs would be best met within a long term residential care setting. Examples:

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

Section 9. Additional Comments

If the individual has specific employment, recreational or social needs, please enter these here or provide a separate report. It is envisaged that these aspects may apply to adult applicants under 65 particularly.

Section10 (a). Health Professional Reports

The purpose of this section is to include a summary of any nursing/therapy/social work reports. 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 the report has been appended.

Section 10(b) Specialist Assessment

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

Adults under 65 years may seek additional assessments including neurology or rehabilitation.

Section 11 Recommendation of MDT

It is envisaged that where a MDT have assessed the person they shall complete this section recommending Residential Care or not and sign as per local policy.
All those undertaking an assessment may comment that residential care is not required or may append a report.

Section 12 – *to be completed by Local Placement Forum (LPF)*

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

Please note that it is the applicant's current care needs that are being considered. An applicant's care needs may best be met in a long term residential care setting now, but may not require care at some point in the future.

Material Alteration in Personal Circumstances
Legislation requires that HSE makes a judgement in relation to the likelihood of a material alteration in personal circumstances of the applicant. An MDT may decide that an applicants care needs are best met in a long term residential care setting or not.. 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. Therefore there would be a high risk of a change in their personal circumstances.

Section 12 sign-off
This should be signed by the chairperson and at least two other members of the LPF.

Signatories to this section are taking responsibility for verifying that, in their professional opinion based on the information provided to them that the Applicant's care needs are/are not best met in a Long Term Residential Care setting at the date of signing.

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 could negate the need for long term residential car