INITIAL ASSESSMENT AND CARE PLANNING POLICY AND PROCEDURE

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Purpose and Scope

This policy and procedure sets out the approach Bilingual Care takes to consumer assessments and planning, that enables the safe and effective delivery of care and services. It forms one part of the care management process for consumers who have approved Support at Home funding and should be read in conjunction with Bilingual Care's *Care Management Policy and Procedure.*

It applies to all care partners and assessment and care planning staff, consumers, their family members, carers, and other supporters, and meets relevant legislation, regulations and Standards.

Applicable Strengthened Aged Care Quality Standards

- *Standard 1. The Individual*
- *Standard 2. The Organisation*
- *Standard 3. The Care and Services*
- *Standard 4. The Environment*
- *Standard 5. Clinical Care*

Definitions

Care Partner – a dedicated Case Manager assigned under the Support at Home program to assist consumers choose and manage services, coordinate care plans, manage budgets and act as liaisons with health providers.

Care Plan - a person-centred document used to formalise a consumer's choice and control over their services. Care Plans are a key resource that documents a consumer's needs, goals, preferences and how funded aged care services will help the consumer achieve their goals. Care Plans will have a different focus for each person.

Care Planning – a personalised, collaborative process that determines and outlines a consumer's assessed needs, goals and care preferences. It acts as a road map for delivering tailored, person-centred support.

Continuity of Care - maintaining safe, quality care from people who are familiar to and trusted by the consumer, including during and after an emergency event. This includes planning for disruptions such as staff shortages, infrastructure failures, and access restrictions, to support consumer's ongoing safety, health and wellness.

Duty of Care - a legal obligation to avoid causing harm or prevent harm occurring to another person through any act that is careless or negligent and arises from a relationship between parties. Aged care workers have a duty of care to the older people they are assisting.

Dignity of Risk - respecting individuals' autonomy and self-determination (or "dignity") to make choices for themselves, including those that involve risk.

Goals - the outcomes a person wants to achieve or maintain in their daily life. They are based on what is important to the individual, their preferences, strengths and abilities. Goals help guide care and support by identifying what the person would like to do, improve, or keep doing, so they can remain as independent, safe and confident as possible.

Individualised Budget - outlines the available funds in a consumer's home care package and how they will be spent.

Open Disclosure - open discussions and communication with each consumer/their representative when something goes wrong within the service that has caused harm or may potentially cause harm to a consumer. This harm may be physical, psychological, or social, resulting in loss of quality of life, impairment, suffering, injury, disability, or death. Further information can be found in the *Aged Care Open Disclosure Framework and Guidance*.

Service Agreement - an agreement between Bilingual Care and a consumer that sets out how services will be provided, who will provide them, and how much they will cost. It includes a *Care Plan* and an Individualised Budget.

Wellness and Reablement[1] – are person-centred ways to support consumers to stay as independent and confident as possible by building on their strengths, abilities and goals. They focus on what a person can do and what matters to them in having quality of life. ***Wellness*** is the overall approach and guides how services are delivered, while ***reablement*** uses time-limited, goal-focused support to build or restore capacity.

Policy

Bilingual Care respects and acknowledges consumers as the experts in their own lives, including relation to their needs, goals, and preferences.

During initial assessments and care planning, Bilingual care will actively partner with consumers, their family, carers, supporters and/or representatives to identify their strengths, needs, risks, and desired outcomes. This collaborative process aims to support and improve each consumer's health, wellbeing, and quality of life. Assessment and planning processes will:

- be holistic and comprehensive
- focus on wellness and reablement
- take into account the consumer's physical, clinical, emotional, social, and environmental needs, and
- recognise and respect:
    - their cultural identity, values, and beliefs
    - language, communication needs, and health literacy
    - family, kinship, and community connections, and
    - historical, social, and trauma-related considerations.

[1] Department of Health, Disability and Ageing (2026), *Wellness and reablement resources*, Australian Government, accessed 12 June 2026, https://www.health.gov.au/resources/collections/wellness-and-reablement-resources?language=en

Only appropriately qualified staff will be responsible for assessing consumer needs and preferences. This includes ensuring the staff responsible have relevant and appropriate experience and qualifications in holistic and comprehensive care planning (preferably in aged care) and assessments. All assessments and care plans will be documented accurately, reviewed with the consumer, and regularly updated to reflect any changes in needs, preferences, or circumstances.

Where consumers are transferring from other services, the same procedures apply to their initial assessment and care planning, and Bilingual Care will not rely solely on previous assessments. The focus is on supporting a smooth transition for the consumer and ensuring continuity of care aligned with their current needs, goals and preferences.

Procedures

Roles and Responsibilities

The Care Partner is responsible for:

- providing information about Bilingual Care's services and program options
- ensuring the consumer and their supporters/representatives understand information about their rights, care and services
- conducting initial screening and intake assessment
- gathering client history, needs, risks, and preferences
- identifying urgency and level of support required
- referring for or completing a comprehensive assessment relevant to the consumer's needs
- developing and maintaining person-centred *Care Plans* based on assessed needs that focus on wellness and reablement and consumer goals
- supporting the consumer to actively participate in the assessment and care planning process and make informed decisions about their care and services
- coordinating services with other health professionals, providers or other stakeholders as required to support the consumer's *Care Plan*
- documenting all intake and assessment information accurately
- ensuring timely commencement or transition to services, and
- conducting regular reviews and reassessments, as per the *Care Review Policy and Procedure*

The Clinical Care Manager is responsible for:

- conducting clinical assessments (e.g. health status, medications, wounds, cognition), as appropriate to the consumer's needs
- identifying clinical risks and required interventions
- contributing to or developing clinical components of *Care Plans* and in alignment with the consumer's *Individualised Budget*
- monitoring and responding to any observed or reported changes in consumers clinical conditions
- providing guidance to staff on clinical care needs, and
- liaising with the consumer's GP and other health professionals as required to develop an appropriate *Care Plan*

All staff delivering aged care services to consumers are responsible for:

- respecting and supporting consumer rights in all interactions
- providing care in line with the consumer's agreed *Care Plan*

- supporting consumers' independence, dignity, and choice
- observing and reporting changes in consumer's condition, risks, or concerns
- documenting care delivery (progress notes) in Ezihealth
- following safety, risk, and escalation procedures, and
- supporting consumers to achieve their goals.

The consumer and/or their family, supporter/s and representative/s are responsible for:

- participating in the assessment and care planning process to the best of their ability
- communicating their goals, preferences and needs and engaging in the development of their *Care Plan*, and
- reporting any changes in their circumstances or needs as soon as possible.

Steps for Onboarding New Consumers

When a consumer has progressed through the intake process (as per the *Service Access and Intake Policy and Procedure*), they will commence onboarding.

The following process outlines how new consumers are onboarded with Bilingual Care

1. **Accept the Referral** – for Support at Home consumers, once they have agreed to go ahead with Bilingual Care's services and to develop a *Service Agreement*, *Care Plan* and *Individualised Budget*, the Care Partner will accept the referral in the *My Aged Care Service and Support Portal*[2]. Note that the referral must be accepted within 56 calendar days of the consumer receiving their funding allocation letter or it will be withdrawn. A 28-day extension can be requested by the consumer if required.

2. **Prepare Documentation** - a *Service Agreement* will be prepared in partnership with the consumer and their family or supporter/s and representatives, as required. If the consumer consents to the *Service Agreement*, the initial assessment and care plan can be developed. All relevant consent forms will be explained by the Care Partner and discussed with the consumer to obtain their decision on consent. The consumer will be provided with the time they need to make a decision (noting the date for their allocated funding to be accepted to avoid it being withdrawn).

3. **Conduct Initial Assessment** – the Clinical Care Manager will undertake a comprehensive initial assessment with the consumer that is focussed on their individual health and wellbeing needs, preferences and goals. Relevant risk assessment must also be completed at this step, such as *Consumer Risk Assessment Form* and *Environmental In-Home Risk Assessment Form*. This will form the basis of the consumer's *Care Plan* and *Individualised Budget*.

4. **Co-develop *Care Plan* and *Individualised Budget*** - the Care Partner will prepare and coordinate the consumer's *Care Plan* and *Individualised Budget* in Ezihealth. The *Care Plan* and *Individualised Budget* must be developed in partnership with the consumer and their supporter/s or representatives with their consent. The focus of the *Care Plan* is to achieve the goals outlined in their support plan, and applying a 'doing with' (not 'doing for') approach to service delivery as appropriate.

   Note: The *Care Plan* and *Individualised Budget* will need to match the services the

[2] Department of Health, Disability and Ageing (2026), *My Aged Care – Service and Support Portal user guide – Part 2: Team leader and staff member functions*, Australian Government, accessed 14 June 2026 https://www.health.gov.au/resources/publications/my-aged-care-service-and-support-portal-user-guide-part-2-team-leader-and-staff-member-functions?language=en

consumer is eligible to receive under their Support at Home funding, based on their assessed needs and as outlined in their Notice of Decision and support plan. Any other services requested by the consumer that is outside of the Support at Home services list or their available funding will need to be agreed separately and paid privately by the consumer.

If the consumer has been allocated an interim budget (60%), the *Care Plan* and *Individualised Budget* must be developed within the budget of the 60% allocation (less 10% care management). It must be focussed on priority services to enable the consumer to live safely at home until their remaining 40% is allocated. When the consumer's budget has been fully funded (100%) then the *Care Plan* and *Individualised Budget* will need to be reviewed and updated for the full funding.

5. **Set up Systems and Roster**
    - Confirm that all required information has been collected and ensure that the documentation has been provided to set up the consumer on Ezihealth and Quickbooks.
    - Match services in the Support at Home services list against the *Care Plan* and *Individualised Budget* to ensure that claims will be accepted.
    - Confirm with the consumer their preferred days/times and preferences for when services are delivered and start date.
    - Coordinate with the Scheduling Manager so that service delivery staff can be matched with the consumer based on relevant needs, experience, compatibility and location.
    - Arrange for introductions with the staff and consumer.
    - Set the roster based on the consumer's *Care Plan* and within their *Individualised Budget*.
    - Coordinate training for staff, including any equipment, as applicable.
    - Make any other arrangements as per their *Care Plan* and *Individualised Budget*, such as requirements under the Restorative Care Pathway, End of Life Pathway and/or Assistive-Technology and Home Modifications funding, and liaising with associated providers or other services who will be or are delivering supports to the consumer.

6. **Notify Services Australia** – the Accounts Advisor will update the *Aged Care Provider Portal* within 28 days of the consumer commencing services.

7. **Commence Services and Monitor** – deliver first services and ensure care remains appropriate. For relevant procedures during care delivery, see:
    - *Service Delivery and Participation Policy and Procedure*
    - *Delivering Telehealth Policy and Procedure*
    - *Care Management Policy and Procedure*
    - *Restorative Care Management Policy and Procedure*
    - *Care Review Policy and Procedure*
    - *End of Life Care Policy and Procedure*
    - *Assistive Technology and Home Modifications Policy and Procedure*

The consumer's ongoing care and services will be regularly monitored and updated in accordance with the consumer's care needs, allocated funding, and as per the *Care Management Policy and Procedure*, *Restorative Care Management Policy and Procedure* (if applicable) and *Care Review Policy and Procedure*.

General

Bilingual Care uses its *Consumer Information Pack* and website to provide consumers, their representatives and carers, and all other stakeholders with information about this policy and procedure, in an easy-to-understand format.

To ensure consumers understand this information, staff will provide information to them and their families, supporters/representatives in ways that suit their individual communication needs. Written information can be provided in different languages and Easy English or explained verbally by staff. Staff can also help consumers access interpreters or advocates where required, as per Bilingual Care's *Decision Making, Dignity and Choice Policy and Procedure*.

As per Bilingual Care's *Training and Development Policy and Procedure*, all staff responsible for consumer assessments must undergo Induction, which includes training in Bilingual Care's assessment and care planning processes. Bilingual Care will support ongoing professional development, including training in contemporary aged care assessment frameworks and regulatory requirements, to maintain consistency, quality, and compliance when undertaking consumer assessments.

Staff knowledge and application of this policy and procedure is monitored on a day-to-day basis, and through formal supervision and annual Performance Reviews. Additional formal and on-the-job training is provided to staff where required.

Systems and Documentation

There are two main government systems that Bilingual Care will access to verify services and budgets for consumers. These are:

1. ***My Aged Care Service and Support Portal***[3], managed by My Aged Care – this secure portal is for registered aged care service providers to manage information about their services, their consumer's services and referrals. The consumer's Notice of Decision and support plan is available in the My Aged Care Service and Support Portal.

2. ***Aged Care Provider Portal***[4] ***(ACPP)***, managed by Services Australia - is a secure, online platform for aged care providers to check consumer budgets, securely manage day-to-day claiming, submit administrative events, and access payment information.

As part of the Initial Assessment meeting, the Care Partner must complete the following with consumers and their family or supporters/representatives:

- *Service Agreement* including *Individualised Budget* and *Care Plan*
- Bilingual Care's relevant consent documentation, such as *Privacy Consent Form* and *Social Media Consent Form*
- *Medication Plan and Consent Form* (if applicable)
- *Consumer* and *Environmental In-Home Risk Assessments*
- any fee payment documentation (for individual contributions/private fees) such as Direct Debit/Ezi-Debit (where applicable) and
- any other required documentation based on the consumer's services requirements.

The Care Partner will also:

[3] https://www.health.gov.au/resources/apps-and-tools/my-aged-care-service-and-support-portal

[4] https://www.servicesaustralia.gov.au/using-aged-care-provider-portal?context=20

- view and confirm consumers' Notice of Decision letter, with individualised contribution percentage (if applicable)
- verify consumers' Support at Home funding allocation (in the *ACPP*) and support plan (in the *My Aged Care Service and Support Portal*)
- confirm the consumer's identity with valid identification, such as a proof of age/photo identification card, a driver's license or passport (up to 2 years expired), or birth certificate / citizenship
- view and copy current Enduring Power of Attorney, Enduring Guardianship, Advance Health directives, Do Not Resuscitate (DNR) orders, and/or Voluntary Assisted Dying (VAD) documentation (where applicable) and
- establish the consumer's *In-Home Communication Folder*

All assessment and care planning documentation must be maintained on consumer files and tracked in Ezihealth.

Service Agreement

Staff must work with consumers and their supporters to formalise the services to be provided by Bilingual Care in a *Service Agreement*. The *Service Agreement* is tailored to the individual needs of each consumer and must be completed within 7 days or before services can commence.

A consumer's Support at Home funding cannot be claimed and services cannot commence unless the consumer has entered into a *Service Agreement* and Bilingual Care has documented this.

The Care Partner is responsible for ensuring consumers and their supporters/representatives understand their *Service Agreement* and each parties' responsibilities within it. The consumer will be provided with sufficient time to consider the *Service Agreement* and be encouraged to ask questions if they are not sure. The Care Partner can also support the consumer to access assistance (e.g. an advocate) if requested or it is identified that additional help is needed.

The consumer has a 14-day cooling-off period to change their mind after they have entered into a *Service Agreement* with Bilingual Care. In this circumstance, and provided services have not commenced, the Finance Advisor will arrange to transfer any funding received for services not yet delivered and update all government and internal systems. See also Bilingual Care's *Service Exit Policy and Procedure* for further guidance.

Service Agreements must include:

- the date the agreement is entered in to
- Bilingual Care's address and contact details
- the consumer's address and contact details
- any consumer representative's contact details
- Power of Attorney details, if applicable
- the commencement date for care and services, and end date, if applicable (e.g. for short-term pathways)
- date the Service Agreement is to be reviewed
- whether the consumer is transferring from another provider and the details related to this
- the current Support at Home funding level the consumer has been allocated (with a copy of the Notice of Decision)
- the care and services that are to be delivered as per the consumer's support plan (issued by Services Australia) and in accordance with the approved Services List

- details of who will deliver services, including details of any other parties who will be providing care and services, such as associated providers
- description of and the inclusion of the *Care Plan*
- description of and the inclusion of an *Individualised Budget* and fees to be paid, including any applicable taxes (e.g. GST) and individual contributions
- details of the consumer's monthly statements, the cost of care for each service and how fees are calculated
- Bilingual Care's responsibilities, aligned with the *Aged Care Code of Conduct*
- the consumer's rights and responsibilities, as per the *Statement of Rights*
- services available and any reasons why a service request may be declined
- what notice is needed for the consumer to change, suspend or leave the *Service Agreement*, how this is done, and what the conditions are (if any), including the 14-day cooling off period
- arrangements to cancel or suspend services and any requirements
- details of equipment to be provided or owned by the consumer, and related work health and safety responsibilities
- how pricing changes will be managed with consumers
- information sharing arrangements
- Bilingual Care's obligations when a consumer chooses to move to another provider
- conditions surrounding requests to vary the agreement
- how the consumer or their representative can make a complaint or raise any concerns, how this will be addressed, and how to escalate to the Aged Care Quality and Safety Commission, and whistleblowing procedures
- guarantee and indemnity requirements, if applicable, and
- Bilingual Care's commitment to protecting the consumer's privacy.

While it is not a mandatory requirement that the *Service Agreement* be physically signed by the consumer or their representative if they have agreed to go ahead, the Care Partner is responsible for ensuring they are encouraged to do so, to demonstrate their understanding and acceptance. This includes giving the consumer and their supporters/representatives sufficient time to peruse the agreement and seek legal advice if desired.

If a consumer wishes to accept a *Service Agreement* but does not wish to sign it and does not have an authorised representative to sign on their behalf, the Care Partner must continue to review the agreement with the consumer at each care review. This ensures they continue to understand and accept the agreement and are given further opportunities to sign. All information surrounding the consumer's decision not to sign should be documented on the consumer's file in Ezihealth

In agreeing to a *Service Agreement* with each consumer, Bilingual Care commits to upholding their right to continuity of care, ensuring they receive aged care services for as long as needed, in alignment with their approved Support at Home budget. Bilingual Care will not cease services if a consumer is awaiting the outcome of a financial hardship application (see Bilingual Care's *Consumer Budget Management Policy and Procedure* for further information about financial hardship).

Should Bilingual Care need to cease the *Service Agreement*, all reasonable steps must be taken to communicate with the consumer and their supporters/representative to resolve any issues or concerns, as per Bilingual Care's *Feedback and Complaints Policy and Procedure*. See Bilingual Care's *Service Exit Policy and Procedure* for further details of the cessation of consumer's care and services.

Care Plan

When developing each consumer's *Care Plan*, the Care Partner is responsible for partnering with consumers and their supporters/representatives to develop the *Care Plan* together, respecting the consumer's right to choose and have control over their care and services.

Care Plans must include the consumer's:

- personal details
- Support at Home funding level and start date for care and services
- background and interests or hobbies (including any information pertaining to sexual identity, and cultural, religious, spiritual, or other needs to be supported)
- preferred links to family, friendships, and other support networks including emergency, substitute decision maker, formal decision maker, Enduring Power of Attorney, and advocate information
- access information and no response plans, should they not be home or don't respond to their usual visits
- health and medical information, including but not limited to Advanced Care Directives, Do Not Resuscitate plans, and health practitioner details
- goals for care, focussed on wellness and reablement, as appropriate
- functional ability and areas support is needed (for example, mobility aids, cognition, and continence) including risks and safety needs
- other providers or services involved in their care (relevant to their aged care services)
- details of any equipment or aids required to support their health and wellbeing
- specific services to be provided by Bilingual Care, and any outsourced arrangements (e.g. associated providers), clearly linked to the approved Services List
- clinical emergency escalation procedures, if applicable
- personal emergency plans if there is an external emergency or disaster
- schedule for support (allowing them to dictate the days, times, and staff providing support, but also manage around their social and other commitments already in place)
- desired level of involvement and control over the management of their budget
- case management arrangements, including how ongoing monitoring and reviews will be managed
- agreement by way of signature (or verbal agreement if signature is not possible) to the details within the plan
- agreement on when the *Care Plan* and any associated arrangements will be reassessed and/or reviewed, and
- any other individual and personalised information relevant to the safety and care needs of each consumer.

Individualised Budget

Following the assessment of a consumer's needs and planning their services, the Care Partner is responsible for developing an *Individualised Budget* with them and ensuring they understand:

- the portion of Government funding (and supplements if eligible) that contributes towards their care and services
- any unspent funds that have been transferred as part of grandfathered home care package (HCP) funds and/or transferred from a previous provider (where applicable)
- any individual contribution amounts the consumer will be asked to pay (if applicable)
- the rates charged for care and services and how that contributes to the total amount of funds spent on care each week, fortnight, month, and year
- any short-term pathway funding arrangements in the consumer's *Individualised*

Budget and how they can be used
- how quarterly budgets are calculated and managed, and
- how to read and understand monthly statements.

The Care Manager is also responsible for ensuring care and services required are achievable within the consumer's allocated funding and *Individualised Budget*. See Bilingual Care's *Consumer Budget Management Policy and Procedure* for how to prepare Support at Home *Individualised Budgets*.

Where changes are made to a consumer's *Care Plan*, Bilingual Care's costs change, or consumers or their supporters/representative request a review of their Support at Home budget, the Care Partner is responsible for developing an updated *Individualised Budget* with consumers and their supporters/representatives. When the *Individualised Budget* is to be updated, the same processes for initial budget establishment apply, including a clear explanation for the consumer to understand what has changed and how it affects their care and services.

Consent

Before a consumer commences services with Bilingual Care, the Care Partner must first obtain written informed consent from consumers or their representatives. To ensure consumers and their representatives have sufficient information to make informed decisions and consent to Bilingual Care's services, the Care Partner must provide information on:
- Bilingual Care's services, with a proposed *Care Plan* provided and explained
- consumer rights and responsibilities
- how Bilingual Care operates, including contacts for emergencies and types of staff who might assist with their needs
- personal information, privacy, and confidentiality, including how this information is sought, used, and shared with health professionals if necessary
- processes to follow if they wish to change their decision about consent, and
- feedback and complaints and whistleblowing procedures.

Information provided to consumers and their supporters/representatives must be accessible and in a way that helps them to understand. This might include explaining information verbally, providing documents in Easy English / Easy Read or other languages, or assisting the consumer to access an advocate or interpreting service.

Bilingual Care understands consumers' rights to refuse some or all proposed care and services. In these instances, the Managing Director will:
- inform them of the expected outcomes of refusal
- notify their referrer (with their consent) and
- document the refusal and the actions taken as a result.

Consumers who refuse some or all proposed care and service will not be excluded from accessing services in the future.

Consumers Transitioning to Bilingual Care from Other Services

Where a consumer is transferring from another service provider, the Care Manager is responsible for:

- seeking consent from the consumer or their representative to contact the previous provider to discuss or obtain the person's support requirements, previous *Care Plan*, and any information about their needs and goals, to assist their transition, as applicable.
- obtaining any information pertaining to the consumer's current Support at Home budget and any unspent funds, to ensure efficient and correct care and budget planning
- confirming with the consumer or their representative, and the previous provider, clear timeframes for the transition (end date for previous provider and the start date with Bilingual Care, with no overlap), and who is responsible for managing the steps involved, with the aim of minimising the impact of change on the consumer to support continuity of care
- identifying, documenting, and responding to risks associated with the transition, and
- developing a *Transition Plan*, which outlines how Bilingual Care will support the transfer. This plan must be agreed upon by all parties involved.

These requirements are additional to all other standard procedures for assessment and care planning for the consumer, as outlined in this policy and procedure.

Assessment Procedures

In accordance with Bilingual Care's *Privacy and Confidentiality Policy and Procedure*, all staff must protect consumers' privacy and confidentiality throughout the assessment and care planning process.

If necessary, and with the consumer's consent, other parties such as service providers who deliver existing or complementary services will be included in assessment and planning activities.

The Care Partner must ensure Bilingual Care uses contemporary, evidence-informed approaches to assessing consumer needs, outcomes, and wellbeing. This includes:

- implementing assessment and outcome measurement tools that support person-centred care, reablement, and continuous improvement
- utilising validated or evidence-informed tools where appropriate, which may include:
    - structured needs identification frameworks (e.g. ONI or similar approaches)
    - outcomes measurement tools (e.g. Older Person's Star / Outcomes Star), and
    - quality-of-life or community care outcome measures (e.g. ACCOM or similar tools)
- ensuring any internally developed tools:
    - are based on recognised frameworks or evidence
    - are consistently applied, and
    - are reviewed for effectiveness and alignment with regulatory requirements.

Note: formal eligibility assessments for Support at Home funding are undertaken through the Australian Government's Single Assessment System using the Integrated Assessment Tool (IAT) and Bilingual Care's assessments do not replace formal government assessment.

Maintaining Currency of Assessment Practices

The Managing Director will participate in industry forums and keep abreast of industry research and articles to determine if and how any changes to practices can be implemented into Bilingual Care's service delivery. This will ensure Bilingual Care uses current assessment and planning methods and provides the best outcomes for its consumers.

The Managing Director must ensure all staff are advised of any updates in Bilingual Care's assessment processes, to ensure consistency throughout service delivery.

Initial Assessment

The Care Partner will arrange an Initial Assessment Meeting at a day, time, and location (predominantly the consumer's home) that suits the consumer and their supporters and/or representatives.

The Care Partner must ensure the consumer and their supporter/representative understand the process of Initial Assessment, what will occur, and what they need to prepare prior to the meeting. This includes offering them a copy of any documentation that will be discussed during the Initial Assessment Meeting ahead of time.

When undertaking the Initial Assessment meeting, the Clinical Care Manager will consider additional information provided about the consumer, such as previous assessments, their Aged Care Assessment (including the Services Australia support plan and assessor comments), or other health and wellbeing reports. They will also take into account any high impact and high prevalence risks that are relevant to the consumer (see Bilingual Care's *High Impact High Prevalence Risks Policy and Procedure* for further guidance).

The Care Partner will conduct all Initial Assessments using an assessment tool best suited to the consumer's situation. The assessment will consider:

- the consumer's personal details such as age, living arrangements, cultural background, sexual identity, and religious and spirituality identity
- their values, beliefs, and past experiences (e.g. recognising the impact of historical and intergenerational trauma, where applicable)
- their primary and other languages
- any communication or mobility or lifestyle aids required
- the consumer's support network, and how they can be supported to engage with their care
- any *Advanced Care Plan*s or End of Life wishes, as applicable
- Enduring Power of Attorney details (and whether enacted)
- the consumer's current and historic medical conditions and current treatment (including clinical and medicinal treatments, and any allergies or intolerances)
- the consumer's vaccination status and any known allergies or side effects to vaccines, medicines or other substances
- the consumer's current health status such as hearing, vision, swallowing and oral health, reflexes, and continence
- their dietary needs and food and drink preferences
- the consumer's clinical and personal care needs
- equipment, aids, devices (assistive technology) or home modification requirements
- the consumer's current lifestyle such as smoking, alcohol, sleep pattern, and social schedule
- the consumer's neurological and cognitive functioning such as their memory, judgement, mood, and diagnoses such as dementia, Alzheimer's, or similar

- falls and mobility risks
- the consumer's understanding of their health and wellbeing and expectations for care
- any barriers to community participation and strategies that could be put in place to help overcome them
- how, when, and where the consumer requires supports to be delivered
- where health or clinical needs are identified, what process needs to be followed to respond to deterioration or medical emergencies
- the goals of care
- the expected outcomes of care
- the delegation of care and
- referrals for any other services if required, e.g., occupational therapist, delivered meals, etc.

The scale and nature of the assessment must be dependent on the consumer's situation and needs. For example, a consumer requesting support with minimal domestic assistance or cleaning services may not require a comprehensive health or clinical assessment. It is the Care Partner's responsibility to determine this during the Initial Assessment meeting and complete the most appropriate assessment for the person. This avoids the assessment feeling intrusive and respects the consumer's dignity and privacy.

If the consumer is on a short-term funding pathway, see the following for further guidance:

- Restorative Care Pathway – *Restorative Care Policy and Procedure*
- End of Life Pathway – *End of Life Care Policy and Procedure*
- Assistive Technology and Home Modifications - *Assistive Technology and Home Modifications (AT-HM) Policy and Procedure*

Where complex care needs are identified during assessment, the consumer's General Practitioner and other relevant health professionals must be involved in determining the consumer's clinical care needs. The Care Manager must consider whether Bilingual Care's services are accessible for the consumer, and if not, how they could be made accessible and meet complex care requirements. This may involve the addition of resources, care aids, staff training, or engaging an associated provider that has necessary skills and experience to safely support the consumer.

At the completion of the consumer's assessment, the Care Partner must advise the consumer and their representative of the assessment outcome and provide them a copy of relevant documentation.

Care Planning

Each consumer is pivotal in the development of their *Care Plan* to ensure it outlines their specific and individual care needs and how these will be met.

The planning process will take account of all relevant and available information, including, but not limited to, My Aged Care assessment and support plan, assessments completed by medical and health professionals. Where relevant, end of life planning, such as Advanced Care Directives, will also be considered.

When developing each consumer's *Care Plan*, the Managing Director is responsible for partnering with consumers and their representatives to develop the *Care Plan* together, respecting the consumer's right to choose and have control over their care and services.

The Care Partner must ensure the consumer and their supporters/representative understand:

- the care and services that can (and cannot) be funded via the Support at Home program
- the supports that can be provided by Bilingual Care to meet the consumer's needs, goals and preferences, based on the least intrusive approach and in accordance with contemporary, evidence-informed practices
- the person-centred care model and wellness and reablement approach Bilingual Care uses for providing care and services, including Bilingual Care's open disclosure framework and practice (as per the *Open Disclosure Policy and Procedure*)
- any supports that may need to be outsourced via associated providers and the choice the consumer has over that
- how to raise feedback or complaints if they are not satisfied with Bilingual Care's services, and
- any risks in relation to the consumer's environment and request for services.

The Care Partner must consider the following when developing *Care Plans*:

- the consumer's essential and non-essential care requirements
- community nursing services that can be delivered remotely
- other services that may prevent clinical or health deterioration
- services that can be delivered remotely e.g. via telehealth
- equipment maintenance requirements / schedules
- potential impacts on a consumer in the event of an emergency or disaster
- whether neighbours, friends, or family can assist in the event of a disruption to services and
- how the consumer accesses medications and consumables items such as continence products.

All information in *Care Plans*, and support provided by Bilingual Care will:

- respect consumers' right to dignity, choice, and control, and align with their preferences and goals
- maintain and strengthen consumers' independence, autonomy, safety, and their capacity to undertake daily activities, and help them develop new skills or return to previous skills, as a part of Bilingual Care's commitment to wellness and reablement
- respect consumers' right to practice their culture, values, and beliefs
- enhance consumers' social and community participation and connections, and
- ensure consumers remain in control of their choices.

The care planning process must also provide referrals and support access to specialised assessments and other services, where required. Where services need to be outsourced via associated providers, all relevant processes must be followed as per Bilingual Care's *Providing Information, Advice and Referrals Policy and Procedure* and *Associated Providers Policy and Procedures.*

The Care Partner must ensure consumers and their supporters/representative understand their *Care Plans*, or are supported to understand them, and are provided with a copy prior to services commencing. No changes are to be made without the consumer or their supporter/representative's permission.

The consumer must be provided a copy of their agreed plans, such as their:

- *Care Plan* (mandatory)
- *Medication Management Plan and Consent*, if applicable
- *End of Life Plan*, if applicable

- *Restorative Care Goal Plan*, if applicable

Copies of agreed *Care Plans* and other relevant health management plans, must also be:

- kept on consumer files, with key elements captured in Bilingual Care's Ezihealth and
- readily available to staff in Ezihealth and the consumer's In-Home Communication Folder. This ensures staff are informed of the person's needs, preferences, goals, tasks, and any alerts or risks that may be present.

Goal Setting

Bilingual Care understands personal goals are an important part of a consumer's *Care Plan*. Setting goals allows the consumer to articulate what they would like to achieve through their aged care services and supports the matching of appropriate care and services to suit.

The Managing Director is responsible for encouraging consumers to develop their own unique goals, however where a consumer requests support, the Managing Director will work with them to articulate what type of lifestyle they would like to maintain, any improvements in their independence, health, or mobility they would like to make, or any new activities they would like to participate in that are enjoyable or meaningful (for example).

The Managing Director is responsible for ensuring consumers' goals are measurable and not simply lists of services that will be provided. The Department of Health, Disability and Ageing's *Principles for Goal Setting*[5] guide can help with forming person-centred goals.

Dignity of Risk

Bilingual Care respects each consumer's right to make choices for themselves that may involve risk, as per Bilingual Care's *Decision Making, Dignity, and Choice Policy and Procedure*.

Staff will accept consumers' wishes with respect to accepting or rejecting support options. They must identify and educate consumers and their representatives about any assessed risks to ensure they understand them clearly when making decisions that may affect their health, safety and wellbeing.

Cultural Considerations

To support culturally safe assessment and planning processes, the Care Partner will:

- adopt a trauma-aware and healing informed approach
- ask culturally appropriate questions
- avoid assumptions about identity or preferences
- document cultural needs clearly in the consumer's *Care Plan*, such as:
    - cultural preferences (e.g. worker gender, language, routines)
    - communication requirements
    - family or community involvement preferences, and
    - any culturally specific risks or supports.

When assessing and planning care for Aboriginal and Torres Strait Islander consumers, staff will acknowledge cultural identity and connection to Country, and will ask about and respect

[5] Department of Health, Disability and Ageing (2021) Principles for goal setting, Australian Government, accessed 14 June 2026, https://www.health.gov.au/resources/publications/principles-for-goal-setting?language=en

cultural protocols and preferences. To complete a holistic assessment, the Care Partner will need to recognise that health and wellbeing may include connection to land, culture, and community, spiritual wellbeing, and family and kinship responsibilities. Aboriginal and Torres Strait Islander consumers may also need to involve extended family, Elders or community members in decision-making, where appropriate.

Support at Home Program - Consumer Control and Budget Management

The Care Partner must ensure each consumer's preference for managing their Support at Home services and budget is documented in their *Care Plan*.

Care Management

All consumers who are approved under the Support at Home program must engage with a registered aged care provider and be connected with a Care Partner. The Care Partner's role is to oversee care management activities, irrespective of how the consumer chooses to manage their services and budget. See Bilingual Care's *Care Management Policy and Procedure* for further guidance.

Self-Direction

Self-direction is part of a consumer's management of their own aged care services and allows them to direct and take a leading role in decision making over their services.

Bilingual Care's practices currently support consumers to self-direct their Support at Home services at a level they request or feel comfortable with (for example, choosing staff and service arrangements, etc.) as part of care planning activities.

Self-Management of Funding

Self-management under the Support at Home program refers to a consumer and/or their representative/s taking a more active role in directing how their allocated funding is used within the Support at Home program rules and based on their support plan. Depending on the consumer's preference and capability, this may involve:

- scheduling and coordinating services
- engaging providers (where permitted under program rules), and
- monitoring expenditure against their allocated budget.

Bilingual Care will support self-management by:

- providing transparent, up-to-date financial information
- ensuring consumers understand budget allocations, expenditure, their available funds and any constraints
- offering tools, guidance, and assistance appropriate to the consumer's needs, and
- ensuring all spending aligns with the consumer's assessed support plan, program rules and service list (in scope vs out of scope items).

See Bilingual Care's *Consumer Budget Management Policy and Procedure* for further information about self-management of funding.

Feedback and Complaints

Consumers can provide feedback or make complaints at any stage of the assessment and care planning process without fear of reprisal. Consumers and their family, carers, supporters and/or representatives, will be actively informed of their right to raise concerns, provide feedback, or make complaints about assessment outcomes, care planning decisions, or the way services are discussed, developed, or agreed as per Bilingual Care's *Feedback and Complaints Policy and Procedure*.

When concerns are raised that relate to the assessment or care planning process, Bilingual Care will work with the consumer to review decisions, make appropriate adjustments, and ensure their preferences and goals are supported where possible, and their rights are respected throughout this process.

Supporting Documents

Documents relevant to this policy and procedure include:

- *Associated Providers Policy and Procedure*
- *Care Management Policy and Procedure*
- *Consumer Budget Management Policy and Procedure*
- *Consumer Rights Policy and Procedure*
- *Decision Making, Dignity, and Choice Policy and Procedure*
- *Feedback and Complaints Policy and Procedure*
- *Open Disclosure Policy and Procedure*
- *Privacy and Confidentiality Policy and Procedure*
- *Providing Information, Advice and Referrals Policy and Procedure*
- *Restorative Care Policy and Procedure*
- *Service Access and Intake Policy and Procedure*
- *Service Exit Policy and Procedure*
- *Training and Development Policy and Procedure*
- *Consumer Information Pack*
- *Transition Plan*
- *Service Agreement*
- *Care Plan*
- *Individualised Budget*
- *Medication Plan and Consent Form*
- *End of Life Care Plan*
- *Restorative Care Goals Plan*
- *Consumer Risk Assessment*
- *Environmental In-Home Risk Assessment*
- *Consumer Emergency Planning Guide*
- *In-Home Communication Folders*

Monitoring and Review

This policy and procedure will be reviewed at least annually by the Leadership Team. Reviews will incorporate staff, consumer, and other stakeholder feedback.

Bilingual Care's feedback collection mechanisms, such as consumer satisfaction surveys, will assess:

- satisfaction with the competency and thoroughness of staff completing consumer assessment and planning activities

- understanding of Bilingual Care's assessment and planning processes and documentation (clearly described by staff)
- satisfaction with support provided during assessment and planning
- satisfaction with the choice, relevance and quality of referrals and connections provided by Bilingual Care staff and
- awareness of and access to information during the assessment and planning process that allows them to make informed choices and remain in control of their care and services.

Bilingual Care's *Continuous Improvement Plan* will be used to record improvements identified and monitor the progress of their implementation. Where relevant, this information will be considered as part of Bilingual Care's service planning and delivery processes.

DOCUMENT CONTROL

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