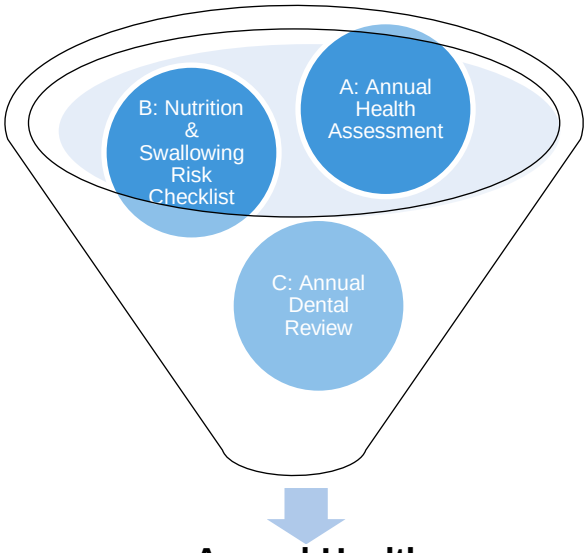
What is the Annual Health Assessment Process?

The Annual Health Assessment and Review Process focuses on preventative health, maintenance and monitoring of existing health conditions through the three focus areas below:



Annual Health Assessment process

The Annual Health Assessment process is mandatory for all of the people we support in Shared and Supported Living (SSL) and Lifestyle Supports (LS) who LWB also supports with health needs. It is made up of three components:

1. Comprehensive Health Assessment Program and review of health support plans, reports and recording charts
2. Nutrition and Swallowing Risk Checklist
3. Oral Health Care Plan

Note: If LWB is not responsible for a person's health needs or the person receives an LWB Product that does not require the Annual Health Assessment to be undertaken, it is good practice to advise the person and/or their Authorised Decision Maker of their entitlement under Medicare to undertake the health assessment at their own discretion.

Preparing for the Annual Health Assessment

The Annual Health Assessment requires preparation of documents for review, partial completion of assessment tools and gathering of information, reports and charts as relevant to the person's health support requirements.

The following resources have been developed to assist staff prepare themselves and the person we support for the Annual Health Assessment:

NDIS LWB 5511 Annual Health Assessment Appointment - Checklist

NDIS LWB 5513 Comprehensive Health Assessment Program – Letter

NDIS LWB 5515 Annual Health Assessment Appointment – GP Fact Sheet

The Annual Health Assessment Appointment Checklist is designed to assist staff to prepare for the appointment, outline the tasks the Health Professional will undertake during the appointment, and what to do after the appointment.

Both the 5513 Letter and 5515 GP Fact Sheet provide the GP with comprehensive information about LWB's requirements and expectations of what will be reviewed during the Annual Health Assessment including updating of;

- Medication Charts
- Medication Record
- PRN Protocols
- Review of person's medication
- Review of specific Health Support plans as applicable (e.g. Epilepsy Management Plan, Diabetes Management Plan, Asthma Management Plan etc.)

Preparing the person we support for their Annual Health Assessment

The person should be supported to prepare for the assessment and choose who supports them to attend - preferably a staff member or support person who knows them well.

The person should take any communication aids/tools to assist them to participate fully in the assessment.

If the preferred staff member is unavailable on the day, the line manager is to offer the person a choice to reschedule the appointment for a time when the chosen staff member or preferable staff member can accompany them.

Where a person requires administration of PRN to attend an appointment, Restrictive Practices Authorisation and a current NDIS LWB 5411 PRN Protocol must be in place prior. Usage of PRN must be recorded as per LWB RPA reporting requirements.

It is important to note that if a person refuses to participate in any of the components of the Annual Health Assessment, they have the opportunity to exercise choice and control through use of the NDIS LWB 931 Independence and Informed Choice procedure and process.

Comprehensive Health Assessment Program (CHAP)

The CHAP is designed to help minimise the barriers to health care for people with intellectual disability by prompting health care and screening. It was developed by the University of Queensland and is used across Australia and the world. The CHAP provides for a structured clinical health assessment carried out by a General Practitioner (GP) and potentially assists the GP in making better diagnoses, providing appropriate treatment and ultimately ensuring overall better health.

CHAP is LWB's preferred health assessment tool however, a GP may elect to use their own equivalent health assessment. In this case, ensure they work through the partially completed CHAP and provide a report with documented health actions as a result of the assessment.

GPs can complete an Annual Health Assessment with a person with an intellectual disability once per annum using Medicare item 705 - long appointment, Medicare item 707 – prolonged appointment or Medicare item 715 - for an Aboriginal or Torres Strait Islander person.

To undergo an Annual Health Assessment, staff must make sure that at least 365 days have passed since their last assessment. When scheduling the appointment, they should request a long appointment and inform the receptionist that it is for an Annual Health Assessment.

Consent must be obtained from the person we support before the assessment can take place. If the person cannot provide consent and object to the review, consent can be given by their Authorised Decision Maker if they have one. Otherwise, the assessment must be rescheduled until the person does consent.

The CHAP consists of 2 parts.

Part 1 is for staff to complete with the person we support, recording any health issues observed or communicated by the person – text is blue and ends on page 13.

Part 2 is for the GP to complete by reviewing each indicator, examining the person and determining the action required – text is green and starts on page 14.

The CHAP assesses the person's:

- Breathing System
- Heart System
- Muscles and Joints
- Gastrointestinal System
- Urinary System
- Nervous System

- Pain Perception
- Medications
- Allergies
- Sleep
- Cause of intellectual disability
- Epilepsy
- Human Relations
- Women's Health
- Men's Health
- Mental Health
- Vison
- Hearing
- Activity and Lifestyle
- Immunisations
- Medical History
- Family Medical History
- Summary of Health concerns – populated by family/staff/support network.
- Health Promotion screening areas including:
  - Dental
  - Blood Pressure
  - Cigarettes
  - Alcohol
  - Thyroid Function
  - Vitamin D
  - Bowel Cancer
  - Diabetes
  - Skin

How to complete the CHAP?

- Obtain a new Comprehensive Health Assessment Program (CHAP) template.
- Staff support the person to complete the first part of the CHAP sourcing information from records, health plans, health recording charts, family members and staff.
- A long appointment is booked with the GP – at a time that suits the person we support and takes into account waiting times. Long waiting times should be avoided where possible.
- Provide the partially completed CHAP to the GP to review at the appointment

What does the GP do?

- The GP will refer to the guidance provided within and look through the first part of the CHAP and complete the second part while examining the person covering off:
  - their medical history
  - undertake examinations
  - review medication
  - review related health support plans e.g. Epilepsy Management
  - arrange further examinations (if needed) and provide any required referral(s) for multidisciplinary support
  - make an overall assessment of the person
  - record the outcome and document actions in a written report
  - provide advice and information to the person, and Authorised Decision Maker if they have one
- It is important that the Action Plan is filled in at the end of the consultation and provided back to the person.

What to do with the completed CHAP?

Upload both parts of CHAP to CIRTS as follows: Plans & Assessments > Assessments - <Annual Health Care Assessment/ CHAP> Comprehensive Assessment Tool. SURNAME, First Name. YYYY.MM.DD

Nutrition and Swallowing Checklist

The Nutrition and Swallowing (N&S) Risk Checklist is the second component of the Annual Health Assessment and is a way of screening people with disability for difficulties related to nutrition and swallowing. The N&S Risk Checklist should also be completed any time the person's needs, abilities or eating and drinking related risks change.

The N&S Risk Checklist is mandatory for people receiving Shared and Supported Living supports, and people receiving Lifestyle Supports where support with eating, drinking and nutrition is provided.

How to complete the N&S Risk Checklist?

The N&S Risk Checklist should be completed less than 7 days prior to the Annual Health Assessment appointment being scheduled. If staff are concerned the person is at risk of choking or having trouble breathing, they must seek urgent medical review.

The NDIS LWB 5520 Nutrition and Swallowing Risk Checklist – Procedure provides step by step, question by question instructions for completing the Checklist.

- Obtain a new NDIS LWB 5521 Nutrition and Swallowing Risk Checklist template from the Disability Pathway
- Once the N&S Risk Checklist is completed, staff review results and:
  - where all questions are answered as No, staff complete the person's name and date and select checkbox beside "**No risk** was identified for the person, GP review is not required" in Part 3 Summary of Results.
  - where questions are answered with **Yes or Unsure,** staff summarise those questions in Part 3 Summary of Results and record the following:
    - question number
    - name of nutrition and swallowing risk
    - describe how the risk affects the person

What does the GP do?

- Reviews associated plans e.g. Mealtime Management Plan, eating and drinking recording charts (if relevant)
- Discusses risks identified, how they affect the person we support, staff observations
- Examine the person's mouth (if needed)
- Reviews the Summary of Results and for each risk, documents action decided which may include instructions for support or no action required

- Provides referrals as required to Allied Health Professional(s) or Specialist(s) for further review
- Provides referrals as required to Signs and dates Part 3 Summary of Results.

Note: concerns identified within the N&S Risk Checklist may assist the person we support with eligibility for disability related health supports which includes funding for Speech Pathology, mealtime management plan development and training for staff.

What to do with the completed Nutrition and Swallowing Risk Checklist?

- **If no N&S needs were identified** the person should be supported to develop an Eating and Drinking Profile using the NDIS LWB 5526 My Meals My Way - Profile template from the Disability Pathway and are supported to live a healthy lifestyle
- **If a Mealtime Management Plan is required** – support the person to access appropriately qualified health professional for development of plan if not obtained within the GP appointment.
- **If an Enteral Nutrition Plan is required** – A review of the person's NDIS Funding may be required to include "High Intensity Daily Personal Activity" funding and all staff require training
- Upload N&S Risk Checklist to CIRTS as follows: Plans & Assessments > Assessments - <Nutrition and Swallowing Checklist> Nutrition and Swallowing checklist. SURNAME, First Name YYYY. MM.DD

Monitoring for Nutrition and Swallowing Risk

If staff notice any change in the way the person eats or drinks, or there is a change their ability to eat or drink e.g. have had their teeth removed, staff must re-do the Nutrition and swallowing Risk Checklist and ensure the person's GP reviews any new risks or areas that have been answered as 'unsure' within 7 days.

Annual Dental Review

An Annual Dental Review and use of the NDIS LWB 5514 Oral Health Care - Plan is mandatory for all people receiving Shared and Supported Living supports, and also people who receive Lifestyle Supports if LWB assist with dental support.

It is best practice to complete the annual dental review around the time of the person's annual health assessment. Dental health is one of the criteria listed in the Medicare health assessment item. During the Annual Health Assessment, the person's dental and oral health will be reviewed to assess the condition of their gums and mouth.

The GP can refer the person for further dental review via dental health services and document support requirements in the Oral Health Care Plan template during the Annual Health Assessment appointment. Where a person as no teeth, the GP can complete instructions within the Oral Health Care Plan template. Otherwise, the person should have their teeth reviewed by a Dentist and instructions for care documented within the Oral Health Care Plan template.

Note: People requiring general anaesthetic to attend a dental appointment will have the appropriate timeframe for dental review determined by their Anaesthetist and Dentist / GP supervising their dental support requirements. The dentist should state the timeframe the Oral Health Care Plan will span for the person.

How to complete the Oral Health Care Plan?

- Obtain a new NDIS LWB 5514 Oral Health Care - Plan template from the Disability Pathway
- Staff support the person to complete Section 1. My Oral Health Care Needs / Preferences addressing:
  - whether the person has teeth or dentures
  - staff support required for oral health
  - location for undertaking oral health support
  - communicating about oral health needs
  - special oral hygiene requirements

What does the Dentist do?

The Dentist will:

- examine the person's teeth and mouth
- undertake any repair, cleaning required
- provide referrals to specialists / surgeons if required
- revise the review period to suit anaesthetic / psychotropic PRN requirements
- update medication chart with PRN requirements if relevant
- review current Oral Health Care Plan
- document dental support requirements in section 2.a Daily Oral Health Care Plan including:
  - when to clean the person's teeth
  - instructions for cleaning teeth and gums
  - recommend a toothbrush, toothpaste, mouthwash and floss if relevant
  - care for dentures
  - treat dry mouth if needed

What does the GP do?

Oral Health should be assessed during the Annual Health Assessment Appointment along with the CHAP and N&S Risk Checklist.

The GP will:

- assess the condition of the person's gums and mouth
- where the person has no teeth: document support requirements in Section 2.b Daily Oral Health Care Plan
- document products to use
- treat dry mouth if needed

What to do with the completed Oral Health Care Plan

- Support the person to purchase any equipment / products required
- Upload the completed Oral Health Care – Plan to CIRTS as follows: Plans & Assessments> Plans - < Health Care Plan> Oral Health Plan. SURNAME, First Name. YYYY.MM.DD

Monitoring for dental issues

Staff should continually monitor the person for signs of dental issues. If any of the following signs or symptoms are identified:

- bleeding, inflamed or reddened gums
- the person appears reluctant to eat or drink their usual food and drinks
- the person is placing their fingers or other objects in their mouth or may be biting down on these
- the person is hitting the side of their face
- swelling
- broken tooth
- the person advises they have dental concerns

staff must notify their Line Manager and if an appointment has not already been made, make an appointment with the person's dentist or GP (if they have no teeth) to ensure all concerns are addressed.

After the Annual Health Assessment

The below actions will need to be completed after the Annual Health Assessment

- Provide new scripts to the Pharmacy
- Obtain Webster Paks / non-packed medication(s)
- Obtain Consumer Medicine Information Sheets for any new medications
- Replace Medication chart with updated version / ensure updated chart is used
- Update team of any urgent actions required using communication book

- Inform the Authorised Decision Maker (if relevant) of assessment outcome - if they didn't attend
- Schedule appointments with any Allied Health Professionals, Specialists or Surgeons if referrals are provided
- Set up reminders using Outlook Calendar / Diary to ensure actions are completed as requested
- Upload updated documents to CIRTS including completed:
  - CHAP
  - N&S Risk Checklist
  - Oral Health Care Plan
  - Reviewed / redeveloped / new Health Support Plans
  - Updated Medication Record
  - Updated PRN Protocols
  - Medical reports
  - Referrals
- Discuss Annual Health Assessment actions at next team meeting (if relevant)