

Merthyr/Rhondda Cynon Taf Unified Assessment Steering Group

Definitions

GLOSSARY OF TERMS

Age discrimination	action which can adversely affect an older person because of their age. Discrimination can also mean positive discrimination that is action taken to promote the best interests of the older person.
Agency	In the Unified Assessment Process, refers to voluntary, health and social care organisations that singularly or in partnership provide services including assessment to clients where needs are identified and the client is eligible to receive services.
Assessment	<p>A statutory process (NHS and community Care Act 1990) whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment identifies problems and includes all relevant viewpoints. It should be a time limited and self-contained piece of work and should culminate in clearly identified needs and objectives for how these needs will be met. It is recognised that needs do not remain static and re-assessment and/or review recognises these changes.</p> <p>Assessment -the process whereby the needs of an individual are identified and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned. Assessment involves both trained and competent practitioner(s), and the person requiring the assessment discussing how needs have arisen, and how different needs interact with each other.</p> <p>Assessment should be taken to include the re-assessment or unscheduled review of the needs of a current service user.</p>
Basic Personal Details	Information captured at the Enquiry Stage
Basic Personal Information (BPI)	Part of the information captured at the Contact Stage
Care Management	A process whereby an individual's needs are identified and assessed, eligibility for services is determined, personal care plans are drafted and implemented, and needs are monitored and re-assessed ("Case Management" is an alternative term).
Care Co-ordination	<p>this is undertaken by a named trained and competent practitioner when a person has needs that require the input of a number of professionals. It ensures that assessment and subsequent action is joined-up, and that the individual service user is able to identify a key, lead worker for their care.</p> <p>Care Coordinator - a person who is responsible for coordinating, monitoring and reviewing the care of an individual. This is usually a professional member of staff working in specific health or social care and could be one of the following:</p> <ul style="list-style-type: none"> ▪ A professional working in mental health services, who has been named and allocated as a care coordinator to a patient currently the subject of a care programme approach. ▪ A care manager or social worker working in a social services department, who is the named worker for assessing and planning for the needs of a service user. ▪ An intermediate care practitioner working in health services who is responsible for assessing and planning for the needs of a patient/service user

Care Package	A combination of services designed to meet a person's assessed needs, as part of the care plan arising from the assessment. Can be one or several services, and can be residential and / or community based.
Care Pathway	An agreed and explicit route which an individual takes through health and social care services. Agreements between the various professionals involved will typically cover the type of care and treatment, which professionals will be involved and their levels of skills, and where treatment of care will take place.
Care Plan	is the record for all clients who receive services, the objectives of that service, preferred outcomes, services to be provided, a review date and other details. Details of the care plan should be in proportion to the assessed/eligible needs and service provision. For people who receive one off support or treatment of a very basic nature, a simple statement of service delivery and purpose is all that is needed. For non basic nature, a care plan may consist of multiple Service Plans. All older people who receive services should receive an appropriate care plan. A care plan is prepared once an assessment is complete.
Care Planning	A process based on an assessment of an individual's needs that involves determining the level of and type of support to meet the assessed needs, and the objectives and potential outcomes that can be achieved. Care planning involves users and professionals discussing the support and treatment that can best meet identified/eligible needs and achieve agreed goals.
Care Plan Summary	A brief statement containing the main points of the Care Plan
Care Programme Approach	The formal process of assessing needs for services for people with severe mental health problems, prior to and after discharge from hospital.
Carer	<p>Defined in the Carers and Disabled Children Act 2000 as 'Carers (aged 16 and over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over'. There is no definition in the Act of substantial and regular care. It is a matter of professional practice to identify the impact of the caring role on the carer in light of the carer's age, general health, employment status, interests and other commitments.</p> <p>Key factors relevant in deciding the impact of the caring role on the carer are the sustainability of the caring role, and the extent of risk to the sustainability of that role.</p> <p>Issues relevant to identifying sustainability of the caring role are autonomy, Health and Safety, managing daily routines and involvement. It is possible for a service user to have more than one carer, and for a carer to be additionally a service user in his / her own right.</p> <p>Carer -For the purposes of the Carers and Disabled Children Act 2000 the term "carer" includes people (age 16 and over) who may or may not be a relative and who may or may not be living with the person for whom they are caring. The 2000 Act excludes from the definition of a carer, paid care workers and volunteers from a voluntary organisation. Children and young people affected by caring situations should be considered and assessed as children in need under the Children Act 1989.</p> <p>Defined in the Carers and Disabled Children's Act 2000 as 'Carers (aged 16 and over) who provide or intend to provide a substantial amount of care on a regular basis for another individual aged 18 or over'.</p>

<p>Carer's Assessment</p>	<p>A carer's assessment under the Carers and Disabled Children Act 2000 is carried out at the request of the Carer in order:</p> <ul style="list-style-type: none"> • to determine whether the carer is eligible for support; • to determine the support needs of the carer, i.e. what will help the carer in their caring role and help them to maintain their own health and well-being; and • to see if those needs can be met by additional services. <p>Carers have a right to an assessment of their needs, even where the person cared for has refused an assessment, or the provision of community care services, provided the person cared for would be eligible for community care services.</p> <p>Carried out at the request of the carer in order to determine eligibility for support, the support needs of the carer and to see if those needs can be met by social or other services.</p>
<p>Care Management</p>	<p>a process whereby an individual's needs are identified and assessed, eligibility for services is determined, care plans are drafted and implemented, and needs are monitored and re-assessed.</p>
<p>Case Finding</p>	<p>A process by which people with needs, who are not referred for health and social care help by either themselves or third parties, might be identified by agencies and invited for assessment.</p>
<p>Clinician</p>	<p>Those directly involved in the care and treatment of patients, including doctors, dentists, nurses, midwives, health visitors, pharmacists, opticians, chiropodists, radiographers, orthoptists, physiotherapists, dieticians, occupational therapists, medical laboratory scientific officers, orthotics and prosthetics, therapist speech and language therapists and all other health professionals.</p>
<p>Comprehensive Assessment</p>	<p>This refers to assessments in which most or all of the domains of the Single Assessment process have been triggered and explored through the use of specialist/in-depth assessments. All people entering care homes or in receipt of intermediate care services should have received a comprehensive assessment. It will include medical assessment.</p> <p>A comprehensive assessment may arise in several ways:</p> <ul style="list-style-type: none"> ▪ Where professional judgement identifies the needs and circumstances of an older person are such that a comprehensive assessment involving specialist assessments of all or most of the domains of the Unified Assessment process should be commenced. In this situation, conducting an overview assessment would be unnecessary ▪ At initial contact there could be less certainty and an overview assessment may be carried out to explore areas of concern. When all the domains of an overview assessment have been surveyed, and specialist assessments carried out in most or all of them, the result is a comprehensive assessment. ▪ Where the level of support and treatment likely to be offered is intensive and prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home.
<p>Contact Assessment</p>	<p>This refers to a first assessment involving the person and professional, establishing the nature of the presented problem and whether or not there are potential wider health and social care needs. Basic personal information will also be collected, or verified if previously collected, at contact assessment.</p>
<p>Continuing Care</p>	<p>Continuing Care (or long term care) is a general term which describes the care that people need over an extended period of time, as the result of disability, accident or illness. to address both physical and mental</p>

	health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings from an NHS hospital, to a nursing home, residential home or hospice, and people's own homes.
Consent	Permission for a for a course of action.
Diagnosis	This is a medical form of assessment that focuses on identifying illness and health conditions, and generating casual hypotheses for them. It results in succinct descriptions such as Alzheimer's Disease, depressive disorder, hypertension, stoke, etc
Domain/Sub-Domains	These are the content areas covered by the Unified Assessment Process. A domain, for example, is 'Users Perspective'. Sub-domains relate to components of a domain. The sub-domains of 'Users Perspective' include problems and issues in the user's own words' etc. They are described in Chapter 4 of Creating a Unified and Fair System for Assessing and Managing Care.
Domiciliary Care	Care provided in a service user's own home or to a person based at home, e.g. home help, home care.
Electronic Social Care Record (ESCR)	A comprehensive social care record encompassing all relevant information about the assessed needs, services and expected outcomes for an individual, accessible in electronic form. This is being developed as part of the Informing Social Care initiative.
Eligibility Criteria	Describe the full range of eligible needs that will be met be local authorities having taken their resources into account. Need more work to reflect health criteria.
Eligible Needs	Those presented needs for which a local authority will provide help because they fall within the local authority's eligibility criteria that are set according to a council's resources. Health also have eligibility criteria for Registered Nursing Care (RNC) and Continuing Health Care (CHC)
Enquiry	The first stage on the Unified Assessment Process. Where information is gathered that will lead to: <ul style="list-style-type: none"> ▪ Signposting to other agencies or services ▪ Request for straight forward service requests ▪ Contact Assessment
Ethnicity	The ethnic categorisation of individuals. The DoH & Social care uses the 2001 Census classifications for all statistical collection.
Fair Access to Care Services (FACS)	In carrying out their duties under Section 47 of the NHS and Community Care Act 1990, councils should keep assessment in proportion to individuals' needs using the general principles of assessment included in the guidance, and/or by reference to the most appropriate assessment framework (in Buckinghamshire that is Single Assessment Process). Services are matched to eligible needs through the use of statements of purposes, which all providers should make available.
Health Care Professional	A person who is professionally qualified to practice the delivery of health care services and is contracted to or provides healthcare for a particular organisation or health care provider.
Holistic assessment -	The need for the assessment to take a broad view of a person's assessed needs within the context of their health, social and family networks.
Independence	Managing everyday living skills to maximise ability, taking account of the support available and needed.
In-Depth	This refers to further exploration of assessment Domains that have been

Assessment	triggered by Contact or Overview Assessment as part of an assessment under the Single Assessment process. In-depth assessment will usually be carried out by qualified professionals, including specialists, and may require the use of scales. It will result in detailed knowledge and insights about particular problems.
Initial Contact	This is the date when first contact is received from or on behalf of the service user in relation to the possible need for services, which then becomes a subject of assessment or re-assessment/review. The contact may be by way of personal call, phone call, letter, or other form. It may be direct or through an intermediary. The date of first contact is not necessarily the same as the date of screening, though in many local authorities screening will take place on the same day as contact. See also Contact Assessment.
Intermediate Care	A short period (normally no longer than six weeks) of intensive rehabilitation and treatment to enable patients to return home following hospitalisation, or to prevent admission to long term residential care; or intensive care at home to prevent unnecessary hospital admission.
Mental Health Care Team (Community)	A team of professionals delivering specialist mental health services, including secondary and self-referral services, for adult and elderly patients. This includes the care or assessment of adult and elderly patients with drug or alcohol dependence but excludes child and adolescent psychiatry patients and patients with learning disabilities. The team can be multidisciplinary and may contain members who are employees of the health care provider or be employees of another NHS or non-NHS organisation.
Monitoring	A regular process of enquiry that checks the progress of the care plan and ensures its suitability for the current needs of the service user.
Multi-disciplinary	Multidisciplinary refers to when professionals from different disciplines - such as social services, nursing, occupational therapy work together.
Multi-disciplinary Assessment	is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.
Needs (Presenting need)	Those needs that are reported by older people or others on their behalf. The needs of a service user that have been identified
Outcome Approach to Assessment	An approach that emphasises the relevance of establishing intended outcomes in the assessment process in order to provide clearer links between both assessment and the resulting personal plan of care, and as a basis for clear information to providers. Outcomes can be described as the changes and effects that the service user requires resulting from service provision and the support network available to them.
Overview Assessment	This refers to situations where all or most of the domains of the single assessment process are explored. Overview assessment may be able to fully identify and describe needs; if not, it should indicate or trigger where specialist assessment is required.
Person Centred Care	For clients <ul style="list-style-type: none"> ▪ They should expect respect and courtesy. ▪ The assessment of their needs should begin with their perspective and their views should be kept to the fore at all times. ▪ They should feel confident and be encouraged to take the lead in their own assessment. ▪ If needed, clients should be given preparation or assistance in taking a lead. for example through the use of a translator. advocacv or

	<p>communication equipment and help in filling out forms, if that is what they want.</p> <ul style="list-style-type: none"> ▪ They should be able to share information in confidence. This includes being asked their permission to share information about them with other professionals involved in delivering their care. ▪ They should be expected to be involved in all decisions ▪ They should have access information that enables both informed decision making and the understanding of key decisions. <p>For agencies</p> <ul style="list-style-type: none"> ▪ Working in partnership and having a shared vision. Agencies have to agree to work together and have the desire to do so. They need to decide what the partnership looks like and agree on what needs to be done to achieve the vision. ▪ Taking ownership and learning to trust. All partners need to have a say and participation towards the vision. Agencies need to acknowledge their differences and begin to trust each other, through gaining greater understanding. ▪ Develop skills and recognise the need to learn from each other. In particular, agencies should take every opportunity to enhance their understanding of joint working.
Person Centred Approach	<p>The older person seeking help from health and social services experiences a single assessment process where:</p> <ul style="list-style-type: none"> ▪ Information about needs is given once, no matter that the assessment and subsequent care planning and service delivery involves a number of professionals and agencies <p>Professionals work together in the best interests of the older person (as defined by the older person or those close to them)</p>
Personal Care Plan	<p>A record that sets out, for people who are to be provided with help, the objectives of that help, preferred outcomes, services to be provided, a review date, and other details. All older people who receive services should receive an appropriate Personal Care Plan.</p>
Presented Needs	<p>The needs or issues that are identified when individuals contact or are referred to agencies seeking support are defined as presented needs. Those presented needs for which a local authority will provide help because they fall within the local authority's eligibility criteria become eligible needs.</p>
Re-assessment	<p>A re-evaluation of the needs of a service user, prompted by either a scheduled review, or a contact indicating a change in their circumstances.</p>
Reliable	<p>Generally speaking, this refers to the trust that can be placed on an assessment tool when used to score the needs of an individual by different assessors, or over time. For an assessment tool to be reliable, there should be evidence of a measurement of reliability of a scale's use in at least one similar population and that this was of an acceptable degree. Reliability refers to the degree of agreement that is achieved between different assessors, using the same scale at around the same time on the same person, or between different times.</p>
Residential Accommodation	<p>This refers to nursing homes and residential care homes that provide around-the-clock care for vulnerable adults who can no longer be supported in their own homes. These homes may be run by local councils or independent organisations. Admission to residential accommodation can be made on a temporary or permanent basis.</p>
Respite Care	<p>Over-night care provided as respite for a carer somewhere other than in a service users own home. Normally this will be in residential/nursing accommodation. The period of care should cover at least one night but should not exceed 3 months.</p>

Review	<p>This refers to a review of people's needs and issues, and consideration of the extent to which services are meeting the stated objectives and helping to achieve the desirable outcomes, which may lead to a re-assessment. Reviews are scheduled as part of the care planning process.</p> <p>A review is an examination of the assessed needs of a service user needs and services (the care plan where it exists) at or by a predetermined date. A further defining characteristic of a review is that it is about both the needs and service provision for the individual service user.</p>
Risk/Risk Assessment	<p>'Risk' and 'Risk Assessment' in the Unified Assessment Process relates to evaluating factors that impact on a person's independence. Key factors include a person's health, their safety and their ability to manage essential daily routines.</p> <p>This evaluation should take full account of the likely outcome if help were not to be provided. Consideration to be given to how needs and risks may change over time and what the impact this would have on a person's independence both in the immediate and longer term. Risk assessment involves the professional and individual exploring the individual needs which could include moving and handling, mental health, risk of neglect or self harm, skin care.</p>
Scale	<p>This is a means of identifying the presence and/or severity of a particular problem, such as depression or difficulties with personal care.</p>
Service plan	
Scheduled Review	<p>A review which has been planned in advance.</p>
Screening	<p>This is the initial phase with a contact when basic data is gathered, along with sufficient indication of the purpose of the contact to determine whether information / advice or a basic service is a relevant response, and / or whether further investigation and assessment are warranted. It is also the stage at which callers who have come inappropriately to the local authority will be filtered out and / or re-directed.</p>
Service Provider	<p>An individual or an organisation providing a health or social care service.</p>
Service Provision	<p>A provision of service by a service provider</p>
Service User / Patient / Client	<p>This refers to a person who is in receipt of either health or social care services. It includes patients of the NHS.</p>
Social Care	<p>Social Care is provided by statutory and independent organisations and describes a wide spectrum of activities which support and help people live their daily lives. It can include: intimate personal care, managing finances, adapting housing conditions, and help attending leisure pursuits.</p>
Specialist/in-depth Assessment	<p>This refers to further exploration of assessment domains that have been triggered by contact or overview assessment.</p> <p>Specialist assessment offers a way of exploring specific needs, often in detail, and may be triggered by a contact or overview assessment. As a result of a specialist assessment, professionals should be able to confirm the presence, extent, cause and likely development of a health condition or problem or social care need, and establish links to other conditions. problems and needs. Qualified professionals will usually</p>

	carry out specialist assessment. It will result in detailed knowledge and insights about particular needs.
Step Down Care	Less intensive care that helps people achieve greater independence and living skills, according to assessed need as part of a planned programme.
Statement of Purpose	Should set out the objectives and philosophy of care, nature of services, facilities, physical access and likely charges. They should also describe the types of circumstances and types of people for whom the service is designed. The statements of purpose should be used at the care planning stage to match services to needs and desired outcomes.
Summary Record	The most current record, made up of (at a minimum) the Contact Assessment, triggered domains of the Overview Assessment (including generic overview pages and the Summary of Personal Plan of Care. In Social Services operations, it may also contain the Care Plan and Service Plans as directed by local policy.
Supported Discharge	A short-term period of nursing and /or therapeutic support and sometimes supported by community equipment and/or housing.
Tool	This is a collection of scales, questions and checklists that have been brought together for assessment purposes. An alternative term for 'tool' is 'instrument'.
Treatment	Is to care for medicinally or surgically; to manage in the use of remedies or appliances; to treat a disease, a wound, or a patient.
Unified Assessment Process (UAP)	The UAP for older people applies to health and social care services. It recognises that many older people have health and social care needs, and that agencies need to work together so that assessment and subsequent care planning are effective and coordinated.
Unmet Needs	A presented need that is identified, but to which a service response is not available or a preferred option is not available and an alternative has to be provided. <i>These must be recorded by practitioners, and evaluated periodically in order to inform the forward planning processes of the agencies involved in assessments of need.</i>
Unscheduled Review	An unplanned review arranged in response to notification of a service user's changed needs or circumstances.
Valid	Generally speaking, this refers to a scale actually measuring what it is supposed to measure.

Document Control

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Revision History

This document is only valid on the day it was printed. The source of the document currently resides locally with the author. Refer to the author if you are in any doubt about the currency of this document.

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Approvals

This document requires following approvals before release

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Distribution

This document has been distributed to

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