Integrated Care of Older People: the WHO ICOPE program and the ICOPE App

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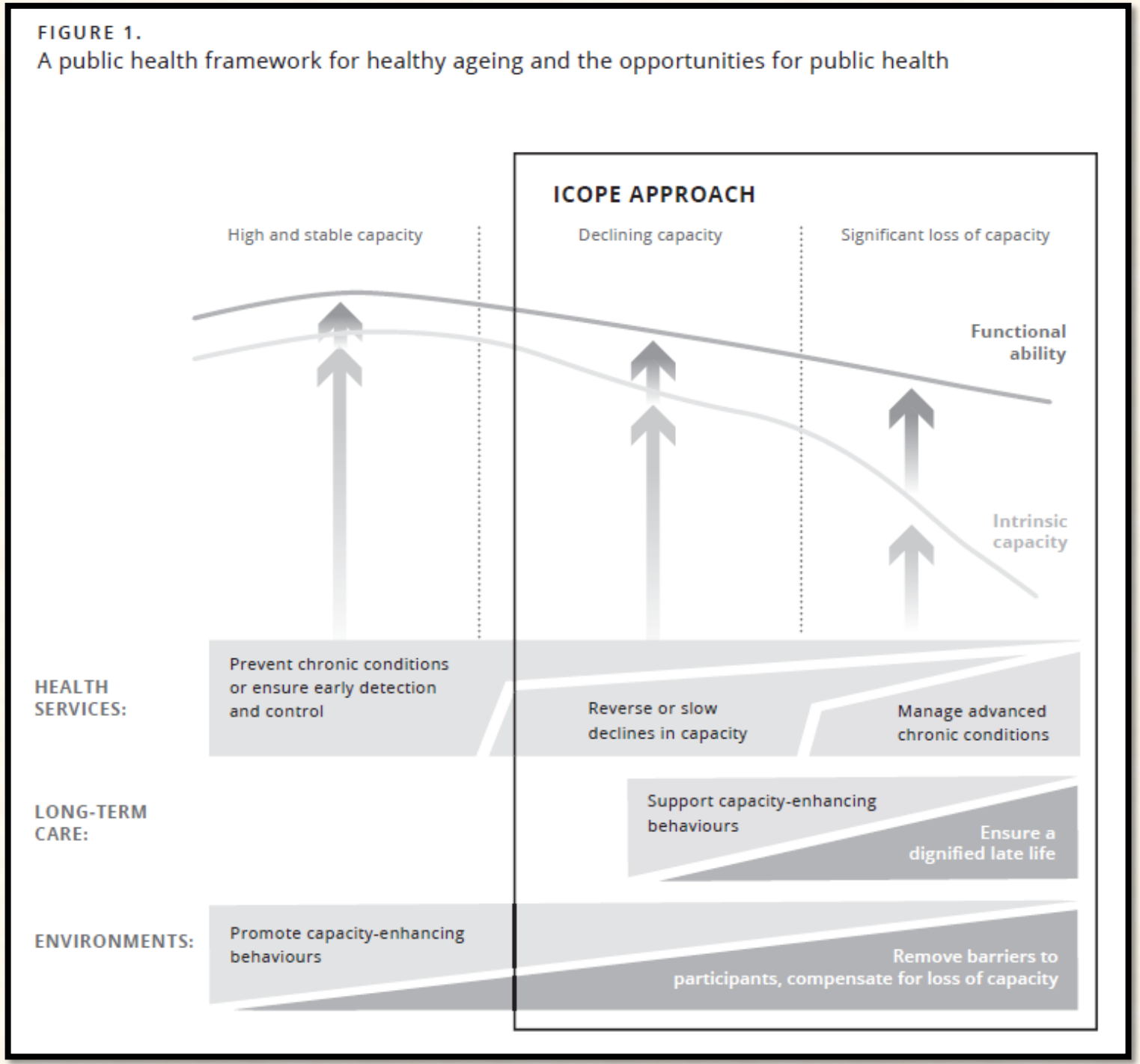
The Journey to Age Equality

The theme of the 2019 United Nations International Day of Older Persons (IDOP 2019) is The Journey to Age Equality.

The right to health applies to all, regardless of age, ability, gender, geographical location, socio-economic status without discrimination of any kind. But many health systems around the world struggle to respond to the complex health needs of older people.

Intrinsic capacity and functional ability decline with increasing age. Intervening at an early stage of declining capacity is essential to prevent or delay the decline so that older people can continue doing the things that matter to them.

FIGURE 1.
A public health framework for healthy ageing and the opportunities for public health



ICOPE is community-based approach towards a person-centred health and social care to optimize the functional ability of older people

The ICOPE digital App and handbook assist health, social care workers and care givers to:

1. Screen older people at risk of care dependency in the community
2. Undertake a person-centred assessment of older people's health and social care needs in primary care
3. Design a personalized care plan

The ICOPE Implementation Framework guides policy makers and programme managers in assessing the capacity of the systems and services to deliver integrated care at the community level and implement an action plan.

ICOPE

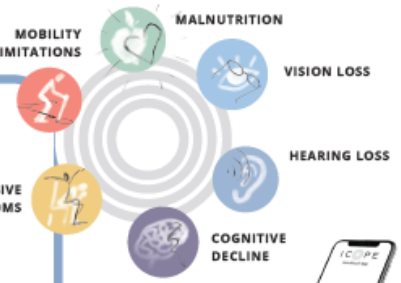
Integrated Care for Older People

1 As people grow older, their health needs are likely to become ***more complex and chronic***.

Intervening at an early stage of declining capacity is essential because the process of becoming care dependent can be prevented or delayed.

2

3 ICOPE addresses priority conditions associated with declines in capacities:



4

The ICOPE App and handbook assist health and social care workers to:

- Screen older people at risk of care dependency in the community
- Undertake a person-centred assessment of older people's health and social care needs in primary care
- Design a personalized care plan

5 ICOPE is a ***community-based approach*** towards person-centred health and social care to ***optimize the functional ability of older people***

World Health Organization

For more information:
https://www.who.int/ageing/health-systems/icope/en/

World Health Organization

INTEGRATED CARE FOR OLDER PEOPLE

Older people are frequently faced with...

1 Fragmented services

2 Too far from where they live

3 Ageist attitudes of healthcare workers

4 Lack of interventions to optimize Intrinsic Capacity and Functional Ability

INTEGRATED CARE

is important to help older adults maximize their Intrinsic Capacity and Functional Ability in the community.

World Health Organization

HOW DOES **INTEGRATED CARE** WORK?

World Health Organization

ICOPE APPROACH

1
Rapid case finding for declines in intrinsic capacity

2
Those with declines are referred for **comprehensive assessment**

3
Design a care plan

- Oral supplemental nutrition
- Cognitive stimulation
- Strength and resistance exercise
- Home adaption to prevent falls

Photo credit:
1. National Cancer Institute/ Rhoda Baer
2. U.S. Air Force photo/Senior Airman Omari Bernard
3. Own work/ Ewien van Bergeijk - Kwant

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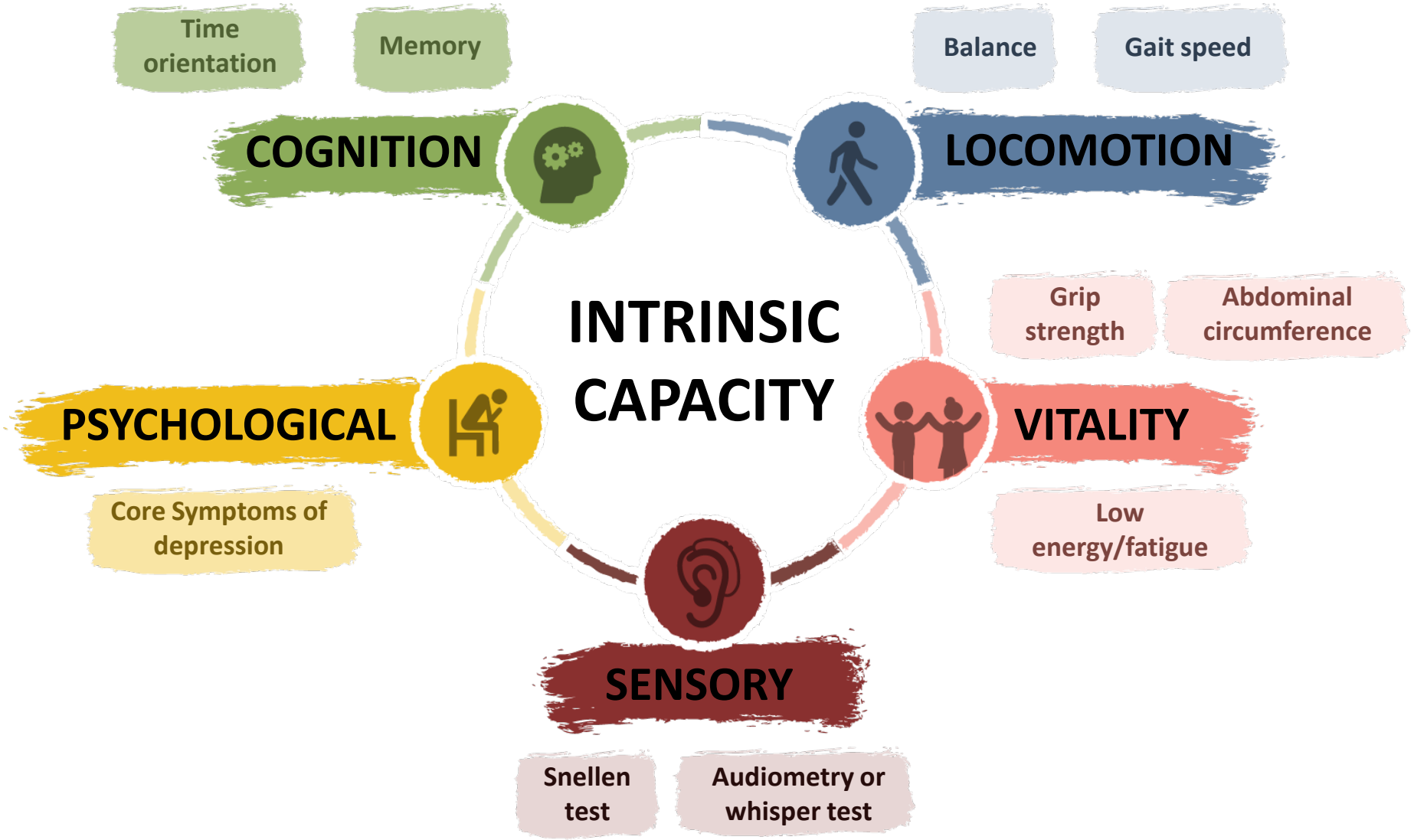
DOMAINS OF INTRINSIC CAPACITY



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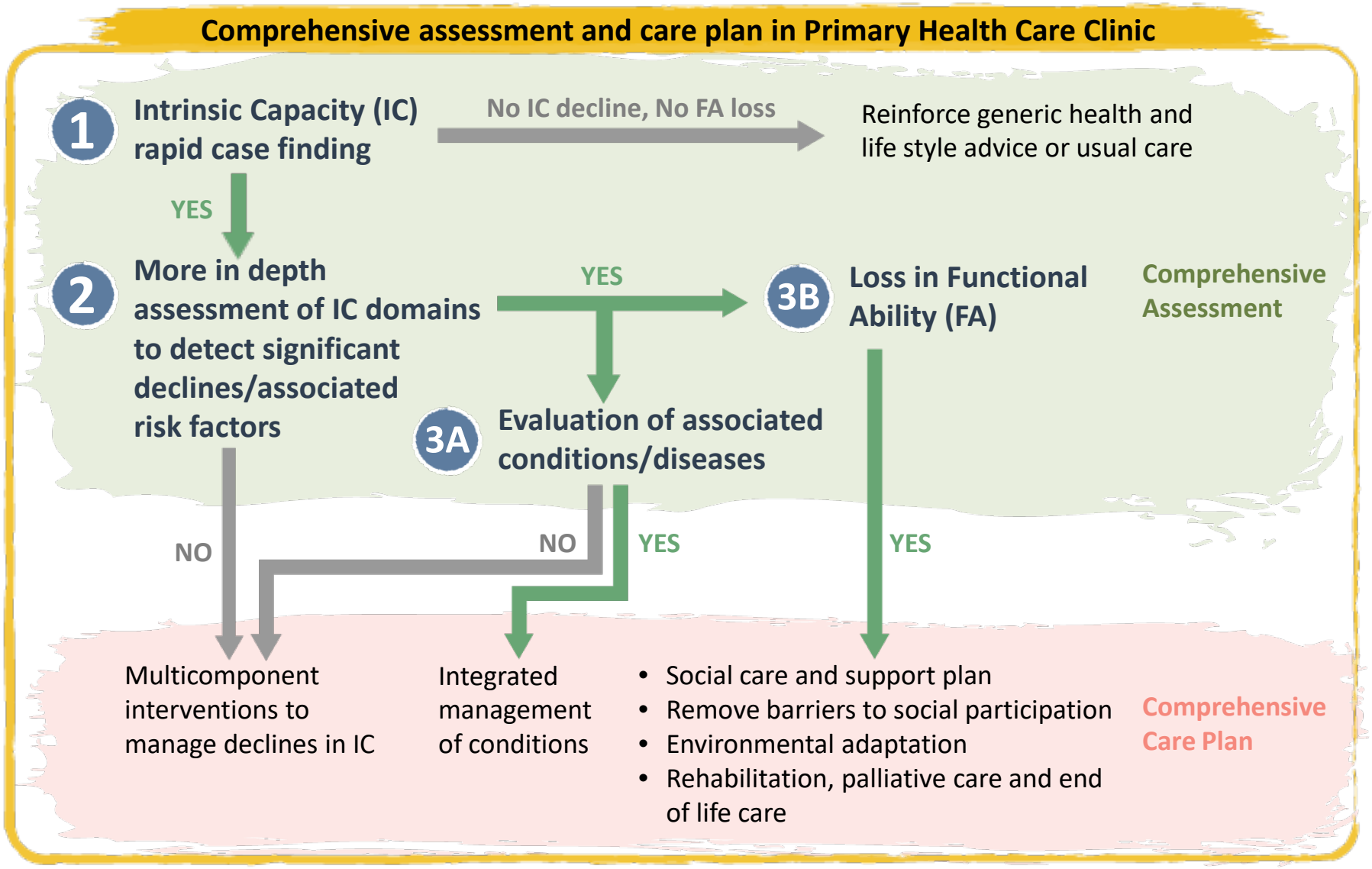


ICOPE

INTEGRATED CARE FOR OLDER PEOPLE

Handbook

Guidance on person-centred assessment and pathways in primary care

World Health Organization

FIGURE 2.

Steps for creating integrated services for older people

1

Know who are the older people in the community in need of care (and type of care)

ICOPE Handbook

2 SERVICES

What is the capacity of the services to respond to identified care needs?

ICOPE Framework

2 SYSTEMS

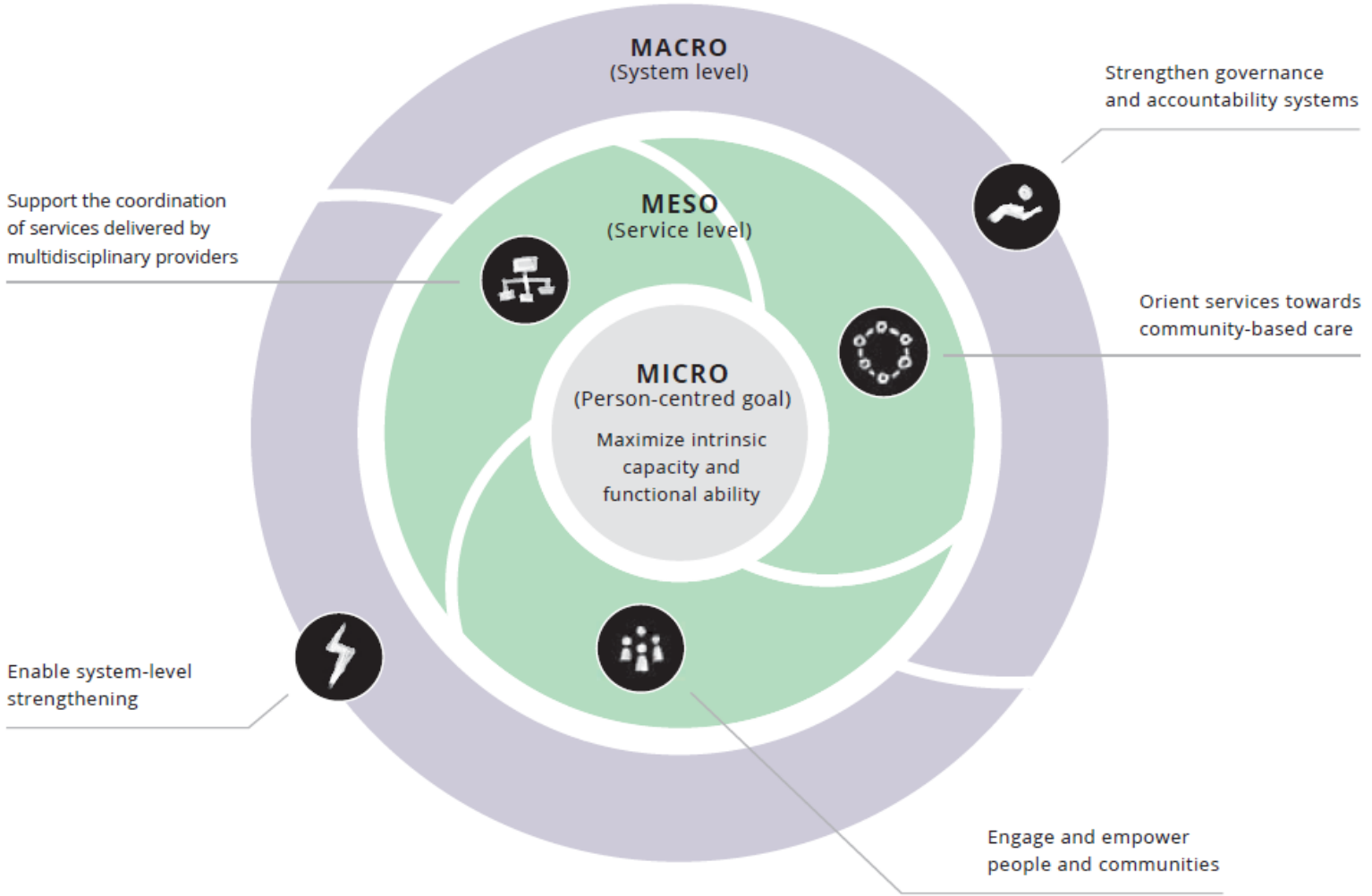
What is the capacity of the system to support integrated services?

3

Draft an implementation plan

FIGURE 3.

ICOPE implementation framework



https://apps.who.int/iris/handle/10665/325669

Service (meso) level

Service actions one to nine in the framework are directed at supporting the implementation of the ICOPE approach in health and social care services.

The actions are intended to assist **service and programme managers**.

Service-level managers will vary according to service designs in each country, but may include roles such as service manager, district manager, programme manager and state health coordinator.

Community-based care is a blend of health and social services provided to an individual or their family or caregivers in their place of residence to promote, maintain or restore health, or to minimize the effects of illness and disability. These services are usually designed to help older people remain independent and in their own homes. They can include, for example, seniors' centres, transport, meal deliveries or sites for meal congregation, visiting nurses or carers, and adult day care services.[21]

The service actions are grouped into three areas of focus:

engage and empower people and communities

support the coordination of services delivered by multidisciplinary providers

orient services towards community-based care

ENGAGE AND EMPOWER PEOPLE AND COMMUNITIES

Service actions 1 and 2

1 Actively engage older people, their families and caregivers and civil society in service delivery

SCORE	ACTION(S) NEEDED
0	➢ Identify the scope, nature and capacity of community services in the local area. ➢ Develop a strategy to formally engage the local community in health and social care service delivery.
2	➢ Consult with community groups and other local services to identify opportunities for expanding engagement with the community. ➢ Formalize the relationship of health and social services with the community, for example by establishing weekly support and monitoring visits from care workers to community volunteers, registering volunteers in the health facility and providing incentives and training.
3	➢ Maintain engagement with community members, community groups and other services in the delivery of health and social care services. ➢ Sustain monitoring and support systems.

2 Offer caregivers support and training

SCORE	ACTION(S) NEEDED
0	➢ Undertake a needs assessment to identify threats to, or impairments in, caregivers' mental and physical well-being, gaps in competencies, and respite care needs. ➢ Undertake a capacity assessment to determine the human, financial and infrastructure resources needed and available to provide caregiver support, respite care and training. Community day centres may be appropriate options, for example.
2	➢ Consult within and across services and with caregivers to evaluate the acceptability of planned or piloted support or of training initiatives, and evaluate opportunities for scaling them up. ➢ Begin efforts to make psychological support available for responding to caregiver burden. ➢ Initiate plans for community-based respite care, such as community day centres or temporary home support.
3	➢ Continue to deliver support and training initiatives and implement a cycle of quality improvement to ensure the initiatives remain relevant and useful to caregivers. For carers of people living with dementia, for example, the WHO iSupport tool (http://www.who.int/mental_health/neurology/dementia/isupport) can be a useful online training platform. It provides information, skills training and support, and uses problem-solving and cognitive behavioural therapy to address caregivers' needs.

SUPPORT THE COORDINATION OF SERVICES DELIVERED BY MULTIDISCIPLINARY PROVIDERS

Service actions 3–6

3 Actively seek and identify older people in need of care in the community

SCORE	ACTION(S) NEEDED
0	➢ Consult providers, community members and civil society to identify locally appropriate and acceptable case-finding strategies. ➢ Assess the capacity within and between services for implementing formal case-finding strategies.
1	➢ Develop a clear case-finding strategy for the community and engage with providers, community members and civil society to consult them on developing implementation strategies. Consultations should include older people and caregivers, judge acceptability and feasibility and identify opportunities for scaling up case finding and its coordination between service providers.
2	➢ Continue case finding and implement a cycle of quality improvement to ensure processes remain effective and locally acceptable.

4 Undertake person-centred assessments when older people enter health or social care services and a decline in intrinsic capacity is suspected or observed

SCORE	ACTION(S) NEEDED
0	➢ Assess the capacity of current services to perform comprehensive assessments, such as the competencies of health and social care workers, the current user admission/enrolment processes in health and social care services, the infrastructure needed to implement a standardized comprehensive assessment and the existence of strategies for case finding and community outreach.
2	➢ Explore the opportunities, capabilities and readiness to implement standardized comprehensive assessments by consulting within and between service providers. ➢ Offer training to health and/or social care workers to perform comprehensive assessments and to develop care plans.
3	➢ Continue undertaking comprehensive assessments and implementing care pathways. ➢ Continue to implement a cycle of quality improvement to ensure assessment processes remain efficient and acceptable to health and social care workers and to older people, families and caregivers.

5 Support appropriately trained health and social care workers to develop personalized care plans

SCORE	ACTION(S) NEEDED
0	➢ Undertake a capacity assessment on the competencies of health and or social care workers to create personalized care plans. ➢ Assess the current user admission/enrolment processes in health and social care services. ➢ Assess the infrastructure needed to create and share personalized care plans.
2	➢ Consult within and between service providers to explore the opportunities, capabilities and readiness for creating personalized care plans. ➢ Offer training to health and social care workers to develop personalized care plans. ➢ Use normative guidance such as the WHO ICOPE guidance on person-centred assessments and pathways in primary care.
3	➢ Implement a quality-improvement cycle to ensure care planning remains effective and acceptable to health and social care workers and to older people and their families or caregivers.

6 Establish networks of health and social care providers to enable timely referral and service provision

SCORE	ACTION(S) NEEDED
0	➢ Do a mapping assessment to identify and create a network of service providers for older people and caregiver respite. ➢ Engage with potential service providers to explore their capabilities and readiness to join a provider network for older people and caregivers.
2	➢ Engage with potential service providers to explore their capabilities and readiness to join a provider network for older people and caregivers.
3	➢ Sustain and further develop the formal network of service providers that enables timely referral or rapid care escalation for older people and their caregivers by continuing to map services and consult service providers.

ORIENT SERVICES TOWARDS COMMUNITY-BASED CARE

Service actions 7–9

7 Deliver care through a community-based workforce, supported by community-based services

SCORE	ACTION(S) NEEDED
0	➢ Undertake a capacity assessment to create a community-based workforce based on local need (e.g. volumes of health and social care workers, the availability of an unpaid workforce, opportunities for new cadres) to deliver health and social care services to older people in their community or home. ➢ Do a mapping exercise to identify local community services capable of supporting a local workforce.
2	➢ Explore opportunities to implement a permanent, community-based workforce through novel configurations that are suitable to the local context (e.g. unpaid roles, new work cadres). ➢ Do a mapping exercise to identify local community services capable of supporting a local workforce.
3	➢ Continue to deliver care to older people in their community or home through a community-based health and social care workforce. ➢ Continue to engage with and support local community services and to map the availability and capabilities of these services to support the workforce. ➢ Continue to support the workforce (paid and unpaid) through local community services.

8 Make available the infrastructure (e.g. physical space, transport, telecommunications) that is needed to support safe and effective care delivery in the community

SCORE	ACTION(S) NEEDED
0	➢ Undertake a needs assessment to identify threats to, or impairments in, caregivers' mental and physical well-being, gaps in competencies, and respite care needs. ➢ Undertake a capacity assessment to determine the human, financial and infrastructure resources needed and available to provide caregiver support, respite care and training. Community day centres may be appropriate options, for example.
2	➢ Consult within and across services and with caregivers to evaluate the acceptability of planned or piloted support or of training initiatives, and evaluate opportunities for scaling them up. ➢ Begin efforts to make psychological support available for responding to caregiver burden. ➢ Initiate plans for community-based respite care, such as community day centres or temporary home support.
3	➢ Continue to monitor infrastructure needs and provision capabilities as services expand or contract according to the health and social care needs of older people in the community.

9 Deliver care (with assistive products when needed) that is acceptable to older people and targets functional ability

SCORE	ACTION(S) NEEDED
0	➢ Modify care interventions in a phased manner to align them with recommended components of care. This may start with aligning to WHO guidelines,8 for example, and orienting interventions towards improving IC and FA.
2	➢ Audit care interventions to evaluate the extent to which they align with the recommended components of care. ➢ Through consultation and reviewing best practice (e.g. WHO guidelines8), modify care interventions to align more closely with recommended components of care.
3	➢ Continue to deliver services that are consistent with the recommended components of care, including buying assistive products and ensuring they are available.

System (macro) level

System actions 10 to 19 in the framework are directed at supporting the implementation of the ICOPE approach in health and long-term care systems (collectively referred to as systems).

The actions are intended to assist **system managers**.

The system actions are grouped into two areas of focus:

strengthen governance and accountability systems

enable system-level strengthening

STRENGTHEN GOVERNANCE AND ACCOUNTABILITY SYSTEMS

System actions 10–13

10 Support the active engagement of older people and their families or caregivers, civil society and local service providers in policy and service development

SCORE	ACTION(S) NEEDED
0	➢ Develop policies or participatory governance frameworks in consultation with the community, older people and caregivers to formally support community engagement (inclusive of all older people and caregivers) in policy and service development.
2	➢ Review informal processes for their ability to be formalized and adopted at greater scale to support community engagement. ➢ Implement policies or participatory governance frameworks.

11 Create or update policy and regulatory frameworks to support integrated care and to protect against elder abuse

SCORE	ACTION(S) NEEDED
0	➢ Create policies or frameworks to support integrated care and protection for older people. These should align with local need, be supported by a case for change against elder abuse and co-created with local champions or leaders. ➢ Identify and engage local champions or leaders to support the implementation of policies or frameworks.
2	➢ Continue to create or update policies or frameworks through participatory governance. ➢ Support local champions or leaders to drive implementation efforts.
3	➢ Maintain contemporary policies or frameworks to provide integrated care and protection for older people, supported by a contemporary case for change against elder abuse. ➢ Continue to identify local champions or leaders and support them ➢ to disseminate policies and drive implementation.

12 Implement quality assurance and improvement processes for health and social care services

SCORE	ACTION(S) NEEDED
0	➢ Identify the critical areas in service delivery where quality assurance is needed. ➢ Select the appropriate tools (PROMs, PREMs, person-centred outcomes). ➢ Develop a process to implement measurement tools.
2	➢ Develop processes for the use of quality outcomes data for service improvement. ➢ Expand system-level quality measures to include person-centred and provider outcomes across services.
3	➢ Continue to measure person-centred and provider outcomesacross services and use these data to inform service improvement. ➢ Implement valid and reliable contemporary outcome measures.

13 Regularly review the capacity to deliver care equitably

SCORE	ACTION(S) NEEDED
0	➢ Adopt the actions recommended by this framework as the criteria for assessing the capacity to deliver equitable ICOPE. ➢ Develop processes within systems to evaluate the capacity based on these criteria.
2	➢ Implement routine capacity and performance assessments for integrated care (e.g. every five years), ensuring that assessments include disadvantaged groups and that outcomes are meaningful to system managers.
3	➢ Routinely continue to assess the capacity to deliver ICOPE, and to evaluate the performance of the system in delivering this care. ➢ Routinely review assessment outcomes to ensure they remain meaningful to system managers.

ENABLE SYSTEM-LEVEL STRENGTHENING

System actions 14–19

14 Develop capacity in the current and emerging workforce (paid and unpaid) to deliver integrated care

SCORE	ACTION(S) NEEDED
0	➢ Evaluate the current capacity of the workforce, specifically the knowledge and skills to deliver the right care. ➢ Develop workforce capacity-building initiatives to target the current and emerging workforce and both paid and unpaid roles.
2	➢ Expand existing capacity-building processes and initiatives to include all workforce roles, reflect interdisciplinary care and address the recommended components of care for the ICOPE approach. Follow the same key competencies outlined above for systems at the stage of minimal implementation.
3	➢ Continue the system-wide workforce capacity-building initiatives and update them as new evidence or resources emerge. ➢ Monitor the capacity of the workforce so that capacity-building initiatives are responsive to need.

15 Structure financing mechanisms to support integrated health and social care for older people

SCORE	ACTION(S) NEEDED
0	➢ Modify policies and processes to structure financing for health and social care services around a shared or pooled funding model that includes financial incentives for appropriate care coordination at the service level and includes the cost of interventions and essential medicines and devices to maintain intrinsic capacity (IC) and functional ability (FA).
2	➢ Implement modified financing models that support shared or pooled funding approaches for health and social care services, which include financial incentives for appropriate care coordination at the service level. ➢ Evaluate the effectiveness of financial incentive initiatives in supporting sustained and meaningful care coordination at the service level.
3	➢ Continue to fund health and social care services in a point funding mechanism. ➢ Continue to offer financial incentives to support care coordination at the service level, based on an evaluation of effectiveness.

16 Establish equitable human resource management processes to support the paid and unpaid workforce

SCORE	ACTION(S) NEEDED
0	➢ Develop system-level, semi-structured HR processes to support the equitable management of the workforce, including paid and unpaid workers, across services, consistent with the principles of the WHO Global strategy on human resources for health: workforce 2030. ➢ Consult workers and service managers in developing HR processes.
2	➢ Implement semi-structured HR processes to support the equitable management of the workforce, including paid and unpaid workers, across services, consistent with the principles of the WHO Global strategy on human resources for health: workforce 2030.
3	➢ Continue to adopt HR processes that support the paid and unpaid workforce in a semi-structured and equitable manner. ➢ Review HR processes periodically (e.g. every five years) to reflect changes in work cadres and respond to service quality-improvement initiatives.

17 Use health information and communications technology to facilitate communication and information exchange

SCORE	ACTION(S) NEEDED
0	➢ Identify where health information storage and sharing and communication between services or providers could be enhanced by secure digital technologies. ➢ Develop a strategy to guide the phased procurement and implementation of digital technologies, supported by a policy for appropriate privacy and security. ➢ Continue to use existing low-tech systems to support information exchange and care coordination among services or providers.
1	➢ Develop a strategy to guide the phased procurement and implementation of digital technologies, supported by a policy for appropriate privacy and security. ➢ Implement digital technologies in a phased approach in consultation with service managers and providers to ensure acceptability and feasibility.
2	➢ Continue to review the needs for digital health technology. ➢ Continue to review the policy for data privacy and security and the latest developments to support digital health technologies.

18 Collect and report data on the intrinsic capacity and functional ability of older adults within existing health information systems

SCORE	ACTION(S) NEEDED
0	➢ Evaluate the capacity to integrate measures of IC and FA into health information systems. ➢ Develop a phased implementation plan to integrate IC and FA measures into health information systems.
1	➢ Implement tools across services to measure the IC and FA of older people as part of system-level health information or surveillance. Use the experiences of services already using or trialling tools to inform implementation. ➢ Develop a reporting plan for IC and FA data.
2	➢ Continue to measure IC and FA within existing health information systems. ➢ Update the measurement tools, under guidance from WHO. ➢ Prospectively report on IC and FA data to evaluate population health needs and changes over time.

19 Use digital technologies to support older people's self-management

SCORE	ACTION(S) NEEDED
0	➢ Undertake a needs and capacity assessment to provide or support digital technologies. ➢ Evaluate available digital technologies to determine effectiveness, acceptability and fit within the existing system.
1	➢ Review evaluation outcomes of trials of digital technologies across services. ➢ Develop a system-level implementation plan for digital technologies identified as appropriate and acceptable to the local setting.
2	➢ Continue to provide or support digital technologies to assist older people with self-management. ➢ Evaluate the impact of digital technologies on self-management capabilities and health service use.

Handbook App

The WHO ICOPE Handbook App supports community and primary care workers to assess the health and social care needs of older people and design a personalised care plan using the WHO ICOPE Handbook: Guidance on Person-Centred Assessment and Pathways in Primary Care

NEW PERSON (coming soon!)

RETURNING PERSON (coming soon!)

TRAINING TOOL

FURTHER INFORMATION

World Health Organization

ICOPE Handbook App

First Version of ICOPE Handbook App

This is the first version of the ICOPE Handbook App to celebrate the International Day of Older Persons. The current version allows you to try out the Training Tool. In the coming weeks, more features will be made available in the App, stay tuned!

PROCEED

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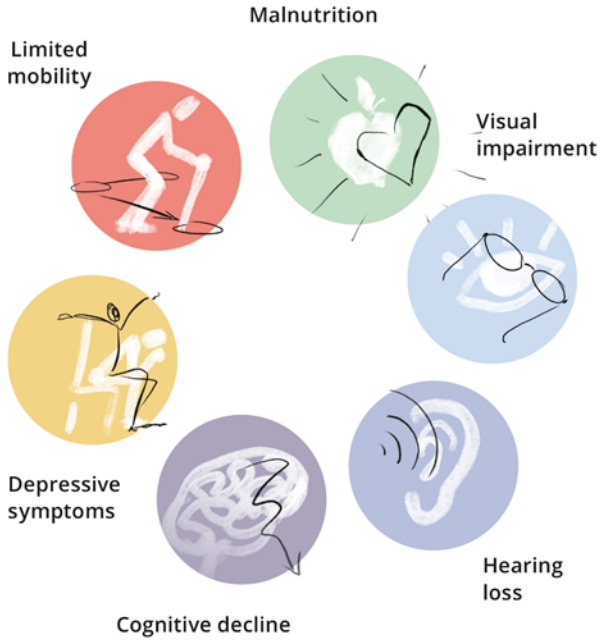
START

The ICOPE training tool is a reference tool to explore the ICOPE screening, assessment and personalised care plan development features of the App.



SCREENING

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SCREENING

COGNITION

Do you have problems with memory or orientation (such as not knowing where one is or what day it is)?

- Yes ○
- No ○

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SCREENING

NUTRITION

1. Have you unintentionally lost more than 3kgs over the last three months?

- Yes ○
- No ○

2. Have you experienced loss of appetite?

- Yes ○
- No ○

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SCREENING

VISION

Do you have any problems with your eyes: difficulties in seeing far, reading, eye diseases or currently under medical treatment (e.g. diabetes, high blood pressure)?

- Yes ○
- No ○

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SCREENING

HEARING

Remember: Whisper words must be familiar to the person

Right ear

Could the person repeat more than three words?

- Yes
- No

Left ear

Could the person repeat more than three words?

- Yes
- No

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SCREENING

MOOD

Over the past two weeks, have you been bothered by:

1. Feeling down, depressed, or hopeless?
   - Yes
   - No
2. Little interest or pleasure in doing things?
   - Yes
   - No

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SCREENING

CHAIR RISE TEST

00:00:00 START RESET

Did the person complete five chair rises within 14 seconds?

- Yes
- No

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SCREENING

CHAIR RISE TEST

00:02:31

START

RESET

Did the person complete five chair rises within 14 seconds?

Yes

No

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Next

SCREENING RESULT

POSSIBLE DECLINE IN INTRINSIC CAPACITY

Refer to primary health care clinic for in-depth assessment

ASSESSMENT

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COGNITION

ASSESS

GPCOG

The General Practitioner Assessment of Cognition (GPCOG) is a very brief cognitive test specifically designed for use in primary care.

PROCEED

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COGNITION

ASSESS

RESULTS OF GPCOG TEST

These results indicate

Normal Cognitive Capacity

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Next

MOBILITY

ASSESS

SPPB

The short physical performance battery (SPPB) is a group of measures that combines the results of the gait speed, chair stand and balance tests. The scores ranges from 0 (worst performance) to 12 (best performance).

PROCEED

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MOBILITY

ASSESS

BALANCE TEST

A. Side-by-side stand

00:00:00

START

RESET

- Held for 10 sec.
- Not held for 10 sec.
- Not attempted

B. Semi-tandem stand

00:00:00

START

RESET

- Held for 10 sec.
- Not held for 10 sec.
- Not attempted

C. Tandem stand

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MOBILITY

ASSESS

GAIT SPEED TEST

00:01:71

START

RESET

- < 4.82 seconds
- 4.82 - 6.20 seconds
- 6.21 - 8.70 seconds
- > 8.70 seconds
- Unable to complete

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Next

MOBILITY

ASSESS

CHAIR RISE TEST

00:00:00

START

RESET

Able to complete five chair rises without arms in 60 seconds?

- < 11.19 sec.
- 11.2 - 13.69 sec.
- 13.7 - 16.69 sec.
- 16.7 - 59.9 sec.
- Unable to complete or > 60 sec.

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MOBILITY

ASSESS

RESULTS OF SPPB

These results indicate

Normal mobility

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NUTRITION

ASSESS

MNA®

The Mini Nutritional Assessment (MNA®) is a validated nutrition screening and assessment tool that can identify older people who are malnourished or at risk of malnutrition.

PROCEED

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NUTRITION

ASSESS

1. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

- severe decrease in food intake ○
- moderate decrease in food intake ○
- no decrease in food intake ○

2. Weight loss during the last 3 months

- weight loss greater than 3 kg (6.6 lbs) ○
- does not know ○
- weight loss between 1 and 3 kg (2.2 and 6.6 lbs) ○
- no weight loss ○

3. Mobility

- bed or chair bound ○
- able to get out of bed / chair but does not go out ○
- goes out ○

4. Has suffered psychological stress or acute

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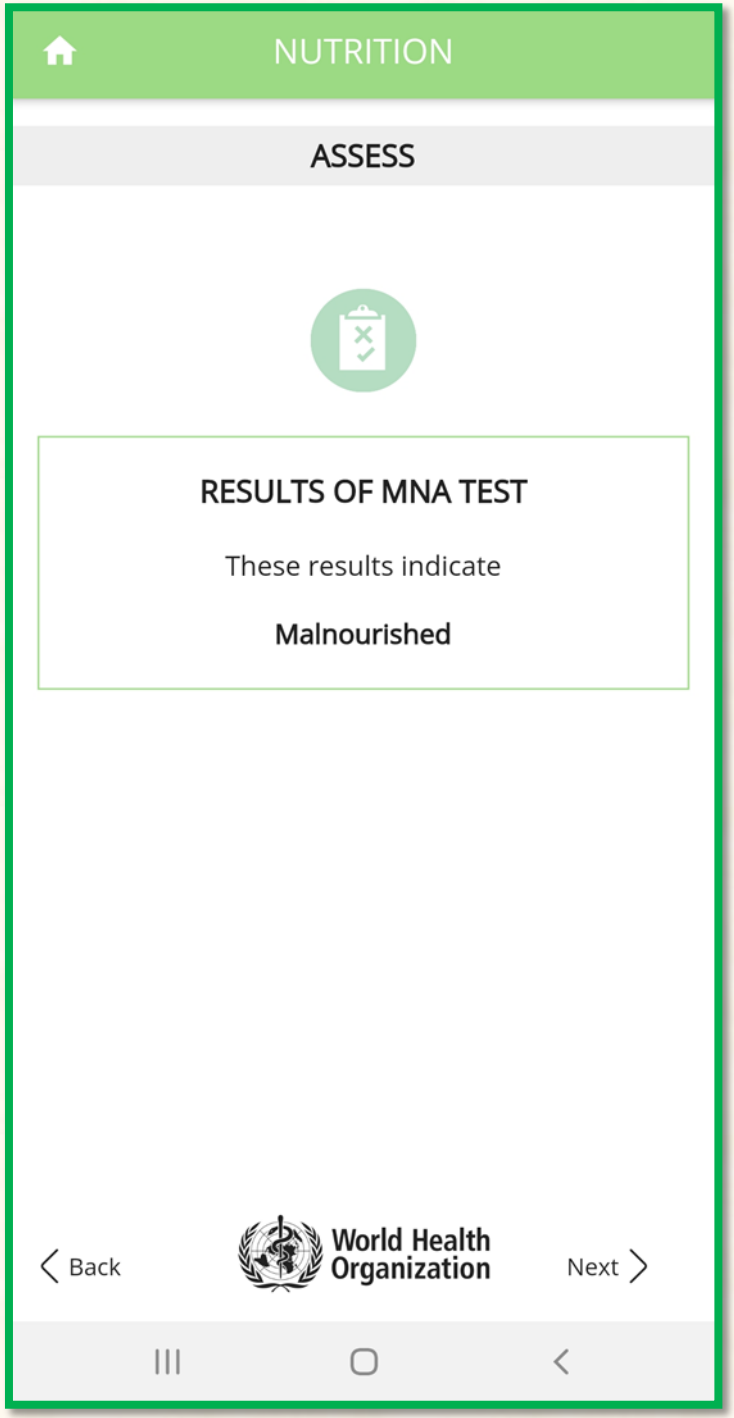
NUTRITION
ASSESS
RESULTS OF MNA TEST
These results indicate
Malnourished
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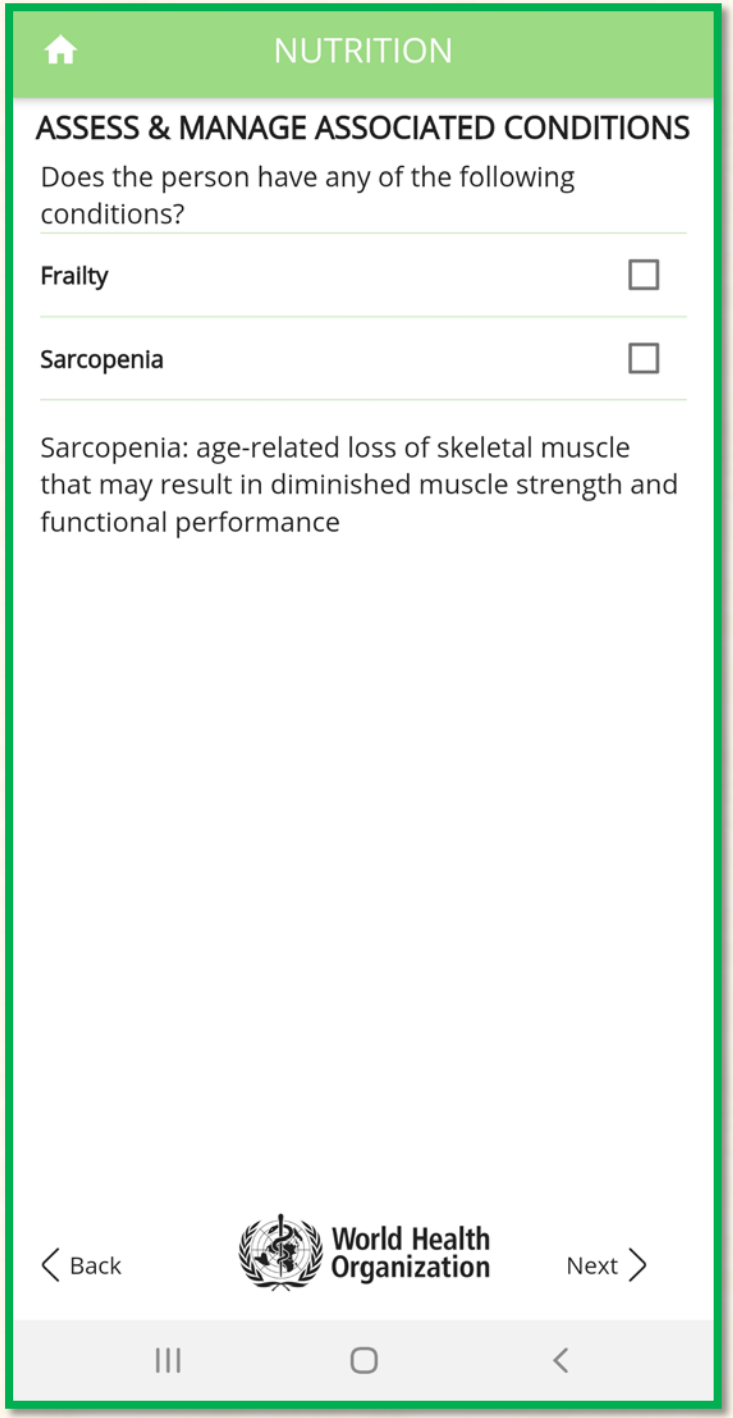
NUTRITION
ASSESS & MANAGE ASSOCIATED CONDITIONS
Does the person have any of the following conditions?
Frailty
Sarcopenia
Sarcopenia: age-related loss of skeletal muscle that may result in diminished muscle strength and functional performance
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VISION

ASSESS

TEST VISUAL ACUITY

DISTANCE VISION

Test with the four small Es at 3 metres

Could the direction of at least three out of the four small Es be seen?

- Yes
- No

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Next

VISION

ASSESS

TEST VISUAL ACUITY

NEAR VISION

Test using the image below -- only proceed to the next row if at least 3 out of the 4 Es can be seen correctly.

At least 3 out of the largest four Es are seen correctly in the first line?

- Yes
- No

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Next

VISION

ASSESS

RESULTS OF VISION ASSESSMENT

These results indicate

Normal Vision

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Next

ASSESS MOOD

Over the last two weeks, have you been bothered by any of the following problems?

- Trouble falling or staying asleep, or sleeping too much ☐
- Feeling tired or having little energy ☐
- Poor appetite or overeating ☐
- Feeling bad about yourself or that you are a failure or that you have let yourself or your family down ☐
- Trouble concentrating on things such as reading the newspaper or watching television ☐
- Moving or speaking so slowly that other people could have noticed ☐
- Being so fidgety or restless that you have been moving around a lot more than usual ☐
- Thoughts that you would be better off dead or of hurting yourself in some way. ☐

ASSESS

RESULTS OF PSYCHOLOGICAL CAPACITY TEST

These results indicate

Depressive symptoms

ASSESS & MANAGE ASSOCIATED CONDITIONS

Does the person have any of the following conditions?

- **Polypharmacy** ☐
- **Anemia/Malnutrition** ☐
- **Hypothyroidism** ☐
- **Pain** ☐

The presence of any of these would suggest a different approach from treatment for depression

ASSESS

Care pathways for social care and support

A. Social care needs (personal assistance) -- check all that apply

- [ ] Difficulty getting around indoors
- [ ] Difficulty using the toilet (or commode)
- [ ] Difficulty dressing yourself
- [ ] Difficulty using the bath or shower
- [ ] Difficulty keeping up your personal appearance
- [ ] Difficulty feeding yourself

ASSESS

Care pathways for social care and support

B. Social support needs -- check all that apply

- [ ] Problems with the place where you live (accommodation)
- [ ] Problems with your finances
- [ ] Do you feel lonely?
- [ ] Not able to pursue leisure interests, hobbies, work, volunteering, supporting your family, educational or spiritual activities which are important to you
- [ ] There is risk for elder abuse

ASSESS

RESULTS OF ASSESSMENT OF NEEDS OF SOCIAL CARE AND SUPPORT

These results indicate

- In need of personal assistance with daily activities
- Loneliless

Proceed to

ASSESSMENT SUMMARY

ASSESSMENT SUMMARY

Name	Gender
John Smith	Male
Date of birth	**Country**
10/05/1949	Spain

COGNITIVE CAPACITY
Normal Cognitive Capacity

LOCOMOTOR CAPACITY
Normal mobility

VITALITY
Malnourished

VISUAL CAPACITY
Normal Vision

PSYCHOLOGICAL CAPACITY
Depressive symptoms

Begin

DESIGN CARE PLAN

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DESIGN CARE PLAN

Personalised Care Plan

1. Review the findings with the older person (and their carers if appropriate) ▶
2. Person-centred goal setting ▶
3. Agree on interventions to be included in the care plan ▶

Once the steps above are completed, click the button below to access the Personalised Care Plan for the older person. Share the PDF produced with the older person, their carers (if appropriate), the assessor, and (subject to consent) to others who might be involved in the older person's care, via the Print, Email or Share buttons.

PERSONALISED CARE PLAN

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PERSON REVIEW

DRAFT CARE PLAN

PERSONAL INFORMATION

Name	John Smith	**Gender**	Male	**Location**	Barcelona
Date of birth	10/05/1949	**Country**	Spain		

COGNITIVE CAPACITY

Assessment Result
Normal Cognitive Capacity

Associated Conditions

VITALITY

Assessment Result
Malnourished

Associated Conditions
-Frailty

VISUAL CAPACITY

Assessment Result
Normal Vision

Associated Conditions

PSYCHOLOGICAL CAPACITY

Assessment Result
Depressive symptoms

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FINISH

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