

# Edmonton Seniors Sector Outreach Worker Toolkit

## Outreach Manual

The toolkit also includes:

- Interview Guide
- Resource List



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Thanks to all who supported the work of the Edmonton Seniors Coordinating Council Outreach Project. Your commitment of time and energy to graciously share your expertise in this collaborative effort has led to a better set of tools to support workers as they reach out to isolated and at-risk seniors in Edmonton.

Our sincere appreciation to those who contributed to the development of this manual, interview guide and resource list through your participation on committees including the Steering Committee, the Executive Director/Designate Group, and/or Outreach Workers Project Group including staff from the following agencies:

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### **For more information contact the Edmonton Seniors Coordinating Council**

Rosalie Gelderman

780-441-9805

[projects@seniorscouncil.net](mailto:projects@seniorscouncil.net)

### **With support from:**



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## Forms, Tools & Templates

### Intake/Supported Referral Form

### Detailed Assessment Forms

**Required: Demographics**

Optional

- |                               |  |
|-------------------------------|--|
| 1. Activities of Daily Living | 11. Social/Recreation/<br>Spiritual/Community                          |
| 2. Food Security/Nutrition    | 12. Elder Abuse  |
| 3. Housing                    | 13. Reliable Contacts/<br>Social Supports & Other<br>Service Providers |
| 4. Physical Health            | 14. Cultural Diversity   |
| 5. Transportation             | 15. Life History   |
| 6. Financial/Legal            | 16. Coping Skills/Strengths  |
| 7. Caregiving                 | 17. Risk Factors Identified  |
| 8. Grief and Loss             | 18. Action Plan  |
| 9. Mental Health              |  |
| 10. Addictions                |  |

## **Tools**

Clutter Image Rating (CIR) Assessment

Gambling Screen

Drug Use Questionnaire (DAST – 10)

Risk Management Tool for Older Adults

EcoMap Tool

## **Templates**

Employee Home Visit Safety Assessment Template

Home Visit Hazards Assessment Template

Outreach Working Alone Safely Policy Template

Confidentiality Agreement Template

Consent to Release of Information Template

# Background

Outreach to isolated and/or at-risk seniors has been identified as a key issue in a number of previous Edmonton projects and reports.

The 2007 *Aging in Place: A Neighborhood Strategy* report, produced for the City of Edmonton by Community Services Consulting Ltd., recommended a review of outreach services available to seniors, with a special focus on the elderly at-risk group. A 2009 Edmonton Seniors Coordinating Council (ESCC) report, *Improving Outreach to Edmonton's Isolated Seniors*, addressed that recommendation. Other work included the hiring of a facilitator to design an improved model for delivering outreach with ESCC and 14 participating agencies, and the release of the report in the fall of 2010, *Helping Seniors Age in Place-A Strategic Framework to Improve Outreach to Edmonton's Isolated Seniors*.

Outreach functions were deemed as essential community support and included as part of Social Services in the *Core Community Support Project: Elements for Community Supports for Aging in Place in Edmonton* published by ESCC in June of 2011. In addition, developing and enhancing outreach services to isolated and/or at-risk seniors including immigrant and refugee seniors, is one of 58 actions identified in the *Vision for an Age-Friendly Edmonton Action Plan* approved by City Council in July 2012.

## The Vision for an Age-Friendly Edmonton Action Plan

The *Vision for an Age-Friendly Edmonton Action Plan* reflects and embodies the following vision and values:

### Vision

Edmonton is a community that values, respects and actively supports the safety, diversity and well-being of seniors.

### Guiding Principles

- Society has a responsibility to ensure the basic needs of seniors are met.
- Seniors have the right to choose where and how they live as long as they don't pose a risk to others.
- Seniors have the right to feel safe in their homes and communities.
- As seniors age, their needs may change and services can adapt to meet these changing needs.
- Services are accessible, affordable, equitable and comprehensive to address a wide range of needs.
- Seniors' access to needed services will not be limited by ability to pay.
- Services will be inclusive and respect diversity; they will be responsive to cultures, varied English language skills, marginalized individuals and persons with disabilities.
- Programs and services will be based on best practices, research and innovation, and will be evaluated for their effectiveness.
- Programs and services will reflect the character of the community.
- Communities will be engaged in supporting seniors.

# Need for Outreach Services:

Characteristics of the seniors population point to an increased need for outreach services.

**Demographics:** In 2012, 13 per cent of Edmonton's population was age 65 or older (106,274) and half of these seniors were over 75. The number of seniors in Edmonton is expected to double over the next 20 years as the baby boomers age.

**Income:** About one-third (31 per cent) of Alberta seniors in 2009 received the Guaranteed Income Supplement, which provides money over and above the Old Age Security benefit to low-income seniors. (*A Profile of Alberta Seniors-Government of Alberta Sept. 2010*) About one-quarter of Edmonton seniors live alone and fall in a low income category, increasing their risk for social isolation.

**Diversity:** The older adult population in Edmonton is also becoming increasingly diverse in terms of ability, interests, background, culture, religion, and support networks. The demand for services that are responsive to this diversity will continue to increase.

**Access to services:** Older adults in Edmonton are faced with trying to find affordable and accessible services and resources that can assist them in the areas of physical and mental health, housing and maintenance, finances, transportation, rights and safety, learning, contributing, and social interaction. The most vulnerable among them need specialized assistance and advocacy to access these resources and opportunities effectively.

**Reaching and serving Edmonton's most vulnerable seniors can prevent isolation and crisis.**

# Purpose of the Project

To achieve the goal of community support services that are inclusive and responsive in meeting the needs of seniors it was identified that outreach services to isolated and/or at-risk seniors, including aboriginal, immigrant and refugee seniors needed to be enhanced. Outreach service enhancements to meet the needs of lesbian, gay, bisexual and transgender (LGBT) individuals are also included in this goal.

A toolkit for seniors sector outreach workers consisting of a manual, interview guide and resource list was developed by the Edmonton Seniors Coordinating Council (ESCC) in collaboration with input from many stakeholders and representatives from senior serving organizations over the period of 2012-2014. The group wanted to ensure there are consistent, relevant and high quality outreach services to isolated and/or at-risk seniors across Edmonton. They were also committed to providing support to outreach workers to aid in service enhancement. The toolkit contributes to these goals.

The toolkit provides information, operating guidelines and suggestions for standards of service. The forms, templates and resources are meant to be used and/or adapted for use by outreach workers in the seniors sector.

## How to Use the Seniors Sector Outreach Worker Toolkit

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### Manual

The manual provides an overview of outreach services and provides necessary background information related to working with isolated and at-risk seniors. The manual includes detailed forms and templates that outreach workers can use to record client information.

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### Interview Guide

The interview guide is used when meeting with seniors. It provides prompts and sample questions outreach workers can use in face-to-face work with seniors.

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### Resource List

The resource list includes agencies and services that may be helpful to meet the needs of isolated and at-risk seniors. The resource list is available as a printed document and an online reference tool. Note that the online resource list will be updated more frequently than the printed document.



# Characteristics of Isolated and/or At-Risk Seniors

*Risk factors* (or characteristics) for social isolation have been identified through research to increase with age and are most common among seniors aged 75 years or more. These risk factors include living alone, having low income, being single, experiencing loss, experiencing language and cultural barriers, and having transportation difficulties. Isolated seniors have reduced well-being and quality of life, poor general health, and may experience abuse, stress and loneliness. *Source: Cooper, Merrill. 2013 Positive social ties (Calgary, AB Family & Community Support Services, The City of Calgary)*

An *isolated senior* (also considered to be at-risk) is 55 years of age or older and typically has one or more of the following characteristics:

- Presents complex needs or circumstances that any single organization may not be able to address
- Typically unable to address needs on his or her own
- Has limited or no contact with family and friends
- Lacks a support system
- Unaware of what help is available
- Lacks transportation or is unable to use public transportation
- Lacks sufficient finances
- Isolation is involuntary

*Source: 2009 ESCC report, Improving Outreach to Edmonton's Isolated Seniors*

# Outreach Description

The purpose of outreach is to *improve the accessibility of services to seniors. It involves programs/workers, primarily but not exclusively known as outreach workers, providing a set of services to seniors in their homes, a centre or elsewhere in the community.* Outreach takes its services beyond an agency or centre into the community because individuals are often unaware of services that exist.

These services are typically focused on assessing the needs and challenges a senior faces and then providing appropriate information and referral services and case management for ongoing engagement with clients.

Outreach workers meet with seniors in order to determine what their aspirations, assets, and needs are. Do they need some information or do they need to be linked to a particular service or program? What talents, resources and abilities do seniors bring to the table that can help achieve their goals?

Sometimes the outreach worker's involvement with a senior is very short-term; other times needs are on-going, which necessarily involves case planning and management.

While information and referral are key elements of outreach, services can also include accompanying a senior to an appointment, participating in case conferences with other service providers, liaising with a senior's family or friends, as well as discovering emerging issues and challenges through the ongoing relationship with the senior.

Outreach means more than bringing existing services into the community; it means being proactive, not just reactive. Outreach is also about seeking out seniors who may need assistance.

## Essential Elements of Outreach:

1. Case Finding
2. Assessment Services
3. Information and Referral Services
4. Case Management
  - Individual Advocacy
  - System Navigation
5. Service Development & System Advocacy
6. Community Engagement/Community Building

## Case Finding

Isolated seniors do not typically seek assistance. An outreach service with a focus on such seniors must be proactive about finding them through liaisons with landlords, businesses, health professionals, etc.

## Assessment Services

Assessment is the linchpin of outreach services. It is client-centered and sets the stage for everything to follow. It identifies a senior's circumstances, his or her living situation, health challenges or conditions, mobility issues and the senior's overall strengths and challenges.

Assessment involves working with the senior and other service providers when applicable in order to ensure the assessment is holistic and comprehensive. Assessments may lead to the development of goals (developed in collaboration with the senior) and a service or action plan.

## Information and Referral Services

Information and referral services include linking seniors to community resources that will meet their needs. The outreach worker's degree of involvement can range from simply providing information, to assisting with a supported referral like filling out government or service provider forms, arranging or accompanying the senior to an appointment.

All referrals should involve follow-up in order to assess if the referral addressed the need(s) of the senior (see Case Management).

## Case Management

The need for case management is determined through the assessment process and becomes necessary when the work with a senior will be ongoing. It involves the following: holistic case planning; identification of goals/outcomes; development, implementation and monitoring of an action plan; and ongoing documentation.

The development and coordination of a holistic action plan should be done in collaboration with, and approved by, the senior. Whenever possible, the plan's development should also involve the client's family, other key helping professionals, and others who are engaged with the senior (e.g. neighbour).

While there is not a predetermined list of services that should be provided within case management services, the general guide is that case management by an outreach worker should include the following:

- Assist seniors to implement their action plans
- Work with the seniors themselves as well as family members, friends and service providers
- Assist seniors to maintain, if not improve, quality of life
- Assist seniors to remain in their own homes for as long as possible

The action plan should clearly and simply identify goals, the actions required to address the goals, and the roles of the various participants in the actions. As well, it should focus on the senior doing as much as possible independently.

The action plan may involve a senior acting alone, with coaching, with direct assistance, or having a worker act on his or her behalf (or connecting to another service that will do so).

Monitoring the progress of the plan is a formal component of case management. It includes meeting with the senior in the home or at another location (e.g. seniors centre, doctor's office, family member's home, etc.).

Monitoring can also be done by telephone but this typically should not be the only method of monitoring.

The outcomes of referrals and services being received by the senior are documented and evaluated. The monitoring phase of case management will often lead to a reassessment of the senior's needs.

Documentation takes place throughout the case management process; it is not a separate step. For an action plan to be optimally effective, documentation should be transparent and shared with the senior and with other participants in the plan, giving appropriate consideration to the senior's right to privacy.

## Service Development & System Advocacy

Because outreach workers are active in the community, they often are among the first to recognize gaps in service, shortcomings in systems and service denials based on ineffective or inadequate policies or practices.

As well, outreach workers have relationships that exist across various professions, helping them to understand the overall service delivery system.

Although it is not the role of the outreach worker alone to undertake the development of new services or engage in advocacy for changes in systems, policies or organizations, it is the outreach worker's role to bring observations, experiences, ideas and issues to the attention of his or her organization's senior staff and to the Interagency Outreach meetings. One of the measures of an effective outreach service system is the extent to which what is learned on the front line translates into system change for the betterment of clients.

## Community Engagement/Community Building

The needs and challenges facing seniors are best addressed by the entire community. A city-wide outreach program for seniors should deploy community development techniques in order to create awareness and mobilize community interest and support for seniors.

Engagement and collaboration should go beyond systems and agencies to include businesses, neighbourhood groups and leaders, and volunteers in the development and sustainability of an age friendly community. Community leagues and volunteer driving organizations are two of many potential partners in engaging the community.

# Outputs, Outcomes & Indicators — Data Collection and Evaluation for Outreach Services

Collecting data and measuring results consistently is recognized as a mark of an effective collaboration. The data can be used to inform decisions, indicate trends and demonstrate the collective impact of an outreach program. A performance measurement system includes collecting data on activities or outputs, determining the results or changes (outcomes) from these activities and identifying how you would know those changes had occurred (indicators that the program had an impact). The following definitions are taken in part from City of Edmonton Family & Community Support Services (FCSS) materials.

## Outputs/Activities

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### Home Visits

A home visit is a direct contact between staff and the program participant in the home. It is an intentional visit that lasts at least 30 minutes.

### Contacts

A contact, usually face to face, is a purposeful or structured contact with content that is related to the program or participant's goals or needs. Contacts do not include home visits or situations where the senior is unexpectedly seen for a few minutes. Some phone calls may be counted as face to face visits if the conversation is related to the achievement of the goals, but calls made to set up appointments are not.

### Information Referrals

Information referrals refer to provision of information where the senior will act on his or her own behalf after receiving the information or referral. No further assistance is required by program staff members.

### Supported Referrals

Supported referrals result from a request made by a participant or from an identified need of a participant. Supported referrals are those that have involvement beyond “information provision” and require further assistance by program staff members. Elements of a

supported referral would include facilitating the referral process, advocacy, reducing barriers to access a support or service, or accompaniment to an appointment in order to support the referral.

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## Detailed Assessment

The detailed assessment identifies the senior's circumstances such as their living situation, health challenges or conditions, mobility issues and their overall strengths and challenges. The detailed assessment leads to an action plan.

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## Transportation

Transportation refers to providing a ride to a senior to get to appointments or essential services. This usually only occurs when individual advocacy is required.

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## Open Files/Case Management

This includes the number of seniors for whom files have been opened and case management services are being provided in support of working towards goals.

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## Groups for Seniors

- **Unregistered:** These are sometimes called “drop-in groups”. Unregistered groups are groups that are “open” and where the participants do not have to commit to attending on a regular basis. A total count of the drop-in groups offered would be reported as the activity. The number of participants that attended should also be recorded.
- **Registered Groups:** Registered groups are “closed” or require registration. A total count of registered groups would be reported as the activity.

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## Unique Participants

Unique participants are participants in programs who receive direct services. All individuals who participated in registered groups, unregistered groups, home visits, supported referrals (or information referrals), and face to face contacts are counted. Participants may be recorded if the organization has a file for that participant, has collected demographic data or if participants are working towards a goal(s). At minimum, the name and age of the person must be known in order to record that individual as a unique participant.

## Outcomes & Indicators for Seniors

The following are the minimum outcomes expected to be tracked by FCSS. More outcomes can be tracked at the discretion of the agency.

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### Outcome 1 Participants increase their network of social support

#### *Indicators:*

Participants report they have one or more new people they turn to for help (may include program staff, other program participants and others in the community).

Participants report making new social connections with peers or in the broader community.

Participants report making new friends or maintaining friendships through their involvement in the program.

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### Outcome 2 Participants are connected to community resources

#### *Indicators:*

Participants report they have contacted one or more community resources that address their information or service needs.

Participants report they have used the resources/services of one or more community resources that address their information or service needs.

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### Outcome 3 Participants make informed choices about their living situation

#### *Indicators:*

Participants report they have information about the options and resources available to them (e.g. types of housing, counselling, safety-related information/support, financial information/support, community involvement, health-related services).

Participants report they have the capacity to decide amongst the options and resources available to them (i.e. understand the information and how it could apply to their situation, feel they have the 'tools' to make the right decision).



## Survey or Interview Questions to Gather Outcome Data

To gather outcome data outreach workers can use the following questions developed by FCSS (found at the following link.)

[http://www.edmonton.ca/for\\_residents/family-community-support-services-grant.aspx](http://www.edmonton.ca/for_residents/family-community-support-services-grant.aspx)

### Outcome 1: Participants increase their network of social support

(Survey or interview with participant):

Since you started this program, have you met any new people that you could turn to for help if needed?    ☐ Yes    ☐ No

(IF YES): Please answer the following questions:

How many program staff have you connected with that you could turn to for help? (If you are not sure of the exact number, please give your best estimate.)

\_\_\_ program staff

How many other program participants (peers) have you connected with, that you could turn to for help? (If you are not sure of the exact number, please give your best estimate.)

\_\_\_ other program participants

How many program volunteers have you connected with that you could turn to for help? (If you are not sure of the exact number, please give your best estimate.)

\_\_\_ volunteers

About how many people in your neighbourhood have you met, through this program, who you now know well enough to ask for a favour? (Favours could be such things as picking up the mail, watering plants, shovelling snow, lending tools or garden equipment, carrying things, feeding pets when neighbours are on holiday, shopping, etc.)? (If not sure of the number, give your best estimate.)

\_\_\_ people in the neighbourhood

**(Open ended elaboration or alternative):**

**Since you started this program, how (if at all) has your network of helpful (supportive) people changed?**

*Prompts: (as needed, to flesh out details of the support network):* How did you meet these people (through the program or somewhere else)? How do you interact with them? What role(s) do they play in your life? Overall, about how many helpful (supportive) people have you met through this program?

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## **Outcome 2 Participants are connected to community resources**

**(Survey or interview with participant):**

**Which of the following programs/services/resources, if any, have you contacted since you started [program], that you had never contacted before you started [program]? Which ones, if any, have you used since you started [program], that you had never used before you started [program]?**

Examples:

- Abuse (safety and prevention related to abuse/violence)
- Community social connections (such as coffee groups, community social gathering events, group social outings)
- Disability Supports (such as AISH, assistance with activities of daily living)
- Emergency services (ambulance, fire, police)
- Ethno-cultural services (such as support for new Canadians with language, employment, community connections; activities to connect people with same cultural background, cross-cultural activities)
- Financial counselling/money management (such as budgeting, banking)
- Food (multiple food groups – including fruits and vegetables – from sources such as food bank, community kitchen, good food box, community garden)
- Health (such as family doctor, dental care, eye care, public health centre, health information, health benefits/coverage available for people with low incomes)
- Housing supports (such as affordable housing options, rent supplements, landlord-tenant information)
- Income Supports (such as OAS, ASB)
- Mental health/emotional support (such as counselling, practical supports for daily living as needed)
- Places of worship/spiritual support
- Recreation/leisure (facilities, programs, groups for people with common hobbies or interests, sports or physical activity groups)

- Shopping assistance/advice (such as sources of affordable food, clothing, household goods, toys)
- Transportation
- Other (please specify)
- None of these

**(Open-ended elaboration or alternative):**

**Please share examples of specific resources you contacted.**

*Prompts* (as needed): People? Places? Community resources?

**NOTE:** Questions below (if used) would need to precede the question above for the indicator, as these supplementary questions address knowledge of resources and process of contact and the question above is about actually contacting the resources.

**Where would you find help in the following areas, if you needed it?** (You could use table of resources from above then probe about: People? Places? Community resources?)

**Please describe how you found out about these resources?**

**Please describe how you decide what resources you contact and what the process usually is?**

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## **Outcome 3 Participants make informed choices about their living situation**

**(Survey or interview with participant):**

**Do you know where to turn if you have concerns with...** (you could use categories from previous list)

**Which of the following types of resources, if any, would you now turn to if you needed advice or support – that you did not know you could turn to before you started [program]?** (see categories from previous list)

**(Open ended elaboration or alternative):**

**Where do you turn when you need advice or support, compared to when you started [program]?**

*Prompts* (as needed): People? Places? Community resources? Reasons for turning to these sources of support? How did you learn about them? How were these sources helpful?

# Referral & Caseload Guidelines

The goal of outreach is to link people in need to appropriate community resources and increase their social connections, where possible. These services are specifically targeted to serve the senior who is not connected with the services that would enable him or her to remain living as independently as possible in the community. The outreach worker facilitates the connection between the isolated/at-risk seniors and the community.

## Eligibility

Outreach workers exercise judgment along the following guidelines in order to determine client eligibility:

- The client is aware of the referral and agrees to receive services, *and*
- The client lives in the community and requires connection with support services, *and*
- The need is best met by Outreach Services rather than another type of service provision. Clients requiring services related directly to their physical and mental health would be referred to the appropriate Alberta Health Services programs. The outreach worker may provide concurrent service to those clients in collaboration with health care provision (e.g. clients can work on clinical needs with a health service provider while the outreach worker may be working on meeting other needs), *and*
- The concerns do not require an immediate crisis response. If it is a crisis, clients are referred to appropriate services.

Clients referred for outreach services are contacted within a reasonable time period of the referral being received (e.g. two business days are identified in the agreement between The Support Network and Detailed Assessment Providers). If it becomes necessary to have a waiting list, an acceptable wait time would not exceed three weeks. Clients who are realistically unable to wait for that period of time would be referred to crisis service agencies. If the wait time exceeded three weeks with any kind of consistency, the first option would be to share referrals between agencies. If that option is unavailable (i.e. all agencies at capacity) the agency's management should consider discussing the situation with relevant stakeholders.

## Caseload Management

An active caseload consists of clients who require a service or action plan as determined after a detailed assessment is completed with the client. Clients who are not served in a set period of time (e.g. three month period) would be considered inactive (unless extenuating

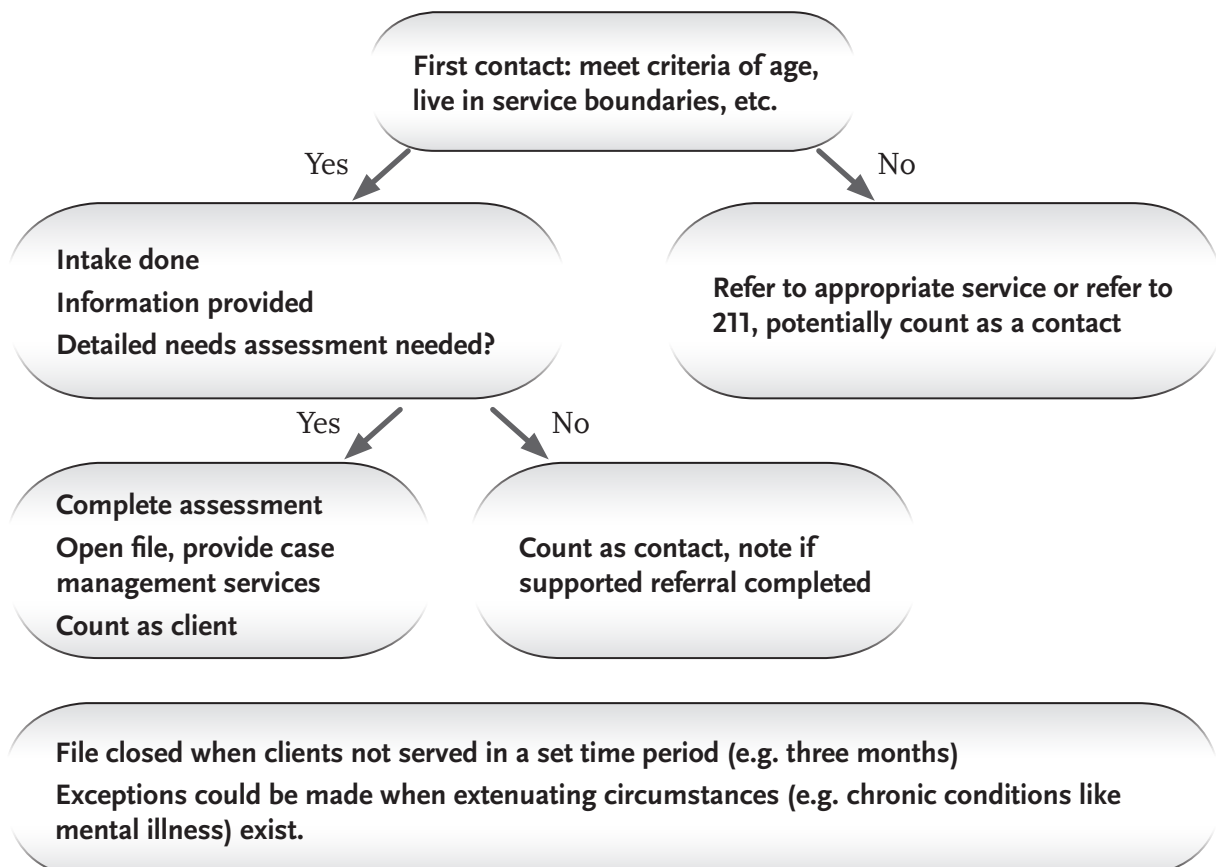
circumstances exist e.g. chronic conditions like mental illness where such a time frame is unreasonable) and their files should be closed. Inactive or closed files are not typically counted for statistical purposes. Closed files are kept for a set period of time before being shredded (e.g. ACSW Standards of Practice recommends 10 years.)

If a caseload exceeds capacity as determined by the appropriate supervisor, it will be reviewed to ensure that: a) the client fits the service guidelines; b) inactive clients are not being maintained as active clients; and c) the service plan is appropriate and can be implemented. This review will assist the outreach worker's ability to continue to provide appropriate service to each client.

When a client enters a supported living environment in which social services are provided, the Outreach Worker should facilitate a transfer to the appropriate staff within the facility as soon as possible after the client has moved.

## Clients and Contacts

In order to distinguish different modalities of outreach service delivery and to clarify output and outcome measures and reports, the terms “client” and “contact” are used. Both terms designate individuals receiving service. Designation as client or contact would be performed according to the process set out in the following diagram:



## Case Record Keeping

Outreach workers should keep systematic and legible records of all client contact. Case records are kept for each client to ensure the outreach worker and outreach supervisor can see what has been mutually agreed to with the client and what next steps are needed. Outreach workers must ensure that all information recorded is: strengths based, focused on reporting, necessary and relevant to the services being requested or provided to the client, or needed for organization administration.

Case records can be kept in whatever form (written or electronic) is required by the agency, provided confidentiality of the information can be ensured.

Case records are accessible to the outreach worker, the outreach supervisor, and to investigations under relevant legislation. For the client to review records, agency policies and procedures must be followed.

Effective documentation must be: clear, concise and comprehensive, factual, accurate, relevant, objective, non-judgemental, permanent, legible, chronological, and timely (critical incidents must be documented immediately). Documentation should not include opinions or assumptions.

Documentation should include: date, location of meeting, who was present, the purpose of the meeting, assessment, basis for decisions made, actions taken, any ethical issues raised and next steps. Every entry must be signed (in the case of hand-written notes).

Corrections in a client record must be made in a straightforward manner. When correcting a hand-written entry it is important to make sure that the mistake is still legible (e.g. draw a straight line through the entry). Initial the error and note that it is an error or draw attention to the correction. Do not erase or use “white-out”. When correcting an electronic entry, strike-through or highlight the error and ensure a declaration of change is included.

# Training Guidelines for Outreach Workers

Outreach workers for seniors are encouraged to pursue professional development in courses such as:

- Suicide Risk Assessment
- Crisis Intervention
- Conflict Resolution
- Grief and Loss
- Professional Boundaries
- Seniors and Addictions
- Family Violence and Elder Abuse
- Mental Health First Aid
- Intercultural Competence
- Aboriginal Cultural Awareness
- Community Engagement/Development
- Motivational Interviewing
- Anti-Oppressive Practise

# Conducting Assessments

Assessments are a vital component of outreach services and enable outreach workers to gather the information necessary to assist the senior. Assessments are client-centered and can range from short conversations to more in-depth interviews. The tips, guidelines and forms in this section can help outreach workers get the most out of the assessment process.

## Interviewing Tips

When interviewing seniors, showing respect is crucial. This can be done in a number of ways from using proper language when addressing and greeting them to being respectful when listening to and consulting with them.

Other overarching principles particularly important in an intercultural setting are:

- Remembering and being aware of the cultural lens, values and potential bias we bring as professionals to our relationship with culturally diverse seniors.
- Being humble, open to growing and learning from the seniors and fully appreciate the seniors
- Being conscious of the power disparity between us who are the providers/professionals and marginalized seniors.

(Source: Yvonne Chui, *Multicultural Health Brokers*)

It is also helpful to work from a strengths-based approach when doing an assessment. *“Thinking about strengths begins with the understanding of what goals and dreams the person has; reflecting on the possibilities and hope in their lives. In this process, they can discover or develop new possibilities for themselves and change toward a better quality of life.”* (Saleebey, D)

Kinds of questions that Saleebey and others have suggested for use are:

1. Survival questions: How have you managed to overcome/survive the challenges that you have faced? “What have you learned about yourself and your world during those struggles?”
2. Support questions: Who are the people that you can rely on? Who has made you feel understood, supported, or encouraged?
3. Exception questions: “When things were going well in life, what was different?”
4. Possibility questions: What do you want to accomplish in your life? What are your hopes for your future, or the future of your family?
5. Esteem questions: What makes you proud about yourself? What positive things do people say about you?



6. Perspective questions: “What are your ideas about your current situation?”
7. Change questions: What do you think is necessary for things to change? What could you do to make that happen? (Source: Saleebey, D. (Ed.). (2006). *The Strengths Perspective in social work practice* (4th ed.). Boston: Allyn & Bacon.)

An assessment interview is best done face-to-face and where a trusting relationship has been established with the senior. It is important to create a calm, open environment, practice active listening, use open questions and listen for meaning. The senior’s environment and community needs to be understood to ensure appropriate next steps.

Other examples of open ended questions are:

- In what ways does your situation concern you?
- How would you like things to be different?
- How would you like your life to be in 2 years?
- What would you be willing to try?

## Using Forms, Tools and Templates for Assessment

The forms, tools and templates included in this manual are intended as tools to strengthen the capacity for and the consistency of the delivery of assessment services. Filling out a form may not be necessary for every interaction with clients. If a simple piece of information is requested, a detailed form is not needed.

The **intake form** (or the equivalent\*) is a basic document to collect minimal information about the client and it can be completed by a member of the outreach program (staff or volunteer) either over the telephone or in-person. It may be the only form used to record client contacts.

When more support is needed by the client, outreach workers are encouraged to use the **detailed assessment forms** (or equivalents\*). The purpose of the detailed assessment is to gain a clear understanding of the senior’s current situation, identifying both their strengths and challenges. It is not necessary to complete all of the detailed assessment forms, although it is standard to collect demographic information. Outreach workers select relevant forms based on issues identified in conversation with the client or upon completion of the intake form. The summary of issues that have arisen through the detailed needs assessment can be used to inform the action plan and revisited at a later time to determine if the goals have been met.

The **interview guide** component of the Seniors Sector Outreach Worker Toolkit has prompts and questions that can be used in conversation with seniors and when conducting assessments. Outreach workers may use the shortened interview guide to gather information in a conversation format and complete the forms at a later time.

The manual also includes a variety of **tools and templates** intended as supplements to the intake and detailed assessment forms. These documents can be adapted as desired.

\*Note: These forms are not intended to replace existing forms if an equivalent tool is already in place.

## Guidelines for Completing the Intake Form

Refer to the forms section of the manual for a copy of the intake form.

**Name and Age:** At minimum, outreach workers need to know the name and date of birth of the person in order to record that individual as a unique participant receiving service, even if information and referrals is the only direct service given. Note actual age if desired.

**Referral From:** Indicate if self-referral or from elsewhere, and if so, the relationship to the senior.

**Presenting Issue:** Could include the reason for referral, senior's description of issue and the family's/friend's/agency's description of issue if applicable.

**Other Issues:** Indicate if more than one issue is raised.

### Additional Information Gathered if Needed:

**Aboriginal, Immigrant/Refugee:** Information requested by FCSS for those who self-identify as being Aboriginal or an immigrant or refugee. Aboriginal populations include those who identify themselves as Aboriginal, First Nations, Métis or Inuit. An immigrant or refugee can be someone who is dealing with the challenges of living in Canada regardless of how many years they have lived in Canada (FCSS definition).

**Home Care Involvement:** If deemed necessary, ask the question and if permission is granted, speak to the case manager to ensure non-duplication of service. Also indicates that a more thorough assessment is likely needed.

**Home Safety Assessment Needed:** May receive information from the senior or from the referral source indicating precaution needed. Also required by Alberta Labour Standards Working Alone Legislation and Worker's Compensation to ask questions related to safety.

## Action Taken/Follow Up

**Referrals/Applications:** Quick reference for statistical purposes and follow up if necessary.

**Supported Referrals:** Supported referrals are those that require involvement beyond “information provision”. Elements of a supported referral would include: facilitating the referral process, advocacy, reducing barriers to access a support or service, filling out the application, or accompaniment to an appointment in order to support the referral.

**Detailed Assessment Required:** Indicates a more thorough assessment is needed; referral may be to an outreach worker at same agency or elsewhere.

**Intake by:** Record the name, especially when the intake is being done by someone other than the referred outreach worker.

## Support Information for Detailed Assessment Topics

Some of the issues faced by isolated and at-risk seniors require a deeper understanding in order to conduct an appropriate assessment. The information in this section provides additional background on these issues.

### Caregiving

People who are caring for their loved one usually do not identify themselves as a caregiver until they are burnt out, in tears and in emotional distress. They have been the caregiver so long and have forgotten about their own self-care and their own needs. They often are consumed with guilt because their loved one is sick. They feel guilty because they are worn out and stressed, angry and short tempered with the one they are caring for. They feel guilty when they want to take care of their own needs and do not know how or are unable to separate themselves from the care receiver. Consequently, without support, their health goes downhill and they succumb to serious stress-related illnesses.

### Grief and Loss

Grief is measured by the perception of the person who is grieving. Many changes can be grieved, from the death of a loved person or pet to the changes experienced in aging. Some people may feel “over” the loss within a very short time; others may continue to grieve for many years.

It’s normal to experience grief after a significant loss. There is no right or wrong way to grieve; people need to be encouraged to follow their own paths. Most people who

experience normal or uncomplicated grief can move forward eventually with support from family and friends. But if it's been several months or more since the loss, and emotions remain so intense or debilitating that the person has trouble going about their normal routine, it may help to address the issues with a supportive listener.

A person may benefit from professional help if they:

- Can focus on little else but the loved one's death
- Have persistent pining or longing for the deceased person
- Have thoughts of guilt or self-blame
- Believe that they did something wrong or could have prevented the death
- Feel as if life isn't worth living
- Have lost their sense of purpose in life
- Wish they had died along with their loved one

## Mental Health

Keep in mind the 3 D's: Delirium, Dementia and Depression

**Delirium** is a confusional state. This means that people with delirium are disoriented, with an altered level of consciousness (hyperactive or hypoactive) and trouble understanding the environment. Delirium develops quickly over a period of hours or days and the symptoms of delirium may fluctuate over a 24 hour period and are often worse at night. Delirium is a medical emergency caused by many different factors and is reversible if treated immediately. Two common factors are medications (either starting new medications or mixing with over the counter medications) or urinary tract infections.

**Dementia** is an illness characterized by the loss of intellectual abilities that is severe enough to interfere with a person's ability to function. Dementia results in changes in the way the person thinks, feels and behaves, along with memory impairment. It tends to develop slowly over a period of months or years and progresses over time. Alzheimer's disease is an example of dementia.

**Depression** can cause people to feel persistently low in spirits and lose interest in things that used to give them pleasure. Other symptoms often include sleep and appetite changes and anxiety. Depression is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason. When a person is severely (i.e. clinically) depressed, the chemicals in his or her brain may be out of balance.

All three of these conditions can occur at the same time. It helps to understand the differences between these conditions so that you can identify them and get the proper help.

## Addictions

Substance use problems among seniors are most likely to be related to their use of alcohol and prescription drugs. Most seniors do not develop problems related to drinking alcohol, but six to 10 per cent of seniors who drink will. Alcohol affects every system of the body and can negatively affect appetite and digestion, sleep patterns, nerve, muscles and joint functioning. With even mild alcohol consumption, seniors are at increased risk for falls, memory problems, sleep problems, sexual difficulties, hip fractures and mental health concerns.

Because alcohol interacts with more than 150 medications commonly prescribed for seniors, it is important to consider possible harmful interactions between alcohol and prescription and over-the-counter medications. Problems may include difficulties in motor functioning leading to falls and co-ordination problems, confusion and forgetfulness, and harmful interactions between alcohol and medications used to treat diseases or conditions, either by increasing or by blocking the effect of the medications.

Family members and health-care providers sometimes overlook substance use problems among seniors. The signs and symptoms are often mistaken for those of dementia, depression or other problems common to older adults. (*Source : Alberta Health Services: Addictions Awareness Series*)

## Elder Abuse

Elder Abuse can take many forms, and it can affect any senior, regardless of socio-economic background, health status or cultural heritage. It is abuse whenever someone limits or controls the rights and freedoms of a senior. The senior is unable to freely make choices because they are afraid of being humiliated, hurt, left alone, or of the relationship ending.

Abuse of seniors often occurs within the family, by adult children or grandchildren. Other relatives, friends, neighbours, paid or unpaid caregivers, landlords, financial advisors or any individual in a position of power, trust or authority can also be abusive.

Risk factors are isolation (physical, social or cultural), history of domestic violence, shared living situations, dependency on an older adult (for shelter or financial help), addiction issues, depression and other mental health issues, and cognitive impairment.

It is vital to SEE it! (recognize the warning signs of abuse), NAME it! (talk to the senior and name your concern), and CHECK it! (ask questions, check for danger – help with safety planning).

## Cultural Diversity

In caring for Aboriginal and immigrant/refugee seniors, important underlying core values are equity, respect, true inclusion and anti-oppressive practice.

### Overarching Principles:

- Remembering and being aware of the cultural lens, values and potential bias we bring as professionals to our relationship with culturally diverse seniors.
- Being humble, open to growing and learning from the seniors and fully appreciating the seniors
- Being conscious of the power disparity between us who are the providers/professionals and marginalized seniors.

### Key Reminders:

- Keep in mind the realities of Aboriginal and immigrant/refugee seniors

Many Aboriginal, immigrant and refugee seniors in Edmonton struggle with financial hardship, and often experience social isolation because of linguistic and cultural barriers. Often, these seniors have limited knowledge of the formal systems (health, social/recreational, income support, etc.) and the senior-serving sector. They may not have confidence or the trust required to reach out for help and support.

Many Aboriginal seniors are affected by the history of residential schools or experienced discrimination and racism. For immigrant and refugee seniors, their pre-migration realities also impact their health and mental health now, such as PTSD (Post Traumatic Stress Disorder) among refugee seniors.

The best way to truly reveal such factors would be to humbly ask the seniors themselves.

- Address the core issue of language barrier

Among Aboriginal and immigrant/refugee seniors, language is the core barrier to accessing and reaching out for support. Find out from the seniors what language they most prefer to communicate in. Also seek their guidance regarding whom they would like to address this barrier (family members, natural helpers or community outreach worker/Cultural Brokers whom they trust). There is often sensitivity and concerns about privacy and confidentiality. Learning how to involve a trusted interpreter or cultural resource person in the assessment or care process to address language and cultural barriers is important.

Many refugee seniors are illiterate so may not be able to read material in their first language.

- Take time to build a trusting relationship with the seniors

A trusting relationship is the foundation to culturally relevant and respectful care. Being genuine and humble when establishing cultural safety and rapport is essential and most helpful. Learning basic greetings in the first languages of the seniors is often appreciated by the seniors.

- Ask the seniors to guide you regarding culturally respectful assessment and care

There is often cultural diversity among Aboriginal seniors and immigrant/refugee seniors of the same linguistic or cultural background regarding beliefs, customs and cultural orientation. Ask the seniors to guide you in terms of their cultural orientation and preferences. Asking is always better than assuming.

- Spirituality and religion may play a pivotal role in the daily lives of Aboriginal and immigrant/refugee seniors.

Among many Aboriginal seniors, immigrant and refugee seniors, spirituality or religion is integral to their daily lives. Seek to understand from the seniors themselves how spirituality or their religion is part of their lives and how it impacts their health and mental health.

- Appreciate and recognize the strengths and gifts, cultural and social capital of Aboriginal and immigrant/refugee seniors.

Aboriginal, immigrant and refugee seniors despite their vulnerable conditions, have gifts and strengths that are traditionally honored and respected. When you're able to uncover them with the seniors and recognize them, it strengthens the relationship and provides opportunities to move forward. Extended family, friends and natural networks within their communities may often provide them with the support they need. Uncover that and access such social capital in relevant ways as a resource for the seniors.

- Holistic Care Approach

Traditional Aboriginal health and well-being perspectives, as well as cultural orientation of immigrants and refugee seniors are often holistic, encompassing physical, mental, emotional, spiritual (or religious) and social well-being. Seek to understand this orientation and practice accordingly. (*Source: Edmonton Multicultural Health Brokers*)





# Forms, Tools & Templates

## Intake/Supported Referral Form

## Detailed Assessment Forms

### Required: Demographics

#### Optional

- |                               |  |
|-------------------------------|--|
| 1. Activities of Daily Living | 11. Social/Recreation/<br>Spiritual/Community                          |
| 2. Food Security/Nutrition    | 12. Elder Abuse  |
| 3. Housing                    | 13. Reliable Contacts/<br>Social Supports & Other<br>Service Providers |
| 4. Physical Health            | 14. Cultural Diversity   |
| 5. Transportation             | 15. Life History   |
| 6. Financial/Legal            | 16. Coping Skills/Strengths  |
| 7. Caregiving                 | 17. Risk Factors Identified  |
| 8. Grief and Loss             | 18. Action Plan  |
| 9. Mental Health              |  |
| 10. Addictions                |  |

## Tools

Clutter Image Rating (CIR) Assessment

Gambling Screen

Drug Use Questionnaire (DAST – 10)

Risk Management Tool for Older Adults

EcoMap Tool

## Templates

Employee Home Visit Safety Assessment Template

Home Visit Hazards Assessment Template

Outreach Working Alone Safely Policy Template

Confidentiality Agreement Template

Consent to Release of Information Template



# Forms





# Outreach Intake/Supported Referral Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Gender: ☐ M ☐ F ☐ Other

Phone #: \_\_\_\_\_ Alt #: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Edmonton, AB \_\_\_\_\_

Referral From: \_\_\_\_\_

Phone # : \_\_\_\_\_

Relationship to Senior: \_\_\_\_\_

Presenting Issue(s): \_\_\_\_\_

Other Issues(s): \_\_\_\_\_

Additional Info gathered if needed:

Aboriginal: ☐ Yes ☐ No

Immigrant/Refugee: ☐ Yes ☐ No

Preferred Language \_\_\_\_\_

Interpreter Needed: ☐ Yes ☐ No

Home Care Involvement: ☐ Yes ☐ N

Consent given? ☐ Yes ☐ No

Other Barriers: \_\_\_\_\_

Home Safety Assessment Needed? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_

Action(s) Taken/Follow up: \_\_\_\_\_

Referrals made and to whom: \_\_\_\_\_

Supported Referrals: ☐ Yes ☐ No

Applications completed or forms filled out (if applicable/no file opened): \_\_\_\_\_

Detailed Assessment Required: ☐ Yes ☐ No

Intake By: \_\_\_\_\_ Referred to: \_\_\_\_\_









# Detailed Assessment: Demographics (Required)

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Birthdate: y \_\_\_\_/m \_\_\_\_/d \_\_\_\_ Age: \_\_\_\_

Address: \_\_\_\_\_ Edmonton, AB \_\_\_\_\_

Gender: ☐ M ☐ F ☐ OtherMarital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐ SingleImmigrant/Refugee: ☐ Yes ☐ No Aboriginal: ☐ Yes ☐ No \_\_\_\_\_Immigrant Status: ☐ Immigrant ☐ Refugee ☐ Visitor ☐ Other \_\_\_\_\_

Preferred Languages: \_\_\_\_\_

Interpreting services required? ☐ Yes ☐ No

Country of Origin: \_\_\_\_\_ Length of stay in Canada: \_\_\_\_\_

Religion (if required/important to them) \_\_\_\_\_

Referral Source:	Emergency Contact:
Name: _____	Name: _____
Phone: _____	Phone (H): _____
Agency/Relationship: _____	(Other): _____
Email: _____	Relationship: _____
	Email: _____

Presenting Issues(s): \_\_\_\_\_

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Senior's Perception of Need: \_\_\_\_\_

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Relevant History: \_\_\_\_\_

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<input type="checkbox"/> Safety Assessment Done	By Phone (Date): _____	In Home (Date): _____
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# 1. Activities of Daily Living (Optional)

Are aids required to get around (cane, wheelchair, walker, chairs, etc.)? ☐ Yes ☐ No

If yes, what? \_\_\_\_\_

Any falls and how many in the last three months? \_\_\_\_\_

Were there injuries as a result of these falls? \_\_\_\_\_

Have they seen a health care provider to explore why they are falling? ☐ Yes ☐ No

Is assistance required in the home? Who helps currently? (Family, neighbor, agency, etc.)

Housekeeping ☐ Yes ☐ No \_\_\_\_\_

Personal Care ☐ Yes ☐ No \_\_\_\_\_

Shopping ☐ Yes ☐ No \_\_\_\_\_

Yard work, snow removal ☐ Yes ☐ No \_\_\_\_\_

Is Home Care providing services? ☐ Yes ☐ No

Coordinators Name: \_\_\_\_\_

What services are provided? \_\_\_\_\_ How many hours a week? \_\_\_\_\_

Other service/company providing service if applicable \_\_\_\_\_

\_\_\_\_\_

Additional notes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 1. Activities of Daily Living (Optional)

(Option 2: if more details are required)

Requires assistance with Activities of Daily Living

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bathing       | <input type="checkbox"/> Finances/Banking     | <input type="checkbox"/> Personal Grooming    |
| <input type="checkbox"/> Companionship | <input type="checkbox"/> Medication           | <input type="checkbox"/> Using Phone          |
| <input type="checkbox"/> Dressing      | <input type="checkbox"/> Household Management | <input type="checkbox"/> Shopping             |
| <input type="checkbox"/> Eating        | <input type="checkbox"/> Language Interpreter | <input type="checkbox"/> Financial Management |
| <input type="checkbox"/> Meal Prep     | <input type="checkbox"/> Transportation       | <input type="checkbox"/> Property Maintenance |

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Receiving Support for Activities of Daily Living

- |                                    |  |                                    |
|------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Family    | <input type="checkbox"/> Friends       | <input type="checkbox"/> Home Care |
| <input type="checkbox"/> Neighbors | <input type="checkbox"/> No assistance | <input type="checkbox"/> Other     |

Specify Other: \_\_\_\_\_

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Currently using Aids for Daily Living

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Cane        | <input type="checkbox"/> Glasses       | <input type="checkbox"/> Oxygen/Respirator |
| <input type="checkbox"/> Walker      | <input type="checkbox"/> Hearing Aids  | <input type="checkbox"/> Bath Aids         |
| <input type="checkbox"/> Wheelchair  | <input type="checkbox"/> Eating Aids   | <input type="checkbox"/> Toileting Aids    |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Dressing Aids | <input type="checkbox"/> Incontinence Aids |
| <input type="checkbox"/> Other _____ |  |  |

If not currently using, requires any of the above? \_\_\_\_\_

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## 2. Food Security/Nutrition (Optional)

Food security refers to the availability and easy access of appropriate, nutritious and affordable food.

**Do they have problems accessing food? (possible concerns may be...)**

- ☐ Grocery shopping
- ☐ Transportation to grocery store or Edmonton Food Bank

Do they have someone who helps them with accessing food?

- ☐ Yes   ☐ No

**Do they have problems preparing meals (possible concerns may be...)**

- ☐ Yes   ☐ No
- ☐ Tired of cooking; tired of eating same meals; cooking is physically too difficult or demanding
- ☐ Need help adjusting to dietary restrictions
- ☐ Hard to cook well-balanced meals everyday
- ☐ Too many convenience foods or restaurant meals; lack of a healthy and varied diet

Do they have someone who helps them by cooking meals?

- ☐ Yes   ☐ No
- ☐ Meals are made for me by my housing provider, home support worker, friends and family or EMOW

**Do they have problems budgeting or paying for food or meals?**

- ☐ Yes   ☐ No
- ☐ Cannot afford adequate or appropriate groceries or meals

**Do they have any concerns or questions about their nutritional status?**

- ☐ Yes   ☐ No

If yes: refer client to discuss with family physician who would determine if a referral to a registered dietitian is needed.

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### 3. Housing (Optional)

Living Situation: ☐ Alone ☐ with Spouse/Partner \_\_\_\_\_

☐ With Family \_\_\_\_\_ Other (specify) \_\_\_\_\_ ☐ Own ☐ Rent

Monthly Housing Cost (rent or mortgage/condo fees) \_\_\_\_\_

Do they carry a debt/expense load that impacts housing choices? ☐ Yes ☐ No

Current Accommodation:

- ☐ No Fixed Address      ☐ Shelter      ☐ Roominghouse  
☐ Apartment      ☐ Condo      ☐ Subsidized Housing      ☐ House  
☐ Lodge      ☐ Designated Assisted Living      ☐ Long-Term Care      ☐ Other

Satisfaction with their living situation: \_\_\_\_\_

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Type of Residence Concern

- ☐ Accessibility      ☐ Safety      ☐ Housekeeping      ☐ Exterior Maintenance  
☐ Interior Maintenance      ☐ Homeless      ☐ Rent Increase      ☐ Eviction  
☐ Relationship with Neighbors/Landlords/Caretakers  
☐ Other \_\_\_\_\_

Details \_\_\_\_\_

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Hoarding Behaviours

*If any of the following are reported by the senior, family or community agency, the Clutter Image Rating tool could be used as the basis for further referral.*

- ☐ Clutter      ☐ Eviction      ☐ Bylaw Notice      ☐ Rodent Infestation      ☐ Bed Bugs  
☐ Residence Unfit for Human Habitation      ☐ Health & Safety Risks

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## 4. Physical Health (Optional)

Is the person looking for information about health services or resources?

- ☐ Family Physician ☐ Home Care/Community Access Program ☐ Medication Coverage  
☐ Other \_\_\_\_\_

**Medication management** (prescription and self-treatment)

Do they know what medications they take and what they are for? ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No \_\_\_\_\_

### Health Concerns

Diabetes: \_\_\_\_\_ Heart: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_

Mobility: \_\_\_\_\_ Hearing: \_\_\_\_\_ Eyesight: \_\_\_\_\_

Cancer: \_\_\_\_\_ Lung: \_\_\_\_\_ Arthritis: \_\_\_\_\_

Nutrition/special diet: \_\_\_\_\_ Other: \_\_\_\_\_

How do they rate their current health status on a scale of 1 to 5 with 5 being healthy?

Is there anything worrying them about their health?

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Have they been in the hospital in the past year?

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Do they have a family physician and how often do they see their doctor?

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**Family Physician/Specialist/etc. Name(s) & Phone Number(s) ( if necessary)**

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## 5. Transportation (Optional)

Do they drive? ☐ Yes ☐ No

If yes, is there a driving retirement plan? ☐ Yes ☐ No

Do they impose any driving restrictions upon themselves? If so, what?

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If no, how do they get around?

☐ Family/Friends ☐ ETS/DATS ☐ LIFT ☐ Taxi ☐ Walk

Interest in exploring options? ☐ Yes ☐ No \_\_\_\_\_

Over the last month have there been commitments or things they needed to do and were unable to do them because of lack of transportation? ☐ Yes ☐ No

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## 6. Financial/Legal (Optional)

PHN: \_\_\_\_\_

Other # \_\_\_\_\_

*PHN#/SIN#:* record only if necessary, e.g. if senior has lost ID or depends on outreach program for ID storage, PHN# is needed for referrals to Home Care, Food Bank, ASB.

**Relevant Income Information:** Income \$ \_\_\_\_\_ (Monthly)  
Income \$ \_\_\_\_\_ (Annual)

OAS	GIS/ALL	CPP	CPP-D	ASB	IS	AISH	PP	Employ	Other

Expense/Income Issues/Debt Load: \_\_\_\_\_

Is the following in place?

Personal Directive ☐ Yes ☐ No    Power of Attorney ☐ Yes ☐ No    Advance Care Planning ☐ Yes ☐ No

Are any enacted? \_\_\_\_\_ Agent \_\_\_\_\_

Will ☐ Yes ☐ No\_\_

Are there concerns or information wanted on:

Guardianship? ☐ Yes ☐ No    Trusteeship ☐ Yes ☐ No

Other substitute decision making arrangements? ☐ Yes ☐ No

Current Identification Resources:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Personal Health Care Card | <input type="checkbox"/> Alberta ID Card         | <input type="checkbox"/> Birth Certificate    |
| <input type="checkbox"/> Driver's Licence          | <input type="checkbox"/> Social Insurance Number | <input type="checkbox"/> Passport             |
| <input type="checkbox"/> Permanent Resident Card   | <input type="checkbox"/> Status/Treaty Card      | <input type="checkbox"/> Marriage Certificate |
| <input type="checkbox"/> Credit Card               | <input type="checkbox"/> Other _____             |   |

**OAS:** Old Age Security

**GIS/ALL:** Guaranteed Income Security, Allowance, Allowance for the Survivor

**CPP:** Canada Pension Plan Retirement    **CPP-D:** CPP Disability

**ASB:** Alberta Seniors Benefit

**IS:** Income Support (Alberta)

**AISH:** Assured Income for the Severely Handicapped (Alberta)

**PP:** Private Pensions

**Employment:** may be part time, contract, full time

**Other:** e.g. DVA, USA Social Security, Investments



## 7. Caregiving Issues (Optional)

Who are they caring for? \_\_\_\_\_

Does the care receiver live with them, in their own home, or a care facility?

\_\_\_\_\_

Does the care receiver have Home Care Services? ☐ Yes ☐ No

Does the care receiver attend a Day Program? ☐ Yes ☐ No

How many days a week? \_\_\_\_\_

How long have they been caregiving? \_\_\_\_\_

Do they feel prepared to care for their loved one? ☐ Yes ☐ No

Do they have support from family, friends, and/or a caregiver support group? If not, who are their supports? \_\_\_\_\_

\_\_\_\_\_

Do they have time away (respite) from caregiving? How many hours or days off in a week do they receive? \_\_\_\_\_

\_\_\_\_\_

How do they feel they are coping? \_\_\_\_\_

\_\_\_\_\_

Do they identify with caregiver stress and burnout? ☐ Yes ☐ No

Has their physical or mental health been affected by caregiver stress? ☐ Yes ☐ No

E.g. Have they noticed changes in sleep patterns or in their appetite? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do they feel anxious, overwhelmed, angry, sad and/or depressed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has their job been affected by their role as caregiver? How? ☐ Yes ☐ No

\_\_\_\_\_





## 8. Grief & Loss (Optional)

Have they experienced any major losses in the last five years (including the deaths of loved ones or difficult transitions in their life)? ☐ Yes ☐ No

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Have they had or do they want support in dealing with their grief? ☐ Yes ☐ No

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A person may benefit from professional help if they:

- Can focus on little else but the loved one's death
- Have persistent pining or longing for the deceased person
- Have thoughts of guilt or self-blame
- Believe that they did something wrong or could have prevented the death
- Feel as if life isn't worth living
- Have lost their sense of purpose in life
- Wish they had died along with their loved one



## 9. Mental Health (Optional)

Have they ever been given a mental health diagnosis by a qualified health professional?

☐ Yes ☐ No

Have they ever been hospitalized? ☐ Yes ☐ No

Have they ever harmed themselves or thought of harming themselves but not as a direct result of alcohol or drug use? ☐ Yes ☐ No

Have they sometime wondered whether they have seen or heard things that others could not see or hear? **Screening Tool (CAMH, 2012)** ☐ Yes ☐ No

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Are there concerns about mental health? ☐ Yes ☐ No

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Is Mental Health Services involved? ☐ Yes ☐ No

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If so, who: \_\_\_\_\_ Contact Info: \_\_\_\_\_

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Are there concerns about Dementia? ☐ Yes ☐ No

*E.g. History of wandering — has the senior ever gotten lost? Driving — any recent motor vehicle accidents or repeated accidents? Getting lost and unable to find their home? Locking self out of the house? Wearing inappropriate clothing for the weather? Cooking issues — fire or cigarette burns to carpet or clothes. Nutritional needs — excessive weight loss?*

Comments

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## 10. Addictions (Optional Screening Tools)

Have they ever had any problems related to their use of alcohol or other drugs?

☐ Yes    ☐ No

Has a relative, friend, doctor or other health worker been concerned about their drinking or other drug use or suggested cutting down?

☐ Yes    ☐ No

Have they ever said to another person “no, I don’t have an alcohol or drug problem”, when around the same time, they questioned themselves and FELT, “maybe I DO have a problem”?

☐ Yes      ☐ No

(CAMH, 2012)

Have they ever felt they ought to CUT DOWN on their drinking or drug use?

☐ Yes      ☐ No

Have people ANNOYED them by criticizing their drinking or drug use?

☐ Yes    ☐ No

Have they felt bad or GUILTY about their drinking or drug use?

☐ Yes      ☐ No

Have they ever had a drink or used drugs first thing in the morning to steady their nerves or get rid of a hangover (EYE OPENER)?

☐ Yes      ☐ No

(CAGE-AID Screening Questionnaire. Two yes responses are considered a positive test and indicate further assessment is warranted)

[illegible]

Additional screens for gambling and drug use are found in the Tools section.



## 11. Social/Recreation/Spiritual/Community (Optional)

What do they do during the week? \_\_\_\_\_

\_\_\_\_\_

What is a usual day like? \_\_\_\_\_

Where do they feel they belong? Where they can meet their friends? Favourite hangouts?

\_\_\_\_\_

\_\_\_\_\_

Hobbies or recreational activities: \_\_\_\_\_

\_\_\_\_\_

What do they do for fun? \_\_\_\_\_

\_\_\_\_\_

Volunteer involvement: \_\_\_\_\_

\_\_\_\_\_

Neighbourhood involvement: \_\_\_\_\_

\_\_\_\_\_

Cultural community involvement: \_\_\_\_\_

\_\_\_\_\_

Religious/spiritual involvement: \_\_\_\_\_

\_\_\_\_\_

Are they aware of senior's centres? \_\_\_\_\_

\_\_\_\_\_

Do they attend a centre? Which one? Why? Why not? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## 12. Elder Abuse (Optional)

Do they feel taken advantage of or mistreated? How?

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Do they feel they are freely able to make choices? If not, why?

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Has anyone close to them ever tried to harm or hurt them?

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Is there anyone they don't feel comfortable around? Why?

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## 13. Reliable Contacts/ Social Supports (Optional)

Who do they turn to for assistance? If they have an emergency?

☐ Family    ☐ Friends    ☐ Other community supports e.g. church, clubs

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Do they have someone they can trust and confide in? ☐ Yes    ☐ No

Are they satisfied with the number and quality of their relationships? ☐ Yes    ☐ No

Do they enjoy being alone? ☐ Yes    ☐ No

When they are alone, do they feel lonely? ☐ Yes    ☐ No

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### Other Service Providers Involved

Name	Relationship/Organization	Contact Info	Consent Given?	
			Written?	Verbal?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



## 14. Cultural Diversity Issues (Optional)

After areas have been identified to work on (such as financial, housing, food insecurity, health), if needed, share some information about how the community or government services work and how they are not connected to Immigration.

“When we reach out to these services, would you like to have an interpreter or a community worker/community member join you to bridge the language and cultural barriers? Who might that be? How can we get in contact with him/her?”

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“Do you have other concerns about accessing community or government services? (Are you concerned that it would affect your children or family? Would you like me to explain to your children and family about these services, so that they would not be worried?)”

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“Might there be other support you would need in order to access these services, such as transportation support, child care if you’re taking care of your grandchildren, etc.?”

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“You shared with me that you are of \_\_\_\_\_ faith. Can you help me understand more about your religion and what I would need to keep in mind when we access services or organize support for you?”

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## Summary

Summary of issues that have arisen through the detailed needs assessment (can be used to inform the action plan and revisited at a later time to indicate outcomes have been achieved)

	Assessment	No Issue	Minor	Major	Priority	Comments
1	Activities of Daily Living	0	1	2	3	
2	Food Security	0	1	2	3	
3	Housing	0	1	2	3	
4	Physical Health	0	1	2	3	
5	Transportation	0	1	2	3	
6	Financial/Legal	0	1	2	3	
7	Caregiving	0	1	2	3	
8	Grief & Loss	0	1	2	3	
9	Mental Health	0	1	2	3	
10	Addictions	0	1	2	3	
11	Social/Recreation	0	1	2	3	
12	Elder Abuse	0	1	2	3	
13	Reliable Contacts/ Social Supports	0	1	2	3	
14	Cultural Diversity Issues	0	1	2	3	

Another tool that can be used as a visual aid to assess a senior's support system is the EcoMap (see Tools).

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What work did they do after school? What are the significant events/achievements in their life?

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.



## 16. Coping Skills/Strengths (Optional)

How have they managed to overcome/survive the challenges that they have faced?

What did they do to take care of themselves and what do they do to cope with stress in their life?

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## 17. Factors That Can Identify At-Risk or Isolated Seniors (Optional)

over 75 years of age	<input type="checkbox"/> Yes	<input type="checkbox"/> No	living alone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
low income	<input type="checkbox"/> Yes	<input type="checkbox"/> No	single	<input type="checkbox"/> Yes	<input type="checkbox"/> No
experiencing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	language barriers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
transportation difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	cultural barriers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
multiple health problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	potential abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
suicide risk/mental illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	lack of support system	<input type="checkbox"/> Yes	<input type="checkbox"/> No
addictions	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

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## 18. Action Plan (Optional)

0: Goal Abandoned (Why?) 1: No Progress Made 2: Progress Made 3: Goal Achieved

Goal #1: \_\_\_\_\_

Client task: \_\_\_\_\_

OW task: \_\_\_\_\_

Review #1: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Review #2: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Goal #2: \_\_\_\_\_

Client task: \_\_\_\_\_

OW task: \_\_\_\_\_

Review #1: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Review #2: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Goal #3: \_\_\_\_\_

Client task: \_\_\_\_\_

OW task: \_\_\_\_\_

Review #1: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Review #2: date \_\_\_\_\_ Outcome: 0 1 2 3

Method of Contact: Phone Office Community Home

Client Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Outreach Worker: \_\_\_\_\_ Signature: \_\_\_\_\_





# Tools





## Clutter Image Rating

In our work on hoarding, we've found that people have very different ideas about what it means to have a cluttered home. For some, a small pile of things in the corner of an otherwise well-ordered room constitutes serious clutter. For others, only when the narrow pathways make it hard to get through a room does the clutter register. To make sure we get an accurate sense of a clutter problem, we created a series of pictures of rooms in various stages of clutter – from completely clutter-free to very severely cluttered. People can just pick out the picture in each sequence comes closest to the clutter in their own living room, kitchen, and bedroom. This requires some degree of judgment

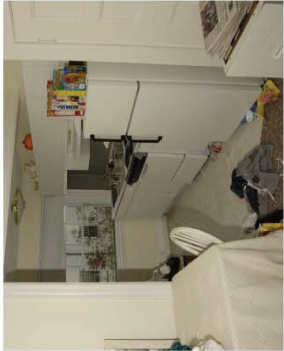
because no two homes look exactly alike, and clutter can be higher in some parts of the room than others. Still, this rating works pretty well as a measure of clutter. In general, clutter that reaches the level of picture # 4 or higher impinges enough on people's lives that we would encourage them to get help for their hoarding problem. These pictures are published in our treatment manual (Compulsive Hoarding and Acquiring: Therapist Guide, Oxford University Press) and in our self-help book (Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding, Oxford University Press).

# Clutter Image Rating Scale: Kitchen

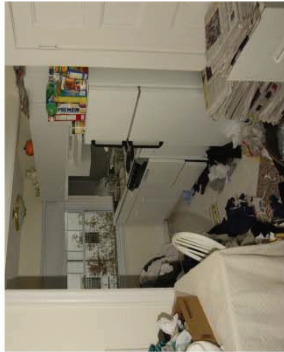
Please select the photo below that most accurately reflects the amount of clutter in your room.



1



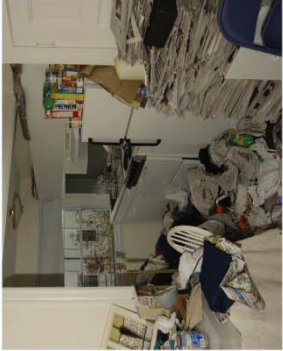
2



3



4



5



6



7



8



9



# Clutter Image Rating: Bedroom

Please select the photo that most accurately reflects the amount of clutter in your room.



1



2



3



4



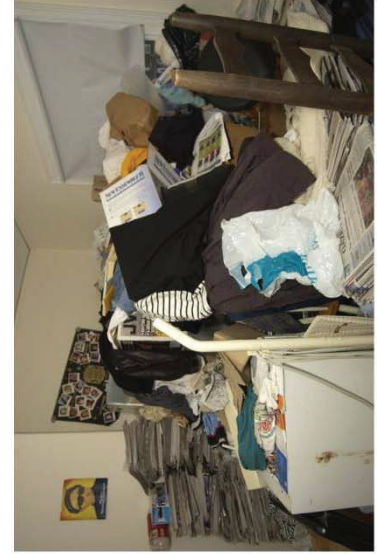
5



6



7



8

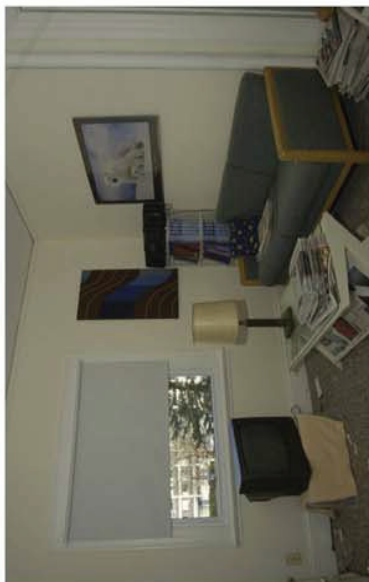


9



# Clutter Image Rating: Living Room

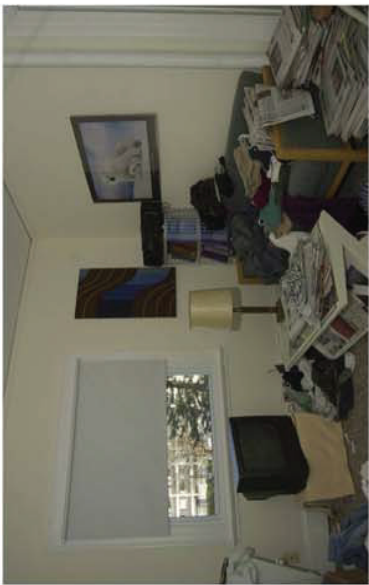
Please select the photo below that most accurately reflects the amount of clutter in your room.



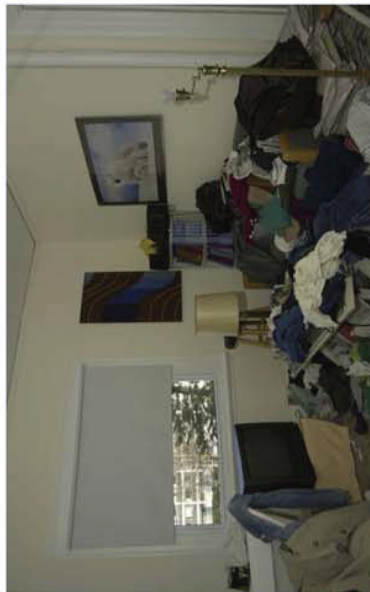
1



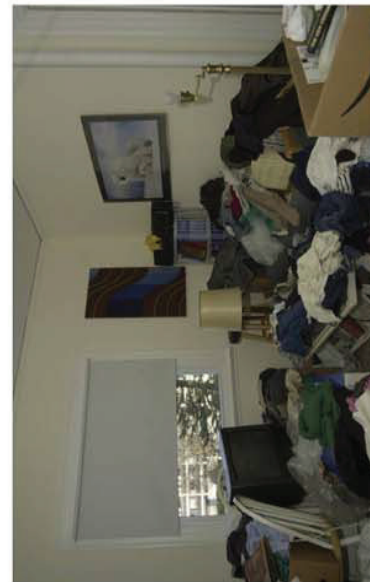
2



3



4



5



6



7



8



9

# Gambling Screen

## (Source: AHS 2009 Addictions Awareness Series)

*These questions may help you explore your gambling experience. If a lot of gambling activity is noted in #1 or you answer “Yes” to questions 2 through 5, you may have a gambling problem. Consider getting more information about, or an assessment of, your gambling.*

1. In the past 12 months have you

- ☐ played bingo
- ☐ bet on sporting events
- ☐ purchased lottery tickets
- ☐ played games of skill for money (e.g. cards)
- ☐ played slot machines or video lottery machines (poker machines)
- ☐ gambled in a casino
- ☐ gambled at the track (include off-track betting as well)
- ☐ participated in any other form of gambling

2. In the past 12 months have you spent more money than you intended on any of the above activities?

- ☐ Yes   ☐ No

3. In the past 12 months has your involvement in the above activities created financial difficulties for you or your family?

- ☐ Yes   ☐ No

4. In the past 12 months has anyone expressed concern about your involvement in these activities?

- ☐ Yes   ☐ No

5. In the past 12 months have you been concerned about your involvement in these activities?

- ☐ Yes   ☐ No





## Drug Use Questionnaire (DAST – 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. In the statements “drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin).

**These questions refer to the past 12 months**

**Circle your Response**

Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you always able to stop using drugs when you want to?	Yes	No
Have you had “blackouts” or “flashbacks” as a result of drug use?	Yes	No
Do you ever feel bad or guilty about your drug use?	Yes	No
Does your spouse ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities in order to obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc. )?	Yes	No



# Risk Management Tool for Older Adults (Source: Sage)

This tool is used after a disclosure of abuse. Consult with the Elder Abuse Intake Line if needed.

Individual's Name \_\_\_\_\_

Date: \_\_\_\_\_

I have some questions to explore with you that will help me better understand what is happening and may help you figure out what options may be best for you. You always are in control and can decide not to answer any question you feel uncomfortable answering.

Before we begin, I would just like to remind you that the law in Alberta requires that a report be made to Children's Services when a child is exposed to family violence. If that is the case in your situation, you and I can work through that together and determine the best way to approach Children's Services for help.

Are you currently living with the person who is abusing you?

☐ Yes ☐ No ☐ Sometimes

Name of person who is abusing you \_\_\_\_\_

Relationship to abusive person \_\_\_\_\_

**Use the Abuser's name throughout the document when asking questions.**

Is \_\_\_\_\_ financially or emotionally dependent on you?

☐ Yes ☐ No ☐ Sometimes

Are you financially or emotionally dependent on \_\_\_\_\_?

☐ Yes ☐ No ☐ Sometimes

**Abuse History: NOTE TO STAFF: Items that are answered in the positive should be further explored with the individual and comments recorded on the back of the page.**

1. Are there any dependent children or dependent adults living in the home?

☐ Yes ☐ No ☐ Sometimes Relationship to you\_\_\_\_\_

—

2. What types of abuse are you experiencing now? Circle each one the individual is experiencing and add others.

Physical	hitting, choking/strangulation, slapping, restraining, pushing, biting, threatening or destroying property, harming pets, etc.
Emotional	name calling, yelling, isolating, bullying, bribing, denied access to visitors or telephone, denied privacy, etc.
Financial	selling your items, forcing you to sign legal papers in their favour, abusing power of attorney, adults living off of their parent's income, putting all bills in your name, having no say in household finances, etc.
Medication	over or under medicating, refusing to buy medication, selling medication on the street, etc.
Neglect	withholding food or fluids, inadequate medical attention, lack of necessary appliances such as walkers, etc.
Sexual	unwanted touching, forced intercourse, sexual name calling, affairs, bringing home STD's, etc.
Spiritual	criticizing or not allowing you to practice your faith, manipulating interpretation of religious scripture to control and isolate, etc.

3. Are you physically dependent on\_\_\_\_\_? (Mobility, grocery shopping, etc.)

☐ Yes ☐ No ☐ Don't Know

4. Has there been a recent increase in frequency or severity of the abuse?

☐ Yes ☐ No ☐ Don't Know

5. Do you have any health conditions that are very serious or that you have had, or will have, for a long time?

☐ Yes ☐ No ☐ Don't Know

6. Have you thought of harming or killing yourself?

☐ Yes ☐ No ☐ Don't Know

7. Do you often have trouble remembering things or understanding new information?

☐ Yes ☐ No ☐ Don't Know

HIGH RISK FACTORS	Yes	No	Don't Know
8. Has there been police involvement?			
9. Part a) Are there any court orders in place to protect you from _____ (Restraining Order, Emergency Protection Order, Queen's Bench Order, Peace Bond)?			
Part b) Have you and _____ complied with the terms of the order since it was granted?			
10. Are there any upcoming court dates? When?			
11. Has _____ threatened or harmed or killed a pet?			
12. Does _____ have access to weapons (guns, knives or tasers)?			
13. Has _____ threatened to hurt you with a weapon?			
14. Has _____ ever threatened or used a weapon against someone else?			
15. Are drugs, alcohol or gambling present in your relationship? If so how?  Abusive person Abused person			
16. Have you or _____ ever attended drug or alcohol, or gambling treatment program?  Abusive person Abused person			
17. Have you separated from _____ and are now in a new relationship?			
18. Has _____ ever threatened or attempted to commit suicide?			
19. Has _____ had past relationships that involved abuse?			

20. How safe do you feel?

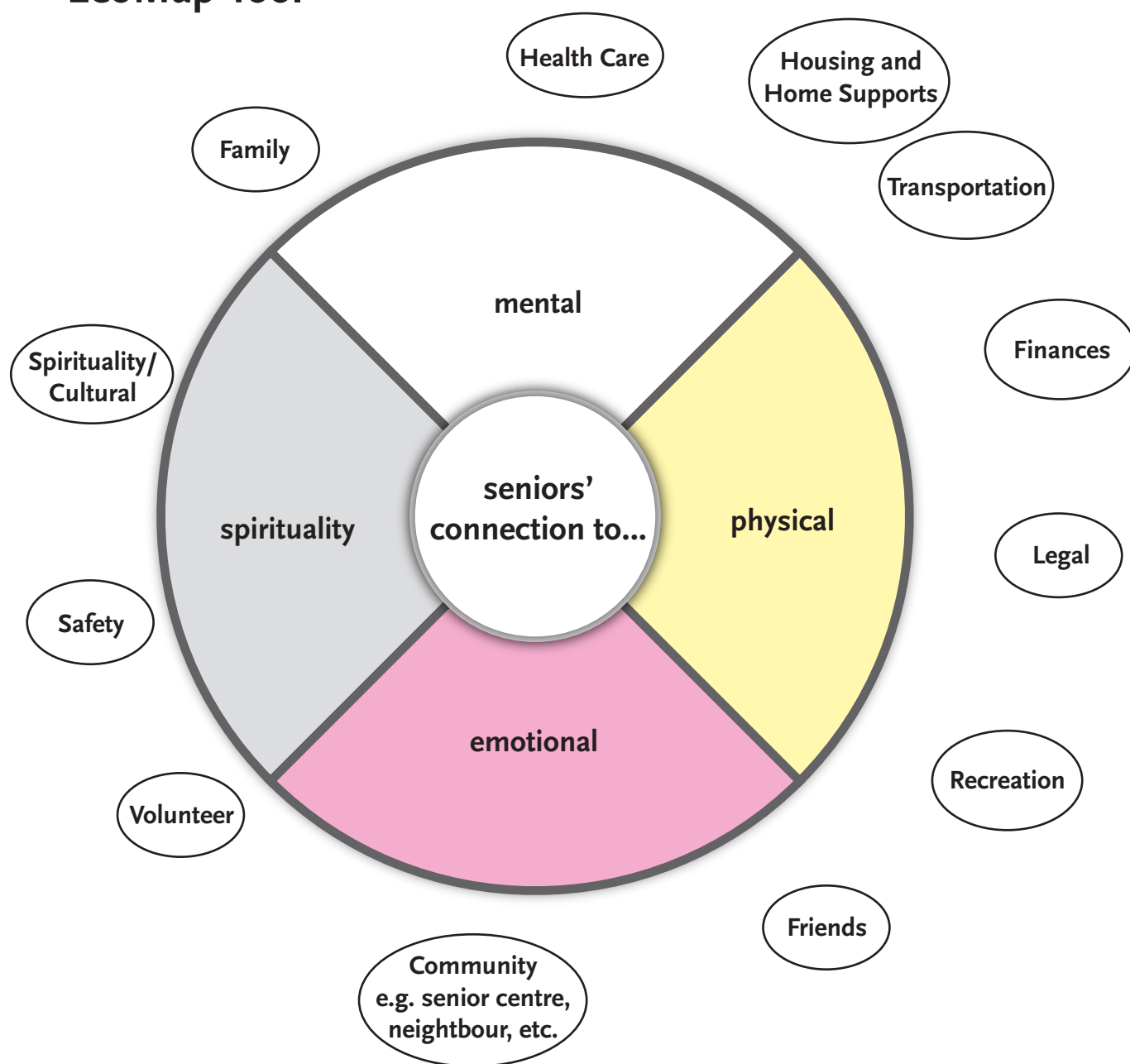
☐ no concern    ☐ very concerned

Ask the individual, **"No one deserves to be abused and we are concerned for your well-being and the well-being of those living in your home. Have you considered your options?"**

Note to staff: While **all abuse is serious**, YES answers to **any** of questions 8 – 19 suggest that this person may be in significant danger and you may consider consulting with your supervisor.



# EcoMap Tool



Use to assess what resources the senior is connected to and to identify whether each is a positive or negative influence in the senior's life.

Arrows can be drawn to identify the flow of energy to or away from the client. An arrow pointing away from the client identifies an unmet need. The type of line indicates the nature of the relationship.

Key: \_\_\_\_\_ Strong, supportive, positive relationship

----- Erratic, conflicted relationship, sometimes supportive and sometimes disruptive;

~~~~~ Negative, disruptive, or nonexistent relationship. (From Betz et al., 1994)





# Templates





# Employee Home Visit Safety Assessment Template

(Source: Calgary FCSS Manual for Outreach to Older Adults)

*(When outreach workers do home visits, they are required by Alberta Labour Standards Working Alone Legislation and Worker's Compensation to ask questions related to safety.)*

|             |                |
|-------------|----------------|
| CLIENT NAME | CLIENT ADDRESS |
|-------------|----------------|

Codes:

|            |                                  |             |
|------------|----------------------------------|-------------|
| S = Safe   | SP = Safety Precautions Required | U = Unsafe  |
| Ph = Phone | LL = Lifeline                    | N = Neither |

Intake / Telephone Assessment:

| Hazard                                                                                                                                              | S | SP | U | Comments |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---|----|---|----------|
| Who lives in the home? Are there any boarders or renters?                                                                                           |   |    |   |          |
| Are there any safety concerns or hazards outside of your home?<br>Tripping/slipping hazards?<br>Neighbourhood concerns?                             |   |    |   |          |
| Are there any safety concerns or hazards inside your home?<br>Smoking? Fire hazards?                                                                |   |    |   |          |
| Are there any pets in the home?<br>Any possible unexpected behaviours?                                                                              |   |    |   |          |
| Are there any communicable diseases in the home? If yes, who and which disease(s)?                                                                  |   |    |   |          |
| Are there any firearms or weapons in the home? How are they stored?                                                                                 |   |    |   |          |
| Do you or anyone in your home use alcohol/drugs on a regular basis?<br>What substance and who is using?                                             |   |    |   |          |
| Is there or has there ever been domestic violence in your home? If yes, describe the nature of violence, last occurrence, and current safety plans. |   |    |   |          |
| Is there any other thing I should be aware of prior to visiting your home regarding health and safety?                                              |   |    |   |          |
| Is there a phone or Lifeline in the home?                                                                                                           |   |    |   |          |

# Employee Home Visit Safety Assessment Template

## First Visit Observations

### External Client Environment:

| Hazard                                                                            | S | SP | U | Comments |
|-----------------------------------------------------------------------------------|---|----|---|----------|
| Tripping/slipping hazards outside the home? (broken steps, ice, uneven ground...) |   |    |   |          |
| Neighbourhood? (adequate lighting, neighbours, crime...)                          |   |    |   |          |
| Litter that causes a threat? (needles, feces, condoms...)                         |   |    |   |          |

### Internal Client Environment:

| Hazard                                                                 | S | SP | U | Comments |
|------------------------------------------------------------------------|---|----|---|----------|
| Environmental hazards? (clutter, slippery surfaces, lighting...)       |   |    |   |          |
| Fire hazards? (combustibles, fire exits, smoking...)                   |   |    |   |          |
| Health hazards? (disease, cleanliness, mould, dangerous substances...) |   |    |   |          |
| Other hazards? (drugs, pets, pornography, violence, weapons)           |   |    |   |          |

### Client Behaviour:

| Hazard                      | S | SP | U | Comments |
|-----------------------------|---|----|---|----------|
| Domestic violence concerns? |   |    |   |          |
| Substance usage concerns?   |   |    |   |          |
| Behavioural concerns?       |   |    |   |          |
| Communication concerns?     |   |    |   |          |

### Recommendations:

Completed By:

Signature:

Date:

---

# Home Visit Hazards – Assessment Template

(Source: FCS Strathcona County)

Risky    Safe

- |                          |                          |                                                                           |
|--------------------------|--------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are there other homes nearby                                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the neighbourhood safe                                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Are the neighbours safe                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is parking close to the home or unit parking                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the building safe                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the building access and security safe                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the lighting good                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a phone in the home                                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there access to an escape route or free exit route                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the client own a pet ► if yes, type _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there smoking in the home                                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a potential risk due to communicable disease at service delivery |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a potential for use of alcohol during the visit                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there a potential for use of drugs during the visit                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there the presence of drug paraphernalia                               |

Does the internal condition of client's residence present a health hazard

- ☐ Yes   ☐ No   ► filth ☐ clutter ☐ rodents ☐ feces ☐ insects ☐

Is there the potential for the:

| client                   | family                   |                                                        | staff                    | self                     | others                   | no threat                |
|--------------------------|--------------------------|--------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | to make <b>physical threats</b> towards                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | to make <b>verbal threats</b> towards                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | to demonstrate <b>unpredictable behaviour</b> towards  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | to demonstrate <b>sexual inappropriateness</b> towards | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | has <b>potential for violence</b> towards              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If a safety risk is identified please comment

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Has a safe visit plan been implemented:   ☐ Yes   ☐ No

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Signature — Staff

Date of assessment



# Outreach Working Alone Safely Policy Template

## (Source: Calgary FCSS Manual For Outreach To Older Adults)

### A. Employer Responsibility

Under the General Safety Regulation – Working Alone section

(Working Alone Safely: a Guide for Employers and Employees, Alberta Employment & Immigration, 2000, [http://employment.alberta.ca/documents/WHS/WHS-PUB\\_workingalone.pdf](http://employment.alberta.ca/documents/WHS/WHS-PUB_workingalone.pdf)), employers have responsibilities to assess their workplace and take preventative measures for minimizing and eliminating risks associated with employees working alone. An employee is considered to be working alone if the employee works alone at a work site in circumstances where assistance is not readily available when needed. In this instance the employer **must**:

1. Conduct a hazard assessment. Employers must closely examine and identify existing or potential safety hazards in the workplace. The assessment must be in writing and communicated to all affected staff. Where practicable, employers must also involve affected employees in conducting the hazard assessment, and in the elimination, reduction or control of the identified hazards.
2. Eliminate or reduce the risks. Employers must take practical steps to eliminate the hazards identified. If it is not practicable to do so, employers must implement procedures to reduce or control the hazards.
3. Establish an effective means of communication. Employers must have a communication system for employees to contact other people who can respond to the employees' need. The system must be appropriate to the hazards involved.
4. Employers must ensure their employees are trained and educated so they can perform their jobs safely. Employees must be made aware of the hazards of working alone and the preventative steps that can be taken to reduce or eliminate potential risks.

### B. Home Visit Procedure

When meeting with a client in their home, the outreach worker must:

1. Complete the Employee Home Visit Safety Assessment with the client prior to the home visit (for first time home visits). If the client refuses to complete assessment the outreach worker will not attend the home.
2. Enter the home visit on *the Agency tracking system* indicating client's name, address, phone number, estimated length of visit and outreach worker's cell phone number. Indicate if it is a first time home visit.
3. If there are safety concerns, the outreach worker will consult with their supervisor. The outreach worker may attend the home in the company of a second outreach worker, or make other arrangements to meet the client possibly out in the community in a public space.
4. After the home visit, the outreach worker is required to call the outreach agency and speak with the appropriate agency staff member to notify the office that the home visit is over.

5. The designated staff member is responsible for attempting to contact the outreach worker 15 minutes after the home visit is scheduled to end, if there has been no phone call.
6. If no answer, the designated staff member must call in another 15 minutes.
7. If there is no response after the second attempt, the designated staff member will notify their supervisor and contact Police Dispatch and request a Check on the Welfare.
8. Outreach workers are required to check in with the designated staff member at the end of day if not returning to the office. If the home visit is after hours, the outreach worker is to call their supervisor on the cell phone to indicator the outreach worker is safe.

## **C. Inappropriate Client Behaviour**

1. Anytime an outreach worker feels threatened during a home visit, that outreach worker is required to leave the home immediately and check in with their supervisor.
2. If a client exhibits undesirable behaviours such as violence or sexual harassment, an Incident Report must be completed and discussed with their supervisor and agency procedures followed. The outreach worker will also note the incident in the client file.



# Confidentiality Agreement Template

## (Source: Calgary FCSS Manual for Outreach to Older Adults)

I/We \_\_\_\_\_ (client's name)  
understand that the information I (we) give to (agency name) is private and confidential  
within the outreach program at (agency name).

Personal information is collected and managed in accordance with the Personal Information Protection Act (PIPA). Information collected by the outreach worker for older adults is stored in a secured location/ electronic database system. Non-identifying information is used to measure and report outcomes of service to funder(s) of the outreach program. I understand that my file will be kept in a secure area and that the outreach worker and supervisors have access to both the electronic and paper information.

Your outreach worker is a professional who is bound by strict codes of ethics, including confidentiality requirements. All meetings are confidential. If communication with a third party is considered necessary or helpful, your permission will be requested.

However, legal exceptions to this confidentiality agreement exist:

1. In cases of imminent danger to you or to others, or actual or suspected child abuse, your outreach worker is legally obliged to notify the proper authority.
2. In case of a subpoena to a court of law, your outreach worker will be required to answer questions and submit files.

The agency is dedicated to a high quality of care. In order to ensure expertise in each case, consultation is available to outreach workers. If the outreach worker discusses you or your family in consultation with others, every means will be taken to protect your privacy by all parties.

I/We understand and consent to the above conditions of confidentiality.

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Client's Signature      Date

---

Client's Name (printed)

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Outreach Worker's Signature      Date

---

Outreach Worker's Name (printed)

Signature of legally authorized representative: \_\_\_\_\_

Legally Authorized Representative (printed) \_\_\_\_\_

Date \_\_\_\_\_



# Consent To Release Of Information Template

## (Source: Calgary FCSS Manual for Outreach to Older Adults)

I/We \_\_\_\_\_ (client(s) name) hereby authorize  
\_\_\_\_\_ (Outreach Worker/Agency Name) to release  
and/or obtain confidential information from (name of person, agency or institution):  
\_\_\_\_\_  
\_\_\_\_\_

This information is to be disclosed for the purpose of:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Effective as of:

\_\_\_\_\_ (day) of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

Expiry Date (maximum one year):

\_\_\_\_\_ (day) of \_\_\_\_\_ (month), \_\_\_\_\_ (year).

I understand that my consent is voluntary, and that failure to provide consent will not result in any adverse decision about my benefits or services, other than limiting the ability of the involved organizations to work together on my behalf. I understand why I have been asked to disclose my identifying information, and have been informed of the risks or benefits of consenting, or refusing to consent to such disclosure. I further understand that I may revoke this consent at any time.

Client or Authorized Representative's Signature: \_\_\_\_\_

If client unable to sign, give reason: \_\_\_\_\_

If client unwilling to sign but gives verbal consent: \_\_\_\_\_

Date: \_\_\_\_\_

Outreach Worker's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Personal information is obtained and disclosed in accordance with the Personal Information Protection Act (PIPA). The Act protects individual privacy by requiring organizations to obtain consent for the collection, use and disclosure of personal information and providing individuals with a right of access to their own personal information.