

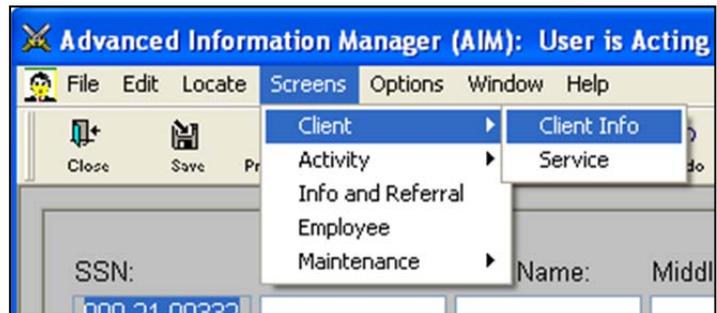
## CHAPTER IV ASSESSMENT DATA

After a client has been entered into **AIM**, the **Assessment Screen** is used to record client assessment and other information.

**NOTE:** This section is perhaps the most vital of the data collection process. Determining the accurate needs of the client, as well as the psycho-social condition of the client, which are often related to determining the accurate needs of the client will affect your agency's ability to best use funds.

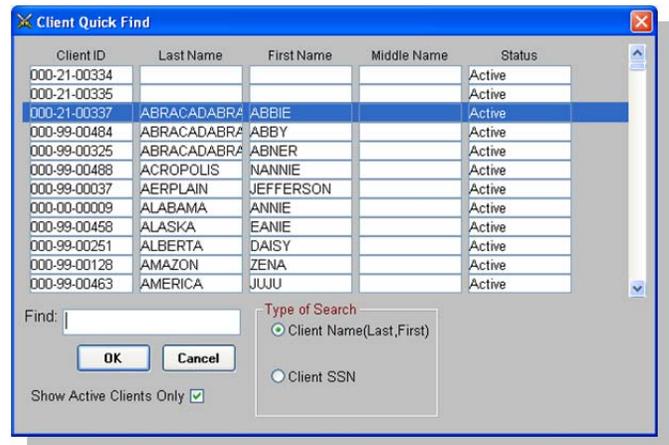
The priority risk score that is automatically generated by assessment answers is an effective way of ranking clients objectively according to greatest need for services.

1. **The Assessment Screen** is accessed through a client's record: From the Client Screen, **Click** on **Screens**, then **Client**, then **Client Info**.



This will bring you to the **Client Quick Find** screen.

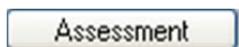
2. **Click** on the client's name to highlight it, then **Click "OK."** The selected client's information screen will appear.



3. Click on the **Assessment** button from the **Quick Link** menu.



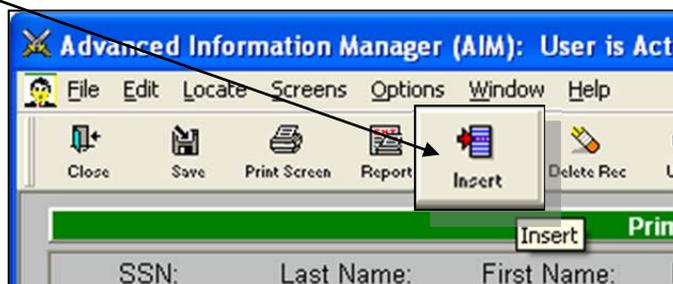
One of two events will occur next, based on whether the Assessment button is in **Bold Print** or in Normal Print:



- **Normal Print:** This is the **FIRST** assessment for this client and the **“No Records Found”** box will appear.
  - **Click OK** to insert the initial assessment.



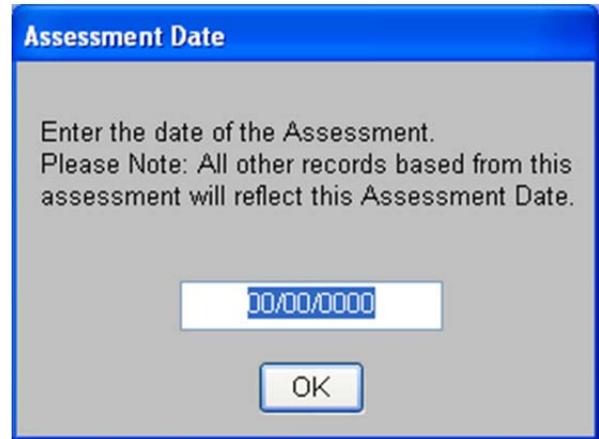
- **Bold Print:** This is **NOT** the first assessment for this client, so the client’s **MOST RECENT** assessment/re-assessment will display.
  - **Click Insert** to insert a re-assessment.



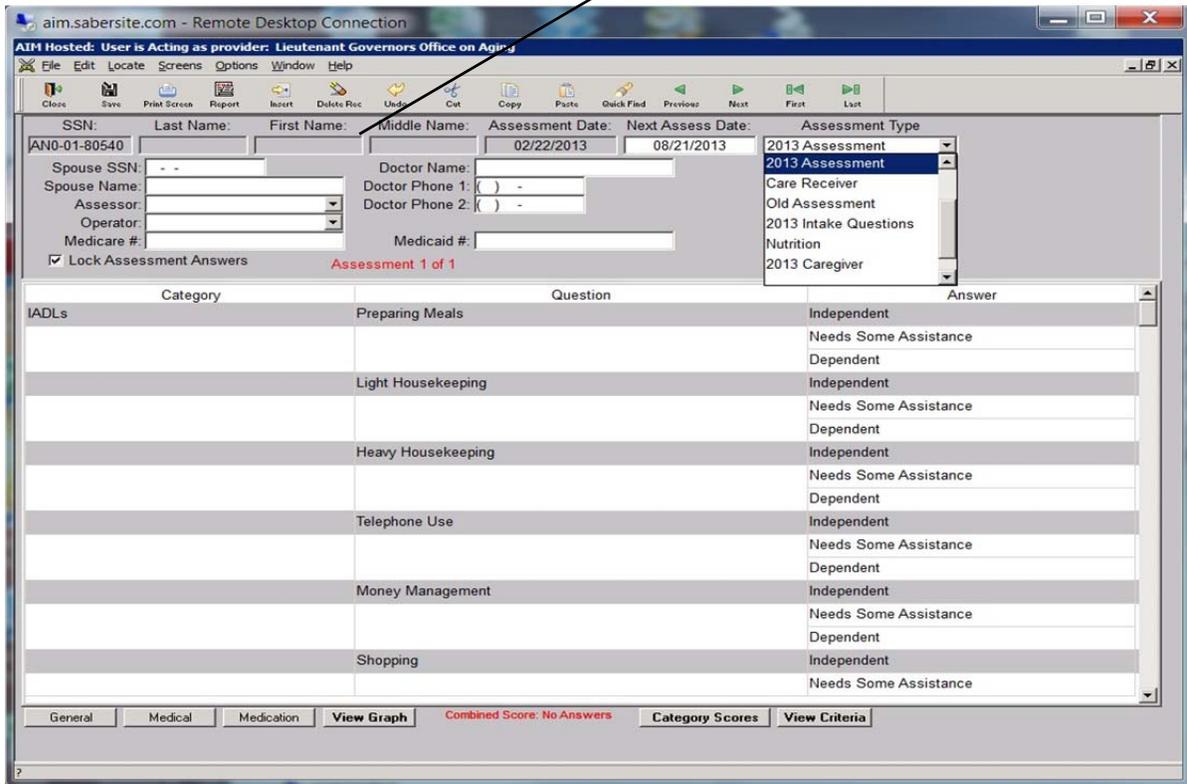
**NOTE:** Regardless of whether you Clicked “OK” to the “No Records Found” window, or whether you clicked “Insert,” once the client’s assessment window opened, you will proceed the same way for entering an Assessment or a Re-Assessment.

- A new window (**Assessment Date**) will pop-up asking for the assessment date.

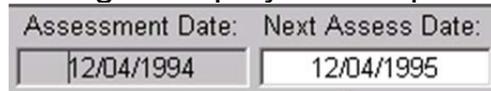
**Type** in the correct date and **click OK**.



The **Assessment Screen** will be displayed, with some information already filled in for the Top Half of the Assessment Screen with the heading **“Primary Assessment Information.”**



The “Next Assessment Date” is defaulted according to how many days between assessments your agency has set as default. If another date is desired, highlight and change the “Next Assessment Date” The AIM administrator can change the default for the next assessment date through “Employee Setup” screens.



## Entering a First Assessment or Re-Assessment

To ensure that those who need services receive them, there must be an in-depth screening process to evaluate an individual's needs. Only after this evaluation, can you recommend the most appropriate services.

### To Enter Data into the Top Half of the Assessment Screen (Primary Assessment Information):

**NOTE:** Only ONE section of the Assessment Screen is “active” at any time. To activate a section, click anywhere in the section below the section heading. The Heading Bar at the top of the section turns **green** to show that the section is “active.”

1. **SSN/UID, Last Name, First Name, and Middle Name:** The first four boxes of the screen are filled in from the client screen and unchangeable.
2. **Assessment Date:** The Actual Date the Assessment was performed. This is the date you typed into the **Assessment Date** window. **AIM will** allow you to select this field. **HOWEVER**, changing this date can cause unexpected results and loss of assessment data. If the date you entered was incorrect, **DELETE** the entire assessment and then re-insert it with the correct date.

Advanced Information Manager (AIM): User is Acting as provider: Your Average Council on Aging - [Assessment]

File Edit Locate Screens Options Window Help

### Primary Assessment Information

SSN:	Last Name:	First Name:	Middle Name:	Assessment Date:
000-99-00484	ABRACADABR	ABBY		10/04/2003

Spouse SSN:	Spouse Name:	Assessor:	Operator:	Medicare #:	Doctor Name:	Doctor Phone 1:	Doctor Phone 2:	Medicaid #:
- -		Suzie,Caseworker	Judge, Joe Brown	0009900484	DR.DOCTOR	( ) -	( ) -	1234567890

**To Delete an Assessment:** you must have the **Primary Assessment Information** section “active”: Click in the top half of the Assessment Screen to ensure that the Heading Bar is green.) Then **Click** the “Delete” button and **Click OK** to the warning message. You must be logged onto AIM as a User with Administrative authority to Delete an Assessment. Delete with caution!

**WARNING:** Once you delete an assessment, it is GONE, there is no “undo”.

**WARNING: DO NOT TYPE OVER THE ASSESSMENT DATE as a shortcut to entering a re-assessment for a client.** You MUST first INSERT a new assessment and then re-answer all questions for a re-assessment.

- Next Assess Date:** *AIM* will automatically insert a calculated date. *AIM* calculates this date by adding to the Assessment Date the number of days specified on the **Employee Defaults** screen. The default number of days can be changed from the Employee Defaults screen for each *AIM* USER. (Notify the appropriate Agency to change this default.) You may also change the Next Assess Date itself by typing over it.

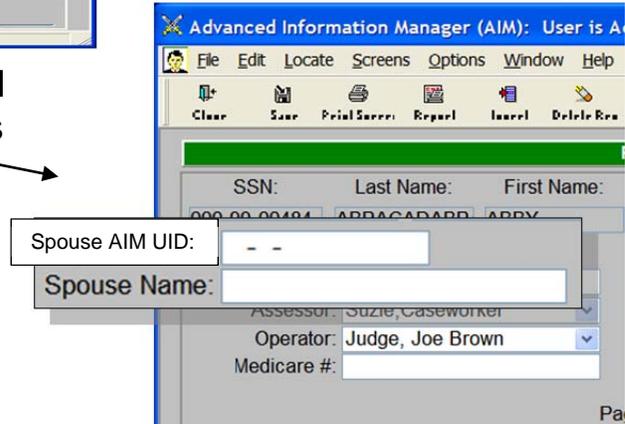
**NOTE: Do Not** confuse Employee Default information set for *AIM* Users with the Assessor for this record. The Next Assessment Date will be calculated based on the *AIM* User logged into *AIM*, NOT on which employee is selected as the Assessor.

**Also NOTE:** The LGOA requires a minimum of **one assessment per year** (365 days) for clients receiving most core services, unless something has changed in the client’s condition or circumstances.

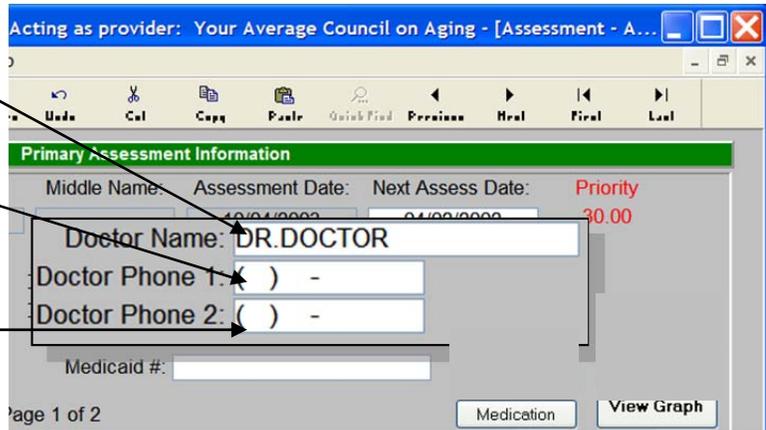
- Priority:** This is a pre-set calculated field. **AIM** will add the values of answers to designated assessment questions (The first 15 Categories) to determine the client's priority score.



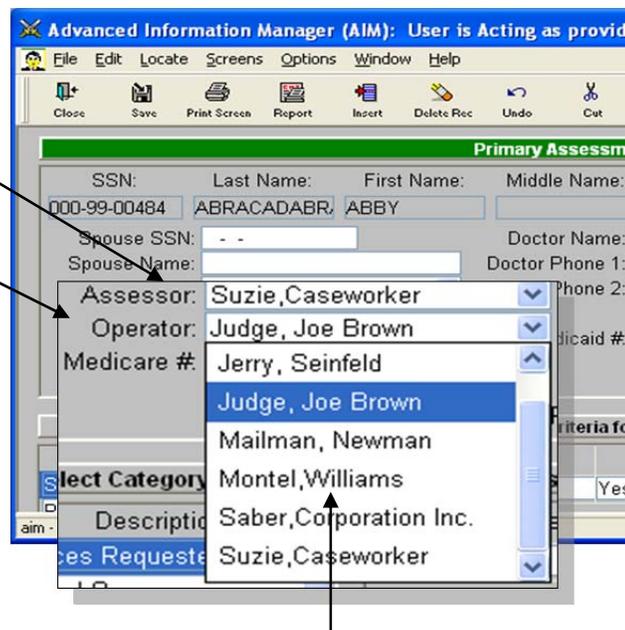
- Spouse AIM UID:** This is the AIM Unique ID assigned to the client's spouses record.
- Spouse Name:** Enter name of spouse, if applicable.



- Doctor Name:** Enter name of client's primary care physician.
- Doctor's Phone #1:** Enter the physician's phone number.
- Doctor's Phone #2:** Enter the physician's emergency number, if any.

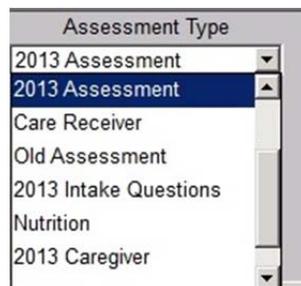


10. **Assessor:** Click on the drop-down box arrow and then on the name of the employee who performed the assessment.
11. **Operator:** Click on the drop-down box arrow and then on your name (as the AIM User performing the data entry task).



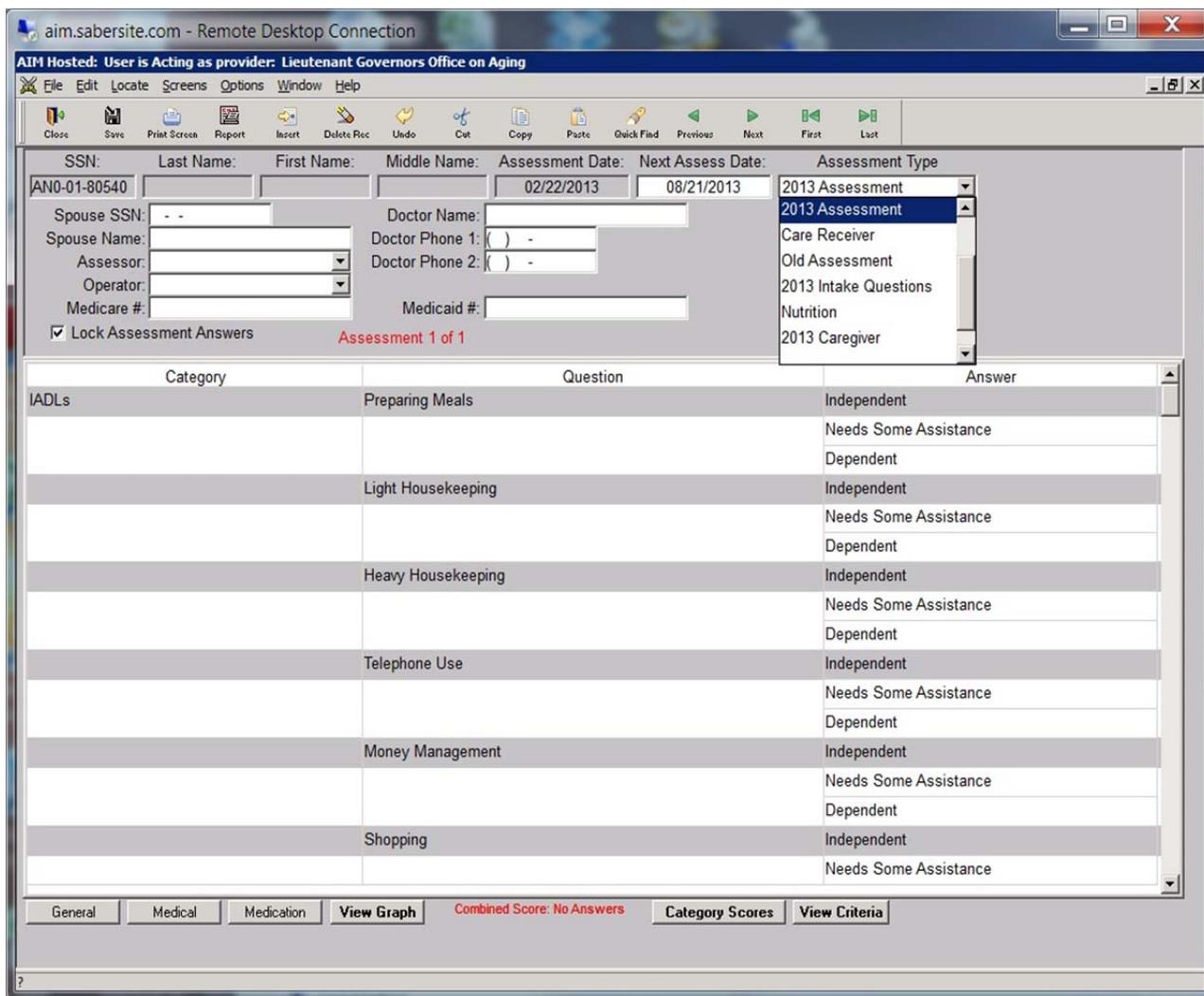
12. **Entering Assessment Criteria Information**

1. The NEW 2013 Intake Questions are:
  - Type of Transportation Needed In An Evacuation
  - Currently Receiving In-Home Services
  - Services Requested



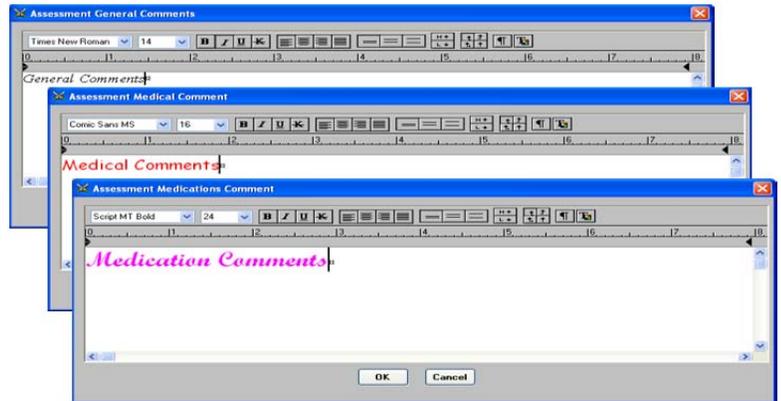


2. The NEW 2013 Assessment Questions. These categories, questions, and answers are listed downwards on the screen. Categories may have several questions, but selected questions may have only one answer.
3. The “Assessment Answers” box must be unchecked before you can highlight and change information.
4. Selected categories and questions do not need to be answered, only answers.

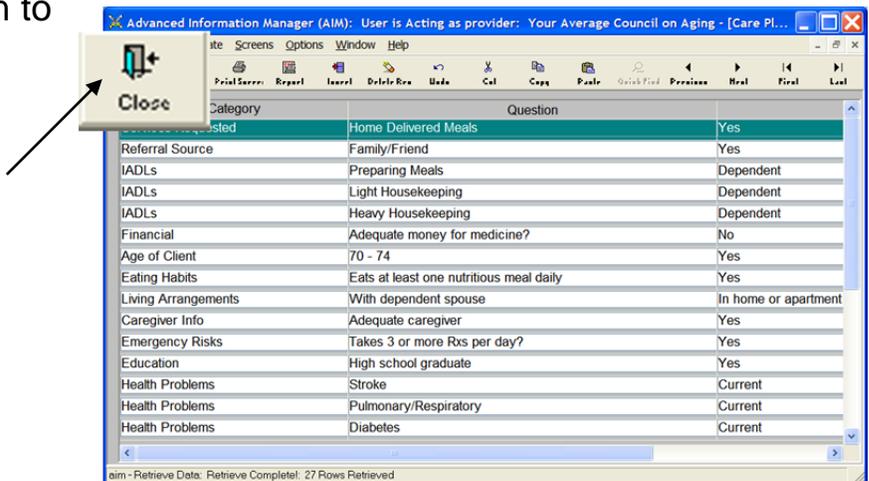




13. **Text Boxes:** Click  on any of these buttons to enter additional relevant **General, Medical** and/or **Medication** information about the client in three separate text boxes.

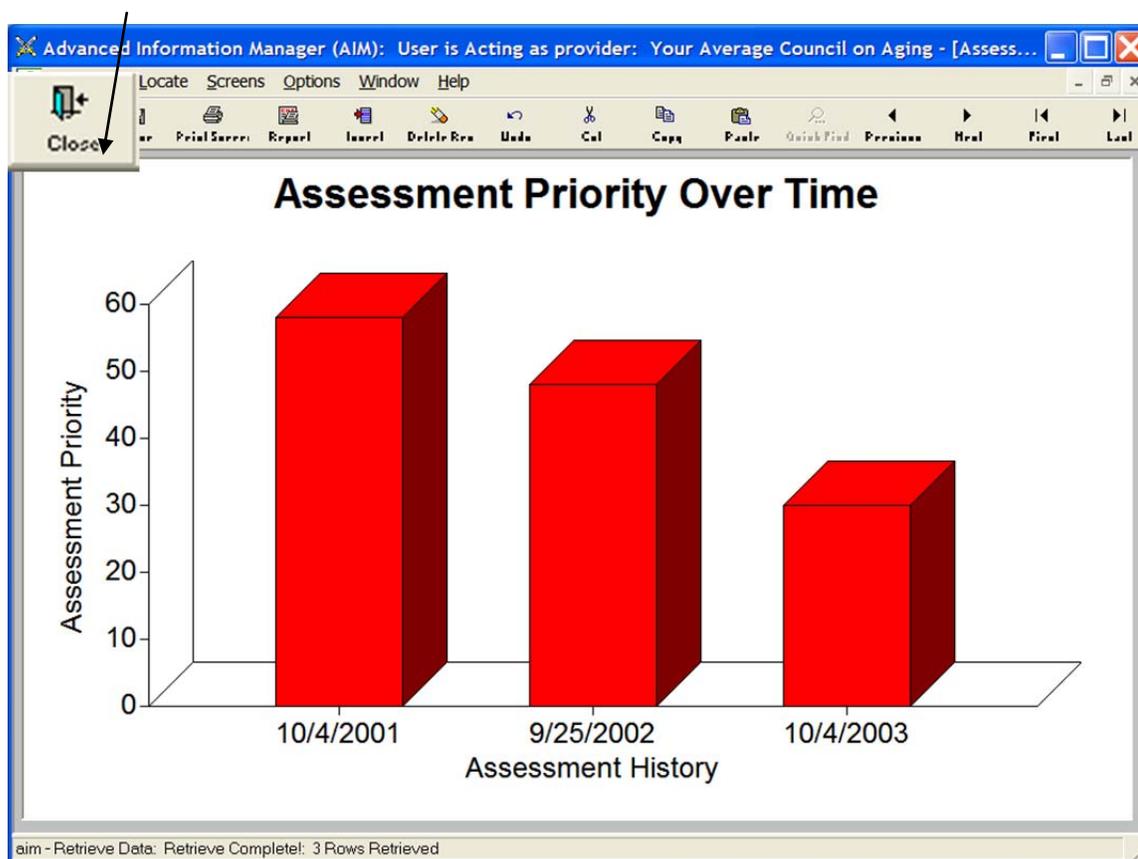


14. **View Criteria:** Once all data entry has been accomplished for this assessment, you may **click** on this button to view all categories of completed assessment data at one time.
15. **Click Close** to return to the Assessment Screen.



16. **View Graph:** As annual assessments are done for a client, **AIM** can produce a bar graph based on the priority scores it compiles. This visual representation is useful in monitoring the client's condition (improvement, maintenance, or decline) over time. This is why you should NEVER DELETE past assessment data.

17. **Click Close** to return to Assessment screen.





## Process to Answer Assessment Questions:

**NOTE:** Regardless of whether you are entering an assessment or re-assessment, you must **Click** on each Category and answer each question in that Category, according to the checklist on the previous page). **DO NOT** skip categories:

1. Repeat Steps 2 and 3 until all questions have been answered for that category.
2. Repeat Steps 1 – 5 until all categories have been completed.

**Following are detailed descriptions of some Assessment Categories, Question and Answer:**

### **CATEGORY: IADLs**

***You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks:***

The IADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall IADL ability.

- **Preparing Meals:** The ability to prepare a full, nutritious meal at least twice a day;
- **Light Housekeeping:** The ability to pick up small, light items, dust, sweep, wash own dishes or put dishes in dishwasher, do light laundry;
- **Heavy Housekeeping:** All of the above plus vacuum, heavy laundry, mop, clean bathroom(s);
- **Telephone Use:** Ability to look up numbers, dial phone, and carry on a conversation;
- **Money Management:** Ability to manage household finances properly;
- **Shopping:** Ability to purchase items, get them into the house, and put them away;
- **Managing Medications:** Ability to take medications timely and properly.

***Use the following definitions to accurately assess the client's level of ability:***

- **Independent:** Indicates the client is totally capable of completing the activity without assistance. The client can also be coded as "Independent" if the client received minor assistance or supervision only

one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times for that week.

**Example:** Mr. U goes out one day a week to visit with family and returns in a fatigued state. He then requires help undressing for bed. He required no help dressing that morning, or any other day that week.

Thus, over the 7-day assessment period, Mr. U was fully self-sufficient 13 times and required hands-on help one time. Based on careful review, the client may be coded “Independent” in dressing.

- **Needs Some Assistance:** Indicates the client is capable of completing the activity with the assistance of a walker, wheelchair, cane, crutches, rails, or another type of assistive device. The client can also be coded as “Independent” if the client received minor assistance or supervision only one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times that week. Or the client is capable of completing the activity independently with only supervision, cuing (reminders), or encouragement. Or the client is capable of completing the activity with only minor assistance from caregivers. The client can also be coded as “Needs Some Assistance” if the client received extensive assistance less than 50% of the time, but was capable of completing the activity all other times during that week.
- **Dependent:** Indicates the client can complete part of the activity, but needs human assistance (hands-on) or verbal directions (continuous step-by-step direction) in relation to the activity 50% of the time. The client can also be coded as “Dependent” if receiving Total Assistance with the activity less than 50% of the time, but was capable of completing part of the activity all other times for that week. Or the client was unable to assist in the activity all seven (7) days.

### **CATEGORY: ADLs**

***You must answer ALL QUESTIONS in this category, regardless of the clients level of ability or inability to perform the tasks listed. Use the following definitions for each of the tasks and to accurately assess the client’s level of ability:***

The ADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between the client’s self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client’s overall ADL ability.

- **Transferring:** Indicates how the client moves between surfaces, i.e., to/from bed, chair, wheelchair, standing position (excludes to/from

toileting).

**Codes:**

- 0 Independent** - Indicates total independence in transferring. If an assistive device is used, the type of device should be identified in the comments section.
- 1 Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
- 2 Supervision and/or Coaching** - Indicates that even though the person is independent is transferring, standby supervision and/or direction is necessary for safety.
- 3 Limited Assistance; needs some help** - Indicates direction or guidance is needed for correct positioning of limbs/appliances (, sliding board), for safety, but client can transfer self.
- 4 Extensive Assistance** - Indicates hands-on assistance or continuous step-by-step direction is necessary for transfer; weight bearing includes few weight bearing steps with pivot.
- 5 Total Dependence** - Indicates transfer requires total human support; non-weight bearing or only able to pivot.

If during the assessment, a transfer deficit is the only identified self-performance problem, the effects of the transfer deficit on all other activities of daily living should be carefully evaluated. **Example:** If the client uses a lift chair, assess the ability to transfer from bed, toilet, etc.

- **Walking/Mobility:** Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating the ability to walk or propel a wheelchair.
  - 0 Independent** - Indicates total independence in walking, in wheelchair, or in motor cart (i.e., client who is completely mobile in electric wheelchair). If an assisting device is used, the type of device should be identified in the comment section (i.e., walker, cane).
  - 1 Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 Supervision and/or Coaching** - With or without assistive device indicates intermittent supervision may be needed with ambulation or wheelchair use. Example: Slow gait but steady.
  - 3 Limited Assistance; needs some help** - Indicates guidance is needed for correct positioning of limbs/appliances (e.g., braces,

prosthesis) or assistance is needed in difficult wheelchair/ambulation maneuvers (awkward thresholds, crowded areas, elevators/stairs, uneven pavement, outside) or for safety with ambulation/wheelchair. The client has the capacity to ambulate or propel wheelchair independently to a destination (more than 20 feet).

- 4 Extensive Assistance** - Indicates the need for physical assistance with ambulation; this need includes unsteadiness with ambulation, assistance with the application of a brace or prosthesis without which a client could not walk. If a client is wheelchair bound, it indicates physical or verbal support is needed for wheelchair use.

It also indicates necessary extensive continuous verbal/hands-on direction to prevent wandering, whether because of the client's habitual tendency or his/her inability to find strategic locations (i.e., bathroom, dining room). Wandering indicates non-goal directed locomotion.

- 5 Total Dependence** - Indicates a client's total inability for walking, even though the ability remains to stand and bear weight or, if wheelchair bound, indicates total inability to operate or manually propel the wheelchair.

- **Dressing:** Assessment should focus on the client's ability to dress self

- 0 Independent** - Indicates the client is totally capable of dressing without assistance.

- 1 Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.

- 2 Supervision and/or Coaching** - Indicates oversight or reminders are needed for dressing.

- 3 Limited Assistance; needs some help** - Indicates help is needed with zippers, buttons, shoes, laying out of clothes, etc.

- 4 Extensive Assistance** - Indicates the client needs physical assistance or continuous verbal step-by-step directions in relation to appropriate dressing at least 50% of the time. Such assistance may be needed by a client who frequently dresses inappropriately for the physical environment (i.e., many layers of clothes when the temperature does not warrant them).

- 5 Total Dependence** - Indicates the client must be dressed by others.

- **Bathing:** This activity rates the maximum amount of physical assistance the client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part

of bathing activity (washing off) indicates that client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)

- 0 **Independent** - Indicates no physical assistance or direction is needed with routine daily bathing.
  - 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 **Supervision and/or Coaching** - Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.
  - 3 **Limited Assistance; needs some help** - Physical Help Limited to Transfer Only - Indicates physical assistance is needed to move from one surface to another (example: getting in and out of tub/shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excludes washing of back and hair).
  - 4 **Extensive Assistance** - Physical Help in Part of Bathing Activity - Indicates necessity hands on physical assistance or continuous step by step direction is needed in bathing 50% or more of the time (excludes washing of back and hair).
  - 5 **Total Dependence** - Indicates total hands-on assistance is required in bathing.
- **Eating:** relates to the activities the client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.

In the home, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, facility staff should evaluate client's ability to accomplish these activities.

- 0 **Independent** - Indicates no assistance is needed in setting up and eating the meal. Setting up the meal is defined as a person's ability to take prepared food, warm it, and serve it for eating.
- 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
- 2 **Supervision and/or Coaching** - Indicates oversight or reminders are needed for meal preparation and/or to eat meals.



- 3 **Limited Assistance; needs some help** - Indicates help is needed in cutting meat, opening prepackaged items, and so forth.
  - 4 **Extensive Assistance** - Indicates the need for physical assistance with or continuous step by step directions pertaining to eating and/or setting up the meal at least 50% of the time.
  - 5 **Total Dependence** - Indicates the client is totally dependent on another for feeding.
- **Toilet Use:** Indicate how the client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

**Note Regarding Ostomy Care:** when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

- 0 **Independent** - Indicates that no assistance is required for toileting.
  - 1 **Assistive Technology Only (no help)** – Indicates that even though the person uses a walker, wheelchair, cane, crutches, rails or any other type of assistive device, he/she is totally independent.
  - 2 **Supervision and/or Coaching** - Indicates oversight is needed for safety in toileting.
  - 3 **Limited Assistance** - Indicates help is needed with arranging clothes or emptying bedpan/bedside commode.
  - 4 **Extensive Assistance** - Indicates routine physical or continuous step by step direction for transfer and/or personal hygiene. This may include a person who frequently toilets in inappropriate places (i.e., floor vents, dresser drawers).
  - 5 **Total Dependence** - Indicates total assistance.
- **Bladder and Bowel Incontinence:** These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the AIM Assessment Form.
    - 0 **Continent:** Indicates complete control. Note: This would be counted as a deficit when indwelling catheter is in place and not self-care.
    - 1 **Usually Continent:** For bladder - Indicates incontinent episodes once a week or less; for bowel - indicates less than weekly



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- 2 **Occasionally incontinent**: For bladder-Indicates 2+ times a week but not daily; for bowel-indicates once a week.
  - 3 **Frequently Incontinent**: For bladder-indicates frequent incontinence, but some control, OR if the client is being toileted (extensive assistance) on a regular basis, i.e., every 2 hours; For bowel - incontinence 2-3 times a week.
  - 4 **Total Incontinence**: Indicates no control (or an indwelling catheter/ostomy that controls the client's bladder/bowel (without leakage).

**Note:** If the client is incontinent, but self-care indicated, this does not constitute a deficit.

**Note Regarding Ostomy Care:** when assessing a client who has a colostomy or ileostomy, make sure that you query the client/caregiver regarding how the client personally cares for the ostomy. Once you determine the level of ability then apply the appropriate score.

### **CATEGORY: FINANCIAL**

Again, it is very important that the client answer this question. All information, including income, is held in the strictest of confidence. We ask for this information for the purpose of gathering data so that we can report on the level of need of our client population. A “No” answer indicates the client has a financial need for the question answered.

**NOTE:** Usually a “Yes” answer indicates a problem area. However in the Financial Category it is the “No” answer that indicates a problem. The short-cut corresponds to this peculiarity by inserting a “No” answer in the Assessment Criteria section when you double-click the financial question.

### **CATEGORY: EATING HABITS**

It is important to ask the client each of the questions to ensure accurate information on their eating habits. Please check that your answers make sense when compared to each other. In other words, if you answer “Yes” to “Eats at least one nutritious meal daily”, then you should **NOT** answer “Yes” to “Eats only snacks or whatever is handy” **NOR** should you answer “Yes” to “Eats sandwiches or light meals only”. However, you could still answer “Yes” to “Professional has nutritional concerns.”

**NOTE:** Even though you may be asking some of these same questions again on the Nutritional Assessment, this portion of the Assessment is part of the overall priority score for the client, the Nutritional Checklist questions and answers are NOT part of the calculated Priority Score.

  
**CATEGORY: LIVING ARRANGEMENTS**

Who do you live with and where do you live? It is important to know the kind of living arrangement the client has. This can be a determining factor for the kinds of services placed in the home. Start off by asking the client if he or she lives with anyone. If the response is “Yes” then follow with, “Whom do you live with?” If the client is living alone then the case manager needs to determine if it is a safe environment. **Please choose and answer ONLY ONE of the Living Arrangements question.** If a client lives with spouse, then you will need to determine if the spouse is dependent on the client or not and choose the “spouse - questions” that best applies. If a client lives with spouse AND others, then choose one of the “spouse - questions”.

**CATEGORY: TRANSPORTATION/DRIVING**

A client’s ability to be self-sufficient depends on transportation, especially for those living in rural communities. It is important to ask a client as many of these questions as necessary to determine their transportation needs. If a client cannot get medications or food or keep a doctor’s appointment then his or her health status is at risk. Answer as many questions as are pertinent to this client.

**CATEGORY: CAREGIVER INFO**

Not all clients need to live with someone. On the other hand, there are clients who need in-home caregiving and none is available. It is important to get a response from the client to this set of questions to determine safety and degree of service needs. If the client is living with the caregiver, then the case manager should try to observe the interaction between client and caregiver when possible, the way the client is dressed and groomed, and the condition of the home and/or the room the client resides in most. These observations will determine if the case manager feels that the client is being properly cared for and treated. Answer as many questions as are pertinent to this client.

**CATEGORY: HEALTH and SAFETY LIMITATIONS (Falls)**

This is an important category particularly if the client is living alone. A fall can be the beginning of a dangerous downward health spiral. If the client is falling in the presence of a caregiver, then there are additional factors that the case manager must take into consideration. When probing for this question, ask the client if they have experienced any falls in the last 30 days, 6 months, and year. If the answer is yes to any of the time frames, then ask how many falls. Answer with number of falls in the last year.



## **CATEGORY: HEALTH PROBLEMS**

It is important to ask the client about any current diagnosed health problems as listed on the Health Assessment Limitations sheet. Tell them you will need information on his or her current health problems and you will be asking about different types of conditions that present current limitations; such as current treatment for heart/circulation problems, high blood pressure, and so on. The only answer choices are “yes” or “no”. Each assessment will now contain only the current conditions that are placing limitations on the client at the time of the assessment. Please answer the health problems logically.

## **CATEGORY: NUTRITIONAL SCREENING**

This category determines if the client is receiving adequate nutrition. Ask the client each question, instructing them to answer yes or no. If you, the assessor, are uncomfortable asking the questions the way they are currently worded, then simply reword the question, just don't change the intent of the question. For example: One of the current questions is “Do you eat few fruits per day?” Reworded, you could say “Do you eat very many fruits each day?” But be careful of the new answer: The current question, answered “Yes”, and the reworded question, answered “No”, imply the same condition: not enough fruits are being eaten each day. You will still need to code the answer in **AIM** according to the original question. So the answer to the question in the example that you would select in **AIM**, would be “**No**”.

**Note:** *Each of these questions must be answered so that the Nutrition Score can be accurately calculated for **AIM** reports.*

## **CATEGORY: END OF RISK SCORE QUESTIONS**

There are, of course no questions and answers in this category. It exists to mark the place where the Priority Score STOPS scoring answers to assessments. It does NOT indicate that no more questions need to be answered. The questions below this category are very important in determining a clients' level of infirmity as well as identifying trends in similar health problems. The information collected in the Nutritional Screening Category, which follows below, is required data for reporting to the federal Administration on Aging through the annual NAPIS report.



  
**CATEGORY: LEGAL SUMMARY**

Many clients do not understand the differences between a “**living**” will and a “**legal**” will and the importance of both. Nor do they understand the need for a durable power of attorney and a health care power of attorney. Anyone conducting an assessment should be familiar with the definition of all of these and be able to refer the client and/or family to someone in the aging community for free advice or assistance if needed.

Answer “**Yes**” if the client has a document. Answer “**No**” if the client does not have a document. ***Use the following definitions to determine which documents a client has:***

- **Living Will:** a document that states how a person wishes to be treated, if he/she becomes incapacitated by illness, injury or old age.
- **Legal Will:** a legal declaration of how one wishes one’s possessions to be disposed of after one’s death.
- **Durable Power of Attorney:** a written power of attorney which contains the words “This power of attorney shall not be affected by my disability,” or “This power of attorney shall become effective upon my disability,” or similar words. In order to be valid it must be signed before the person becomes disabled. The function of a durable power of attorney is to eliminate the need for conservator ship or guardianship proceedings in a court of law should a person ever become incapacitated and unable to manage their own decisions. The person chosen to act on your behalf is called you attorney in fact. This person should be someone you completely trust. The law gives the person choosing someone to act on their behalf the power to impose reasonable limitations and guidelines on the actions.
- **Health Care Power of Attorney:** a document that you, “the principal,” created by appointing another person, the health care “agent” or “attorney in fact,” to make health care decisions for you should you become incapable of the decision themselves.
- **5 Wishes:**

**CATEGORY: RESIDENCE**

This section should be completed every time the client is assessed. A “**Yes**” answer indicates that NO problem exists. A “**No**” answer indicates that a need exists. These “questions” relate to environmental factors which relate to the client's residence. Use the Comments Section if further explanation or clarification is needed.

Once you have completed this Assessment, **click Close**.

The screenshot shows a remote desktop connection window titled "aim.sabersite.com - Remote Desktop Connection". The application window is titled "AIM Hosted: User is Acting as provider... Lieutenant Governors Office on Aging - [New Record]". The interface includes a menu bar (File, Edit, Locate, Screens, Options, Window, Help) and a toolbar with icons for Close, Save, Print Screen, Report, Insert, Delete Rec, Undo, Cut, Copy, Paste, Quick Find, Previous, Next, First, and Last. The main form contains fields for SSN (AN0-01-80540), Last Name, First Name, Middle Name, Assessment Date (02/22/2013), Next Assess Date (08/21/2013), and Assessment Type (2013 Assessment). Other fields include Spouse SSN, Spouse Name, Assessor, Operator, Medicare #, Doctor Name, Doctor Phone 1, Doctor Phone 2, and Medicaid #. A checkbox for "Lock Assessment Answers" is checked. Below the form is a table with the following data:

Category	Question	Answer
IADLs	Preparing Meals	Independent
		Needs Some Assistance
		Dependent
Light Housekeeping	Light Housekeeping	Independent
		Needs Some Assistance
		Dependent
Heavy Housekeeping	Heavy Housekeeping	Independent
		Needs Some Assistance
		Dependent
Telephone Use	Telephone Use	Independent
		Needs Some Assistance
		Dependent
Money Management	Money Management	Independent
		Needs Some Assistance
		Dependent
Shopping	Shopping	Independent
		Needs Some Assistance

At the bottom of the interface, there are buttons for "General", "Medical", "Medication", "View Graph", "Category Scores", and "View Criteria". A status bar at the bottom left indicates "aim - Retrieve Data: Retrieve Complete!: 0 Rows Retrieved".



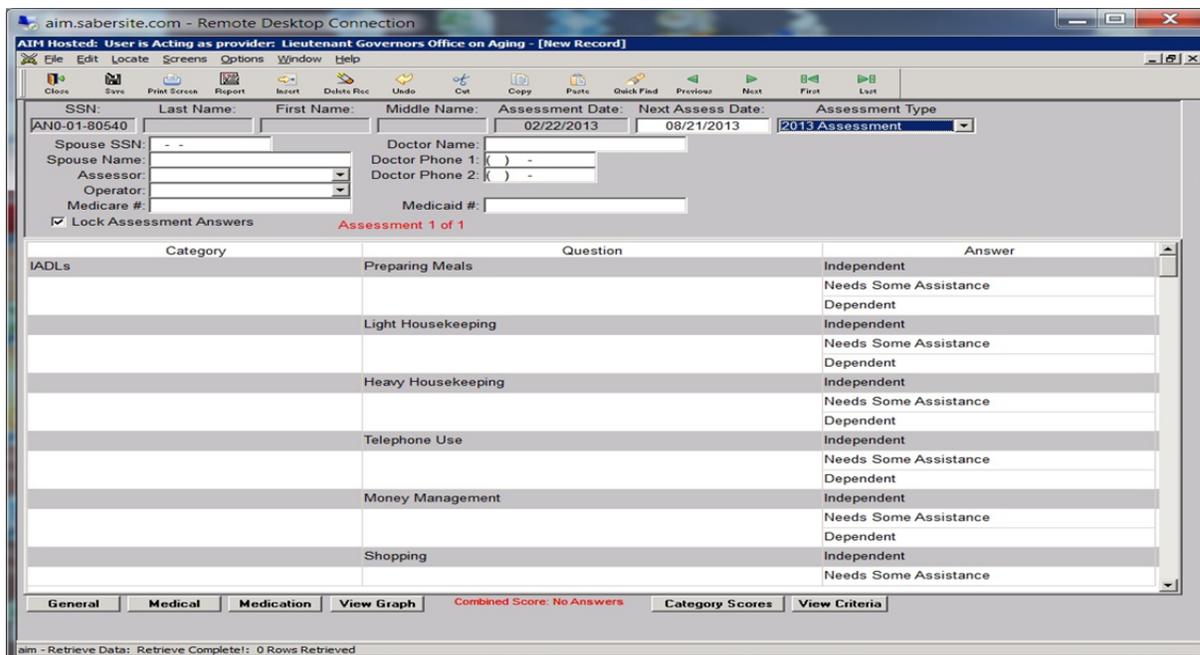
## PART B Updating an Existing Assessment

There are times when minor information on an existing assessment needs to be corrected or updated.

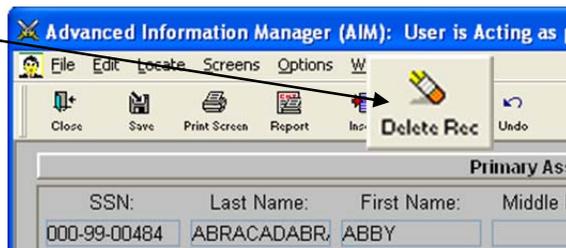
**Note:** If a client's condition has significantly changed, a **NEW** assessment (i.e. a re-assessment) should be performed, rather than updating an existing assessment, even if it has not been a year since the last assessment.

In the case where minor information needs to be updated or corrected, bring up client on the Client Screen and then click on the Assessment Quick Link button.

1. **The Most Recent Assessment** will display, which is where corrections or updates should be entered.
2. **Click** on (to highlight it) any data field in the **Primary Assessment Box** that needs to be updated.
3. Modify the information as needed. For example, if the client's doctor has changed, **double-click** on (or **click and drag**) the name to highlight it, and then type in the new name.
4. Uncheck "Lock Assessment Answers" box in order to change answers on the assessment.
5. Click the Category that contains the information that needs to be corrected.
  - a. **If** there is an additional question that needs to be answered, follow the instructions for inserting questions and answers at the beginning of this chapter.



- b. If there is a **Question-Answer** pair that already exists, but needs to be corrected:
  - i. **Click** on the existing **Question-Answer** pair in the **Assessment Criteria for Primary Assessment** box.
  - ii. **Click** the “**Delete Rec**” icon.
- c. Enter the correct Question-and-Answer, following the instructions for inserting questions and answers at the beginning of this chapter .



- 6. Follow instructions in Part A to select appropriate categories, questions, and answers.

**!!CAUTION!!** BE SURE that the **BOTTOM SECTION** of the Assessment Screen—**Assessment Criteria for Selected Category Section**—is **highlighted in green** BEFORE clicking the Delete Rec Button, or you could wind up deleting your entire Assessment!

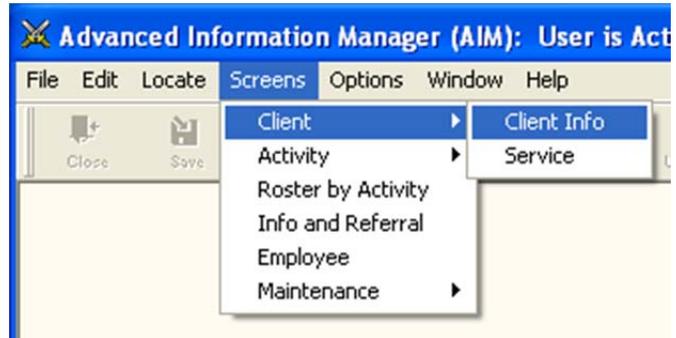
**NOTE:** Again, if you are updating, rather than correcting information in the Assessment Criteria area, you should probably be performing a full re-assessment, rather than updating an existing assessment, even if it has not been a year since the last assessment.



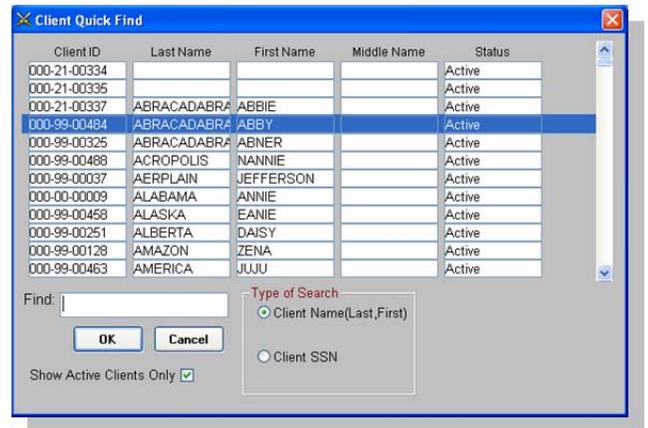
## PART C Deleting an Assessment Record

Deleting records may only be done by the System Administrator. An assessment record should only be deleted when an assessment has been entered on the wrong client or has been entered with the wrong Assessment Date. (Example: someone loads Mary Smith’s assessment data into Mary Jones’ client record; or an Assessment Date of 11/10/2204 was typed instead of 11/10/2004)

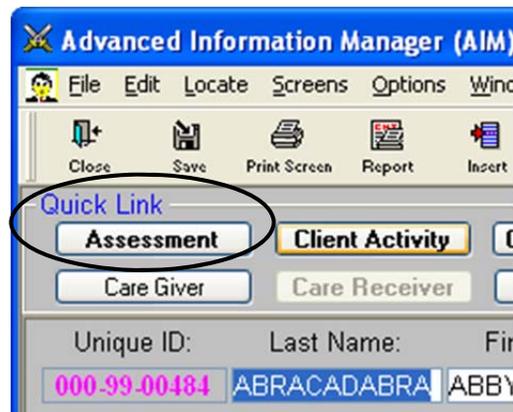
1. Access the **Primary Assessment Information** screen for the client whose assessment data must be deleted:



- a. Click Screens, then Client, then Client Info.
- b. In the Quick Find window, select client for whom you need to delete an assessment.

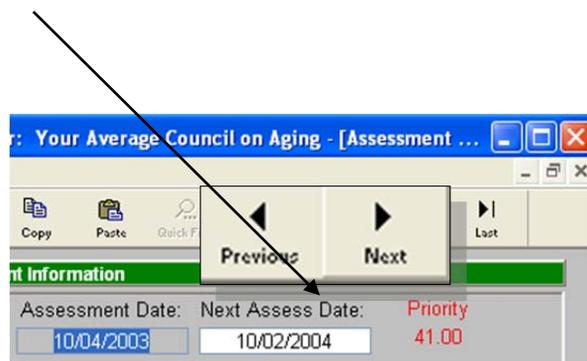


- c. Click the **Assessment Quick Link** Button).

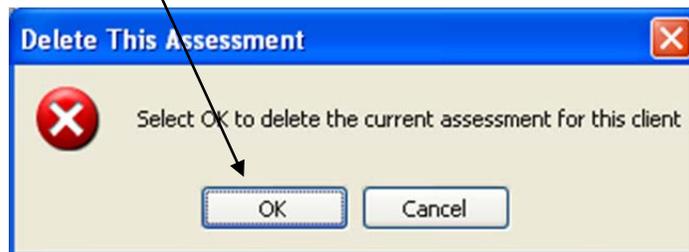


2. When you click the Assessment button, if multiple assessments exist for a client, then the assessment dated LATEST will display first. It is possible you will need to click the “**Previous**” or “**Next**” buttons to find the Assessment you wish to delete.

**NOTE:** This can be VERY confusing, because the “**Previous**” button moves you to LATER assessments for this client and the “**Next**” button moves you to EARLIER assessments for this client.



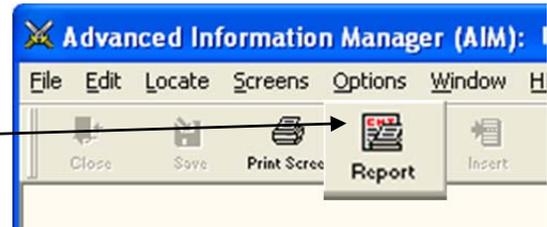
3. The **Primary Assessment Information** bar must be **green**. **Click** anywhere in the upper part of the screen to make sure the bar is green.
4. **Click** on the “**Delete Rec**” icon. The message window, “**Delete This Assessment,**” will pop-up.
5. **Click OK** to confirm that you wish to delete this assessment from the client’s record.



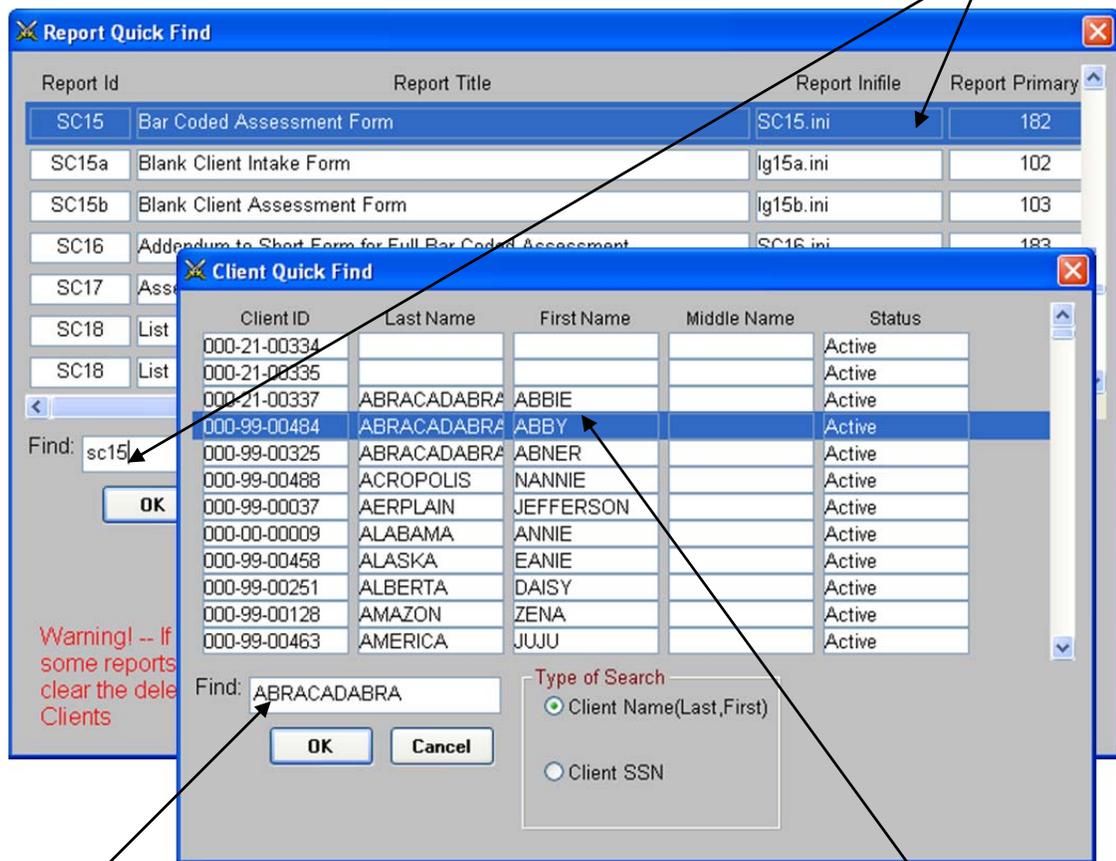
**PART D Using the Bar Code Scanner to Enter Assessment Data**

**Creating Bar Coded Assessment Forms**

1. First, you need to print out a report form with assessment barcodes on it: Click on the **Report** icon on the top menu.



2. The Report Quick Find window will appear.
3. **Scroll** down to, or **type in, SC15** and **double-click** on report row. The **Client Quick-Find** screen will appear for you to select a client for whom you will be performing an assessment.



4. **Type** in the client's last name, then select the correct client from the list, by **Double-clicking**.

5. The **Bar Coded Assessment Form** will appear, with the information from the Client screen already filled out.

6. Move the cursor to the bottom of the screen and **Click “Print.”** This process prints a 15-PAGE form for the selected client with basic information pre-printed on the form, as well as all of the categories, questions, and answers in the assessment criteria section in bar-coded form.

**Note:** If you cannot see the buttons at the bottom of the screen, you need to **HIDE** your Task Bar (The Print button and the others are **BEHIND** the Task Bar).

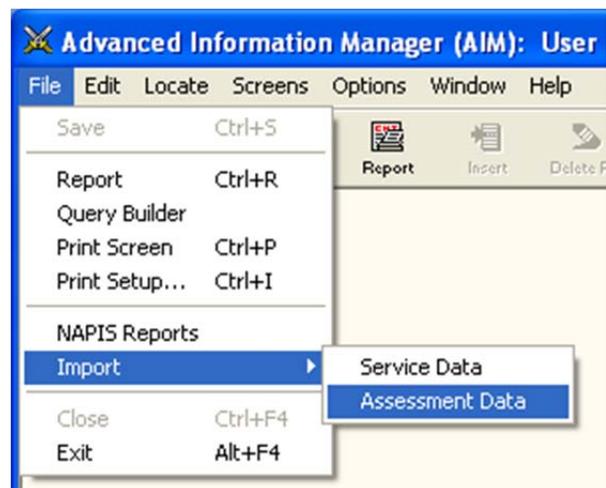
- The client assessment can be completed by circling with pen or pencil, using a highlighter pen, or otherwise indicating the correct response directly on the form. Take care not to put ink or pencil marks on the bar coding.

**Assessment Categories, Questions and Answers**

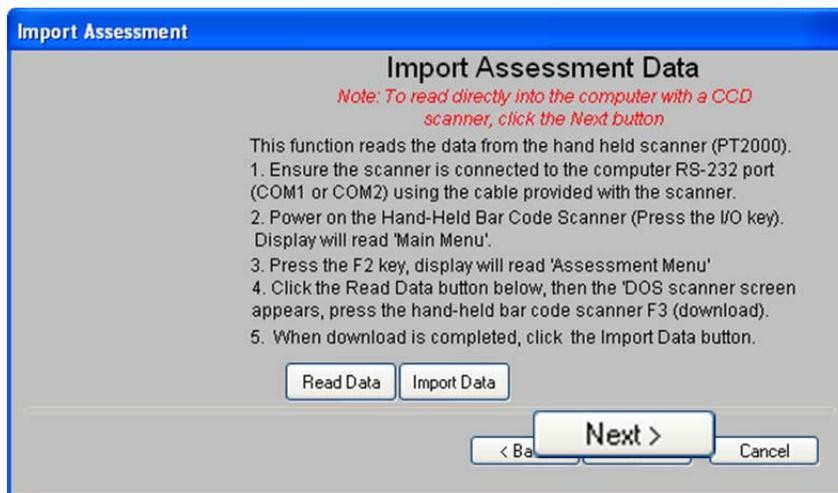
Services Requested		Services Requested	
Information and Assistance	Yes	Home Care	Unmet Need
99Q1A1		99Q6A457	
99Q1A2	No	Home Delivered Meals	Yes
99Q1A455	Unmet Need	99Q7A7	
Congregate Meals	Yes	99Q7A8	No
99Q5A3		99Q7A458	Unmet Need
99Q5A5	No	Transportation	Yes
99Q5A456	Unmet Need	99Q8A9	
Home Care		99Q8A10	No

**Note:** highlighter pens do not harm the bar coding, and can be used directly on the bar code.

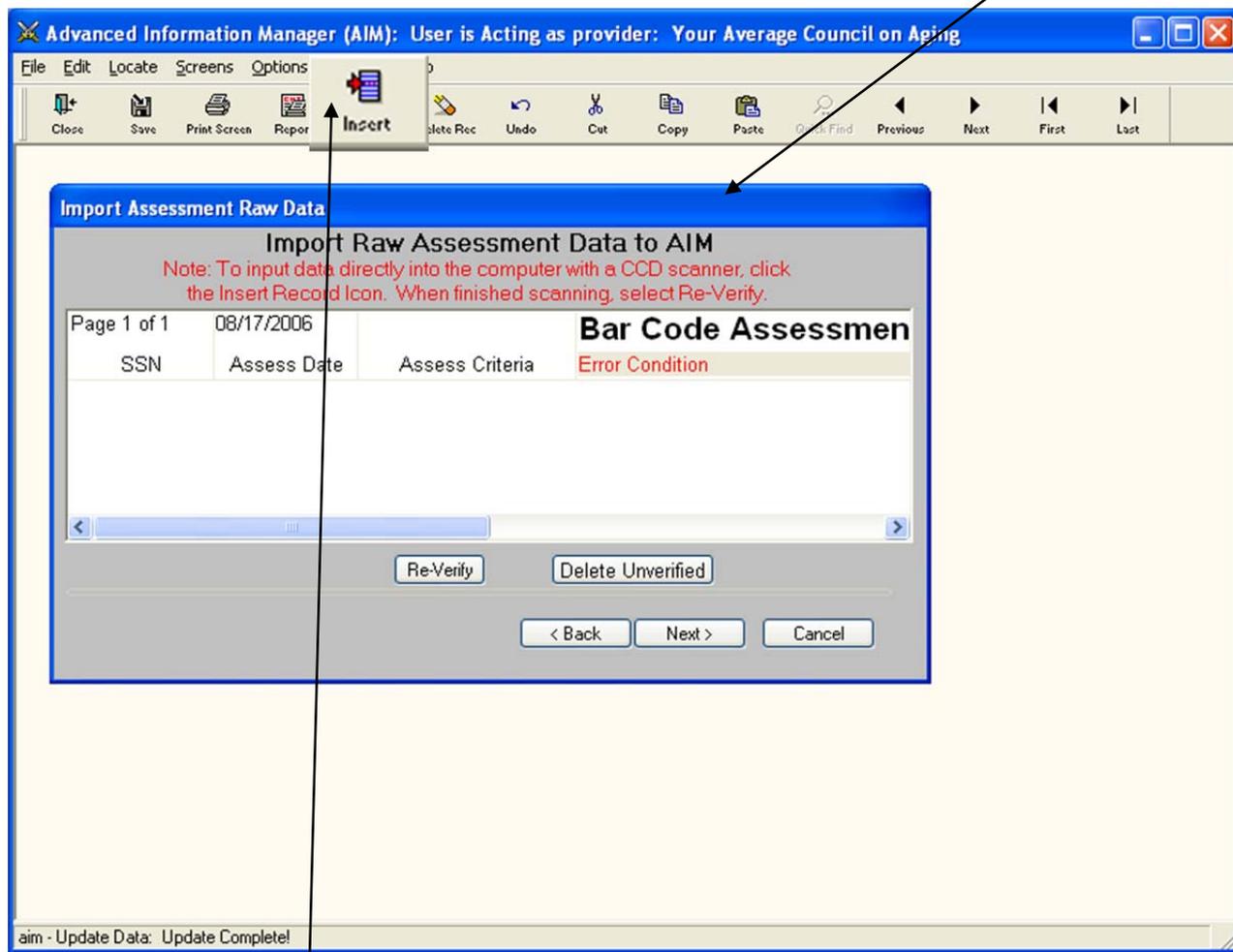
- To enter bar coded assessment data into **AIM**, the scanner must be attached to the computer. (See **Chapter III (3)**, the last page, for installing a bar code scanner to your computer).
- From the **AIM** menu, **Click File**, then **Import**, then **Assessment Data**.



10. The **Import Assessment Data** window will appear. **Click Next.**



11. The **Import Assessment Raw Data** screen will appear.



12. **Click** the **“Insert”** button to enter the first assessment answer.

13. The cursor will be positioned in the **SSN (client identifier)** field. **Scan** the client's identifier from the assessment form, or type it in.

**Note:** the “SSN” entered must be EXACTLY the same as the “SSN” in the client’s record. If it is not, you must update the Client Information screen before you can put in the assessment data.

14. **Click** on the **Assess Date** field.

15. **Type** in the date of the assessment (in the form of mm/dd/yyyy), or **scan**

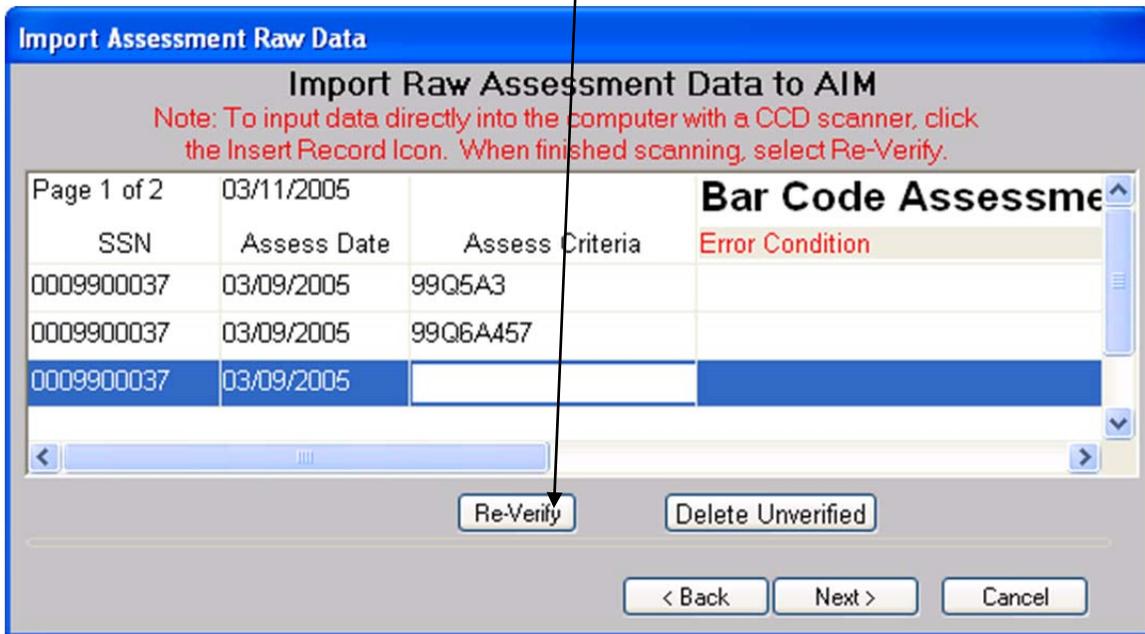
it in from a bar-coded "Dates" form.

16. Click or <Tab> to the **Assess Criteria** field.

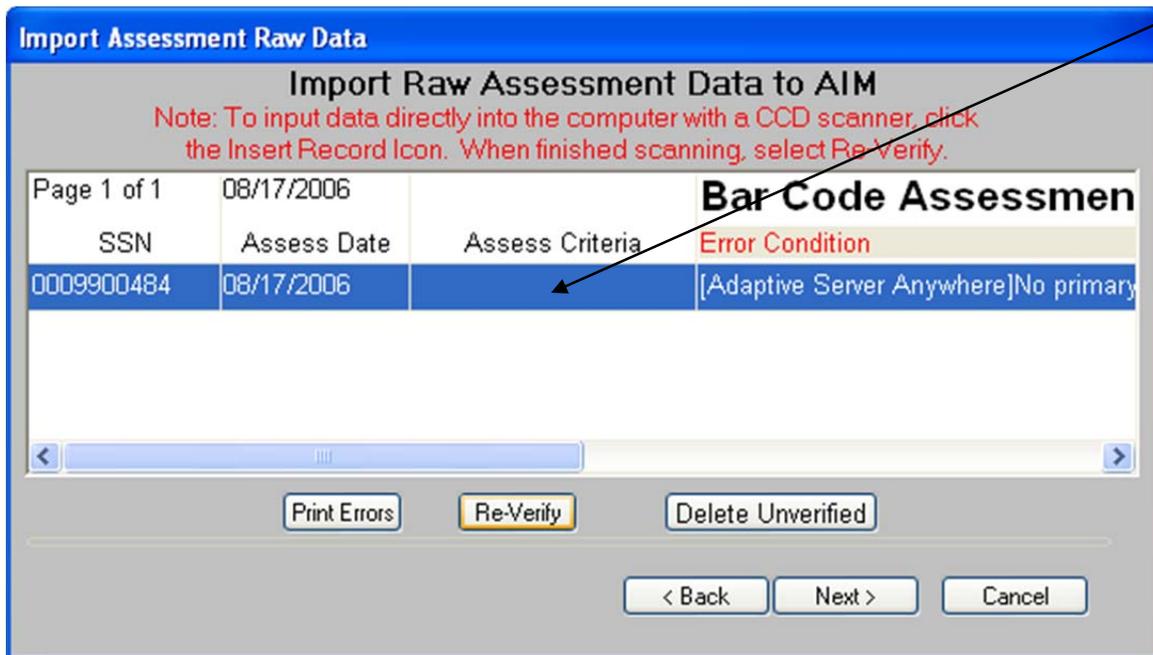
17. **WITH THE CAPS-LOCK OFF, Scan** the first answer from the bar coded assessment form.
18. The screen automatically creates the next line, automatically filling in the client's SSN and Assess Date and ready for entry of the next answer.
19. Continue scanning all answers until finished.

Assessment Categories, Questions and Answers			
<b>Services Requested</b>		<b>Services Requested</b>	
Information and Assistance		Home Care	
99Q1A1	Yes	99Q6A457	Unmet Need
99Q1A2	No	Home Delivered Meals	
99Q1A455	Unmet Need	99Q7A7	Yes
Congregate Meals		99Q7A8	No
99Q5A3	Yes	99Q7A458	Unmet Need
99Q5A5	No	Transportation	
99Q5A456	Unmet Need	99Q8A9	Yes
Home Care		99Q8A10	No

20. When you have finished scanning all answers from all pages of the Bar-Coded Assessment Form, **Click on the Re-Verify** button in the **Import Assessment Raw Data** window.



21. The rows will disappear one by one as they are verified to have a valid SSN, Assess Date, Assessment Answer, and are not duplicate entries.  
 22. There will always be one row left after all other rows have disappeared.



**NOTE:** Even if all data entered is correct and valid, after the Re-Verify process finishes, you will have one row left, containing an error. This is not a true error, just a blank row. So you may simply delete it.

**Import Assessment Raw Data**

**Import Raw Assessment Data to AIM**

Note: To input data directly into the computer with a CCD scanner, click the Insert Record Icon. When finished scanning, select Re-Verify.

Page 1 of 1	08/17/2006	<b>Bar Code Assessment</b>	
SSN	Assess Date	Assess Criteria	Error Condition
0009900484	08/17/2006		[Adaptive Server Anywhere]No primary

Print Errors   Re-Verify   Delete Unverified

< Back   Next >   Cancel

23. Any error in scanned data will appear in the window. You may make corrections at this time by typing over incorrect information or deleting duplicate rows (See the error message interpretation in the next step). If corrections are made, select the **Re-Verify** button. If no corrections are made, and an error report is desired, **click the Print Errors** button.

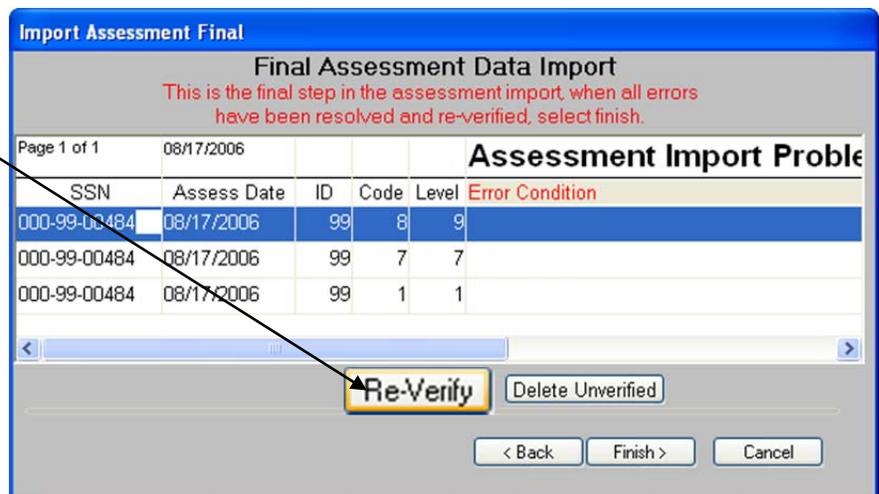
24. Though the Error messages may seem daunting, they can be very easily interpreted. Simply skip over the words “[Adaptive Server Anywhere]” and look at the message following (you will need to scroll to the right to read the entire message): the most common messages have the meanings as follows:

Error Condition says...	Interpretation...
no primary key value for foreign key 'id_choice' in table 'assessment_interim'	The code is wrong in the <b>Assess Criteria</b> column. The most common error is either a blank line, or the Q's and A's are lower case, instead of upper case (To scan them in Upper Case, TURN OFF Caps Lock.)
no primary key value for foreign key 'client' in table 'assessment_interim'	The <b>SSN</b> for the client is incorrect. There is no such SSN for any client in the database.
primary key value for table 'assessment_interim' <b>is not unique</b>	That particular Assessment Answer for that particular client on that particular date <b>ALREADY exists</b> in that client's assessment. Either you scanned the same bar-code twice, or if you have lots of these messages, then that client has an assessment for that date in the already in the system.

25. Try to correct the data, if possible. If any remaining data cannot be corrected, you may delete it by **clicking** on the **Delete Unverified** button.

26. Once there are no more rows showing, Click **Next**.

27. On the **Final Assessment Data Import** screen, you will see all your rows of verified data, again, in a slightly different format. Don't make changes from this screen. Just **Click Re-Verify**.



28. One by one, the rows will again disappear. At this point, it is possible you will again get error messages. If you do, the screen will jump back to the bar-code scanning screen, where you can correct or delete the erroneous rows. Once you have Re-Verified the corrected rows and deleted any left over rows, you will be returned to the **Final Assessment Data Import** screen.
29. **Click Re-Verify** again and all the remaining rows should disappear.

Import Assessment Final

**Final Assessment Data Import**  
 This is the final step in the assessment import when all errors have been resolved and re-verified, select finish.

Page 1 of 1      08/17/2006      **Assessment Import Problem**

SSN	Assess Date	ID	Code	Level	Error Condition

Re-Verify      Delete Unverified

< Back      **Finish >**      Cancel

30. **Click the Finish** button.
31. The **Import Assessment** window will disappear and you be back to a blank **AIM** screen.
32. To check the assessment you entered, you can run the **LG52** report "Data for a Single Client." (See **Chapter X**, for how to run different reports.)