H&H Care SA Pty Ltd	**Form05.** Client Assessment and Home Risk Assessment **Australian Government Support at Home Program**	
Doc No: Form05	**Version No: 01**	**Version Date: 24/10/2026**

Policy and procedure 5
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA assesses client needs, strengths and goals, identifies risks in the home and agrees practical controls before and during care. It supports safe, respectful services while protecting client choice and worker safety.

Document control	Details
Policy number	HH SAH ASSESS 005
Version and status	1.0 — Draft for Director approval
Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Huy Le, Director — signature: _____
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Managers, coordinators, nurses, workers and approved contractors assessing or providing home services

1 Purpose and scope

Assessment identifies what matters to the client, what the person can do independently, what assistance is needed and how the approved service can be delivered safely. The home is the client's private space and also a workplace during service delivery. Consult the client and workers when assessing hazards and choosing controls.

This policy applies to Support at Home services delivered on behalf of The Fig Trees and other separately approved registered providers. H&H Care's service assessment does not replace the government aged care needs assessment or determine funding eligibility. Specialist clinical, functional, building or electrical assessments must be completed by appropriately qualified people.

2 Responsibilities

The Coordinator obtains existing plans, assigns a competent assessor, coordinates the home assessment and records outstanding actions. The Clinical Lead RN assesses or arranges review of clinical needs, sets clinical escalation instructions within scope and confirms nursing readiness. Workers identify changes and perform a brief safety check each visit. The Director ensures resources, consultation, oversight and safe service decisions.

Agree in writing with the registered provider who undertakes each assessment, approves plan changes, arranges equipment and follows up referrals. The registered provider retains its statutory responsibilities. H&H Care remains accountable for its own service and WHS duties; responsibilities cannot be transferred simply by asking a client or family to sign a form.

Assessment preparation and client participation

3 When assessment is required

Complete a pre-visit risk screen before the initial assessment visit. Obtain sufficient client and environmental information before relevant care begins, and verify the home conditions in person before affected tasks are performed. A staged start may cover only specifically authorised tasks with essential controls already in place, as described in Policy 4.

Reassess after deterioration, hospital discharge, falls or near misses, medication or transfer changes, new equipment, infection, changed household conditions, carer breakdown, concerns raised by the person or workers, or a change in service tasks. Review promptly after an incident; do not wait for an annual date.

4 Prepare and obtain consent

- Check referral and service authorisation, existing care and clinical plans, relevant assessments, known risks, communication preferences and emergency contacts. Confirm who will provide missing information.
- Contact the client, explain the purpose and limits of the assessment, obtain relevant consent and ask who they want involved. Verify any representative's authority. Arrange an interpreter or communication aids where needed.
- Ask about safe access, stairs, parking, animals, smoking, infectious illness, known violence or threats, equipment and utilities. Decide whether a joint visit, two workers or specialist attendance is needed.
- Agree the visit and assessor, establish lone-worker check-in and escalation arrangements, and ensure the assessor has necessary safety equipment. Do not enter an environment with an immediate uncontrolled threat.

5 Conduct a person centred assessment

Speak directly to the client. Ask about goals, routines, culture, dignity, preferred supports and what they want to continue doing independently. Explain observations and ask permission before examining rooms, equipment, medicines or personal belongings. Inspect only areas relevant to the service; do not photograph the home without an appropriate purpose and consent or other lawful basis.

Use discussion, observation and relevant existing records. Confirm information rather than assuming a referral is complete. Clearly distinguish observed facts, client reports and professional conclusions. Record strengths as well as needs. Do not diagnose outside professional scope or infer inability to decide from age, dementia, limited English or disagreement with staff.

Use validated screening tools when appropriate to the service and assessor's competence. Record the tool and version, result, interpretation and action. A screening score is not a diagnosis, a substitute for clinical judgement or a guarantee that the person is safe.

Client needs and clinical risks

6 Assessment domains

Domain	Assess and document proportionately to the service
Goals and independence	Client priorities, strengths, preferred routines, community connections, reablement opportunities and assistance the person wants.
Communication and decisions	Language, interpreter and sensory needs, communication aids, consent, chosen supporters and verified decision-making authority.
Daily activities and carers	Personal care, toileting, meals, cleaning, shopping, finances where relevant, informal support availability and carer strain.
Mobility and transfers	Walking, balance, falls history, bed/chair/toilet/shower transfers, weight bearing, prescribed aids, staffing and manual handling plan.
Health and medicines	Relevant diagnoses, allergies, deterioration signs, pain, medication role, current authorised instructions and clinical contacts.
Nutrition and swallowing	Appetite, intake, hydration, weight concerns, choking history and any prescribed texture, fluid or swallowing instructions.
Skin and continence	Pressure injury risk, wounds, skin concerns, continence, bowel issues, hygiene and relevant care plans.
Cognition and wellbeing	Usual cognition, changes from baseline, distress, mood, sleep, social isolation and safety concerns; seek clinical review when needed.
Specialised care	Condition-specific plans, nursing tasks, delegation, required monitoring, equipment and escalation for complex care.
Safety and emergencies	Safeguarding concerns, ability to seek help, emergency contacts, evacuation assistance, advance care documents where relevant and contingency support.

7 Clinical escalation and specialist referral

Report new or worsening clinical concerns promptly to the RN and registered provider; use emergency services for an emergency. Sudden confusion, suspected stroke, severe breathing difficulty, serious injury or active choking require urgent action under the emergency procedures. Do not leave urgent observations only in routine case notes.

Arrange relevant referrals through agreed pathways, for example GP or RN review, occupational therapy for transfers or equipment, physiotherapy for mobility, speech pathology for swallowing, or dietetic review for nutrition. Track referral acceptance, interim controls and outcomes. Workers must not independently change medication doses, prescribe exercises or alter food/fluid textures.

Home environment and worker safety

8 Home risk assessment domains

Area	Hazards and controls to consider
Approach and access	Uneven paths, steps, handrails, lighting, parking, gate entry, locked doors, keys and emergency access.
Living and work areas	Clutter, rugs, slippery floors, trailing cords, furniture stability, space for equipment and privacy during care.
Bathroom and toilet	Wet surfaces, access, shower equipment, grab rails, hot-water/scald risks and safe assistance. Do not improvise an unassessed transfer.
Bedroom and transfers	Bed height and access, hoist clearance, suitable sling, aid condition, prescribed transfer method and required number of workers.
Kitchen and food	Food hygiene, storage, safe meal preparation, spills, cooking appliances, burns and task-appropriate chemical storage.
Equipment and electricity	Visible damage, unsafe leads, charging, maintenance evidence and instructions. Isolate unsafe items; qualified people assess repairs.
Infection and waste	Hand hygiene facilities, exposure risks, PPE, cleaning, sharps, clinical waste and safe disposal arrangements.
Fire and utilities	Exits, fire hazards, smoke alarms, smoking or oxygen risks, heating/cooling, water/electricity outages and emergency arrangements.
People and animals	Uncontrolled animals, visitors, threats, aggression, intoxication, weapons concerns and domestic violence; plan safe contact and exit.
Lone work and transport	Check-ins, phone coverage, fatigue, safe departure, emergency backup, vehicle suitability and client mobility needs.
Environment and property	Heat, poor ventilation, mould, infestation, structural concerns, hoarding and hazardous substances; obtain specialist help as needed.

Use objective, respectful descriptions. A diagnosis, pet ownership or untidy home alone does not establish unacceptable risk. Record the actual hazard, exposure, possible harm and controls needed. Consult workers and other relevant duty holders, sharing only necessary information through lawful channels.

9 Safe task and equipment assessment

Before a transfer or equipment-dependent task, confirm the individual plan, current ability, suitable equipment, safe space and trained staff. A second worker does not automatically make a manual lift safe. Do not lift a person from the floor or use a hoist outside the approved plan and competence. Arrange an appropriate response and reassessment.

Workers may identify visible hazards but must not certify electrical, structural, plumbing or fire compliance outside competence. Do not alter the client's home, fit rails or repair equipment without consent, relevant approvals and qualified personnel. Confirm who organises and pays for changes; do not assume funding or H&H liability.

Risk controls escalation and review

10 Identify assess control and review

For each material risk, record who could be harmed and how; existing controls; likely severity and likelihood; additional controls; responsible person and due date; residual risk; and how effectiveness will be checked. Use H&H Care's internal risk matrix consistently, but act on obvious danger without waiting for a score.

First aim to eliminate exposure, such as removing an unnecessary hazardous task. If elimination is not reasonably practicable, minimise risk using suitable equipment or environmental changes, safe work methods, staffing, supervision and PPE as appropriate. Training and PPE alone must not be the default when stronger controls are reasonably practicable. Consult the client and workers and coordinate with relevant providers.

11 Internal risk rating and authority

Rate likelihood 1 Rare, 2 Unlikely, 3 Possible, 4 Likely or 5 Almost certain, considering the actual task and exposure. Rate consequence 1 Minor, 2 Moderate, 3 Serious, 4 Major or 5 Catastrophic, considering credible injury, illness or other harm. Multiply the ratings; record reasons. These are internal prioritisation categories, not validated clinical screening scores.

Score and level	Required response
1 to 4 Low	Coordinator confirms controls and monitors at routine review.
5 to 9 Medium	Coordinator assigns actions and deadlines; obtain RN input for clinical risk. Start only where current controls make the task safe.
10 to 16 High	Notify manager immediately; RN review for clinical risk. Pause the affected task unless effective controls are verified and manager authorises a safe, defined alternative.
17 to 25 Extreme	Stop or do not commence the affected task, protect people and notify management immediately. Emergency help where needed; resume only after controls reduce risk and appropriate management and clinical approval.

Any immediate serious threat overrides a low numeric score. No person may approve an unlawful task, disregard professional limits or accept uncontrolled worker risk. Record initial and residual ratings separately; changing the number without implementing controls is not risk reduction.

12 Choice refusal and unresolved risks

Discuss risks, benefits and less restrictive options with the client. Respect supported, informed decisions and document their wishes and any refusal of assessment or modification. A risk acknowledgement does not waive rights or duty of care. If needed controls are declined, escalate to management and the registered provider, explain service implications and explore safe alternatives. Maintain essential care continuity and avoid abrupt abandonment. This policy does not authorise restraint or substitute consent.

Set an action-specific review date. As internal controls, check high-risk actions before the next affected task, review unresolved risks at least monthly and perform a full scheduled reassessment at least annually, sooner for higher need or a trigger event. Update the care plan and worker instructions and confirm that workers receive important changes before the next affected visit.

Client assessment summary form

ASSESS F01 | Use with existing assessments and the approved care plan. Expand fields as needed. Do not use this form as a substitute for specialist assessments.

Client name: _____ Identifier: _____
Address: _____
Assessment date: _____ Assessor and role: _____
Registered provider and contact: _____
Assessment reason: Initial / Review / Change / Incident / Other: _____

Client consent and participation: _____
Language or communication support: _____
Supporter and verified authority if relevant: _____

Domain	Strengths needs risks and actions
Goals and preferences	_____ _____
Daily living and carer support	_____ _____
Mobility transfers and falls	_____ _____
Health medicines and pain	_____ _____
Nutrition swallowing and hydration	_____ _____
Skin continence and bowel care	_____ _____
Cognition wellbeing and safeguarding	_____ _____
Clinical plans and equipment	_____ _____
Emergency and contingency support	_____ _____

Sources and assessment tools used: _____
Specialist referrals and interim controls: _____
Missing information and owner: _____
Care plan changes required and person notified: _____

Assessor signature: _____ RN review if needed: _____
Client involvement or disagreement recorded: _____
Review date and earlier triggers: _____

Home assessment and risk control record

ASSESS F02 | One home checklist plus an action record for each material risk. Record evidence and reasons for any item not assessed.

Client: _____ Address: _____
Date: _____ Assessor: _____ Client consent: _____
Workers or others consulted: _____

Area	Safe for task or action reference
Access lighting paths and exits	_____
Floors clutter space and furniture	_____
Bathroom hot water and shower aids	_____
Bedroom transfer area and equipment	_____
Kitchen food and chemicals	_____
Electricity equipment and utilities	_____
Infection cleaning waste and sharps	_____
Fire smoking oxygen and temperature	_____
People pets threats and lone work	_____
Transport and emergency arrangements	_____

Individual risk action record

Risk reference and affected task: _____
Hazard and who may be harmed: _____
Client goals and views: _____
Existing controls: _____
Initial likelihood ___ x consequence ___ = score ___ Level: _____
Further controls and interim arrangements: _____
_____
Action owner: _____ Due date: _____
Implementation evidence: _____
Residual likelihood ___ x consequence ___ = score ___ Level: _____
Task permitted or paused and limitations: _____
Manager approval and date: _____
RN review where clinical: _____
Registered provider notified and time: _____
Workers informed and instruction version: _____
Review date and effectiveness evidence: _____

Attach additional action records for other risks. Verify controls in practice before resuming a paused task; do not rely on a signature alone.

Implementation records and references

13 Records and communication

Keep client assessments, specialist advice, home risk checklists and action records in the controlled client file. Record date, assessor role, sources, consent, limitations, findings, agreed actions and client involvement. Share relevant findings with the client and registered provider and communicate task-specific controls to workers through approved systems. Protect confidential family, clinical and worker information under Policy 3.

Where a referral or modification is outstanding, record the interim care arrangement, responsible person, due date and escalation point. Do not close an action merely because an email was sent. Confirm the control was implemented and that it works. Report incidents and near misses through the incident system as well as updating the assessment.

14 Implementation and quality assurance

Before approval, appoint competent assessors, confirm the RN and specialist referral pathways, agree assessment responsibilities with The Fig Trees, approve the internal matrix and forms, and train workers in pre-visit and dynamic safety checks. Match assessment tools to the service and workforce competence.

At each visit, workers check for material changes, including the person's condition, transfer ability, hazards, equipment and household risks. Pause affected tasks and contact the Coordinator when controls no longer work. As internal controls, management reviews outstanding high-risk actions monthly and audits a risk-based sample of assessments quarterly. Seek client and worker feedback and verify corrective action outcomes.

15 Related documents and references

Related documents: Policies 1 to 4; care planning; falls and manual handling; clinical governance; medication; infection prevention; WHS and lone work; emergency continuity; safeguarding; incident reporting; equipment and records procedures.

- Aged Care Act 2024 and Aged Care Rules 2025, including the Statement of Rights and Code of Conduct; applicable strengthened Quality Standards, especially assessment and planning and the environment.
- Aged Care Quality and Safety Commission — Outcome 3.1 Assessment and planning. https://www.agedcarequality.gov.au/strengthened-quality-standards/care-and-services/assessment-and-planning
- Safe Work Australia — Health care and social assistance managing risks. https://www.safeworkaustralia.gov.au/safety-topic/industry-and-business/health-care-and-social-assistance/managing-risks
- Safe Work Australia — Work environment hazards. https://www.safeworkaustralia.gov.au/book/health-care-and-social-assistance/hazards-risks-and-controls/work-environment-hazards
- Work Health and Safety Act 2012 (SA) and Work Health and Safety Regulations 2012 (SA); applicable professional standards; The Fig Trees brokerage agreement and current approved variations.

Official guidance checked on 24 October 2026. National WHS guidance assists practice; apply South Australian legal requirements and obtain specialist advice where necessary.

Approval signature: _____ Effective date: _____
Next policy review: _____

Version 1.0 — Initial draft prepared 24 October 2026. Approval and implementation remain to be completed.