The FACE Assessment

The Lotus Notes ASCC system includes a version of the FACE Overview Assessment. For the purposes of this guidance this will be termed the FACE form. The FACE form is available in addition to the Needs Assessment.

Generally speaking as at the time of writing – January 2009 – Older People’s teams use FACE assessment and disability teams use Needs Assessments (for more information on these see Guidance sheet 3 – Needs Assessments)

1. Background

Key Points – General

The FACE form is a relatively new form on Lotus Notes – it went live in April 2008. Most of the rest of the system dates from 2000

- A Care Plan can be created from the FACE form (the first time this happens on a case it will be blank apart from the needs identified, but for subsequent ones users will be invited to copy all the values from the previous one)

- You can create a Home Care or Home Meals order so long as a Needs Assessment or FACE form exists – the Needs Assessment or FACE form do not have to be fully filled in or completed.

- A case cannot be closed if a FACE form is in progress, and another Needs Assessment or FACE form cannot be created if one is already in progress.

- The FACE form appears below Needs Assessments in the view (but Care Plans created from a FACE form will follow other Care Plans in date order)

Key Points – Contents

- The form is based on the latest FACE version (5.1) – this differs from Word template version (3.1) staff are used to in the following ways:
  - There are individual detail lines in assessment sections
  - A Mental Capacity question has been added
  - Assistive Technology service has been added as an item

- RBKC management information has been added: e.g.
  - Assessment Decision
  - Client offered SDS
  - User category etc

2. Creating the form

The form can be created in two ways:

- From the Referral – the user must select a Referral Outcome of “Request FACE Assessment”: 
They must also select the name team/worker who will be care coordinator.

- From within an ongoing episode – use the **FACE asst** button at top of screen:

  ![FACE asst button](image1.png)

  You won’t be able to do this if there is a Referral or Needs Assessment or FACE form **already in progress**.

If there is already a **completed** FACE form or a Needs Assessment during the episode the system will warn “Are you sure you want to create another Assessment form from within this episode?”

**Saving the Form**

You can save the form at any time (and come back to it). When the form has been created from within an ongoing episode – the user must have ensured the following fields have been entered before **Save** is allowed:

- Whether there has been **direct contact with the client** (and if Yes, the date).
- Whether the assessment is **hospital discharge related** or not
- The **team** and **name** of worker completing the assessment (usually autofilled but you may need to add one or both of these if not)

**3. Form Content**

**Prefers to be known as**. Self explanatory. May relate to either surname or forename, or both.

**NHS number** – this updates the Basic Information Sheet on the case, and vice versa.

**Address section** – this can be updated if the address is wrong, please see the separate **Guidance Sheet 2c - Using Quick Address**. Note that the Quick Address section does NOT appear when the FACE form is printed out.

Information in the personal details section below the address is “populated” from what was put on the referral. **You can change the information here if it is wrong** or **add information if it was not added or known at the referral stage**. The updated information will then ripple back to the Basic Information Sheet and any other new documents.

**The equality information** (i.e. ethnicity, first language etc) **now becomes mandatory if it was not added earlier**. Note that the equalities information does not appear on the needs assessment when printed out.
**Location of Assessment.** Record where the assessment took place.

**Have you had direct contact with the person being assessed (or their representative)?** You should by now have had direct contact with the client so please enter Yes and then enter the **Date of client contact** and the **Type**.

**Brief Description of Person’s Presenting Problems, Difficulties or Concerns.** Fill in as required.

**Relevant Personal History.** Fill in as required.

**Cultural/Spiritual Issues and/or Personal Preferences Relevant to Assessment.** Fill in as required.

**Formal Care/Support Currently Received section** – this is not mandatory BUT if any item is “checked”, then text must be entered, and vice versa:

<table>
<thead>
<tr>
<th>Formal Care/Support Currently Received (frequency, nature)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Nurse/community matron</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>X</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
</tr>
</tbody>
</table>

Text must be entered here as the **Occupational therapy** field has been checked.

**HOW TO FILL IN THE REST OF THE FORM**

Most of the rest of the FACE form (**Communication, Physical Well Being, Psychological Well Being, Medication, Activities of Daily Living, Interpersonal Relationships, Social Circumstances**) is split into sections.

These sections have a series of **Detail value fields**, and **Supporting text fields**. There is also an **Overall value field** in the heading question:

For all of these sections some basic rules apply:

- All of the **Detail values** are pre-set to **No** (meaning there is no problem). This can be changed – your options are:
  - **Y** There is a problem or need
  - **NO** There is no problem or need
Important note about these Yes and No questions: Y means there is a problem, No means there is not. This may seem obvious, but to make this clear, taking Routine Health Screening as an example - if Y is entered it means there is a problem associated with this issue, some area that needs to be addressed – it does not mean they have physically had a screening.

- If a detail value of Y or ? is entered, supporting text must also be entered,
- If a detail value of No, N/K, N/A or U is entered, supporting text can be entered but is optional
- The other way round is also true - if supporting text is entered, a detail value associated with that text must also be entered:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>No</th>
<th>?</th>
<th>N/K</th>
<th>N/A</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allergic to nuts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- It is always mandatory to enter a value in the Overall field (When you click the Check Form button it will check for this). These values are: Y, NO, ?, N/K, N/A, U

You must decide on the appropriate overall value for an assessment section, depending on the prevalence/importance of the detail values (Y, No, N/K, N/A or U) you have entered (e.g. if any of the detail values are Y, you may decide to set the overall value as Y, on the other hand, even if some of the detail values are set to Y you may decide to set the overall value to N as the sum total of the details do not add up to a significant overall problem)

- If detail lines do not capture the specific information you want to record, or you want to enter a more holistic description, you can also add data to the Additional Comments field at the bottom of each assessment section.

Note: as the FACE form is likely to be shared with Health colleagues, please record detailed information where it is known – and do not just refer the reader to the Additional Comments fields.

These Additional Comments fields allow text “formatting” such as underlining, bold, italic, combinations of these things, different text sizes and tables etc):
These text styles can be accessed either by clicking the relevant buttons on the menu bar:

Or by clicking the Text option on the menu list at the top of the screen:

Then clicking the top option Text Properties and selecting the relevant feature:

Use these features carefully though as the form can look messy if too many styles are used.

**Note** that if a new FACE form is created and you opt to carry forward the information from the previous one, these styles (but not the text itself) will be lost in the new form and will need to be reapplied

**SPECIFIC AREAS ON THE FORM**

**Carers section**

There are extensive carer sections on the form. The form allows details of two carers to be added if required.

**General points on how to fill the carer section/s in**

- If you say there is **NO** carer – carer sections are hidden
- If you say there is **IS** a carer – the carer section is (mostly) mandatory
- If the carer is not present or able to provide their perspective – please record words to that effect in mandatory text fields
● If the carer is NOT having a Joint assessment, the Joint assessment section is hidden (but otherwise is mandatory)

● If you say there is NO other/additional carer, additional carer sections are hidden – if YES the section expands as for a first carer, above.

● You are asked the Carer’s assessment preference – Joint, Separate or Declined. If they are having a Joint or Separate assessment, a Carer Assessment document will be created when the FACE is completed. This is the same functionality as currently with the Needs Assessment.

● If you have said there are two carers, and both are having either Joint or Separate assessment – two Carer Assessment documents will be created (they will pick up the different carer names/details etc).

● You can create a Carer Assessment for a third or more carers by simply creating the document from Additional Documents.

● The carer advice/services section on the FACE form is not mandatory – this information must be entered on the Carer Assessment document

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**CARER ASSESSMENT FLOWCHART**

- **Is there a Carer?**
  - **Yes**
    - Complete mandatory Carer details, carer role etc
    - **Carer’s asst preference?**
      - **Joint**
        - Complete mandatory Carer needs/concerns etc
        - Complete the rest of the FACE form
        - Carer Assessment document created on completion of FACE - to record services
      - **Declined**
        - End of carer recording
  - **No**
    - Section disappears
**Assessment Summary – Risks Arising section**

- Enter a score and explanatory text for risks identified during assessment.
- You **do not** need to refer to FACS categories or FACS levels in this section.
- Scores/text entered in this section should reflect and summarise the assessment detail recorded in the body of the form.
- It is mandatory (Check Form button will flag this) to enter **at least one completed risk line** (unless Assessment Decision is Close – Assessment not Completed).
- The **Risks Arising** section replaces the need to complete a separate Risk Matrix - however, you will still need to complete a FACE Risk Profile if the Risks Arising section identifies significant or greater risk (scored 2 or above).

**Health & Social Care Needs section**

- Practitioners should list the areas where the client needs support in order to manage the risks identified in the Assessment Summary.
- If required, more lines can be created by checking the **Show lines 7-12 below** button:

<table>
<thead>
<tr>
<th>Health and Social Care Needs</th>
<th>Need Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Each area needing support must be assigned a Needs (FACS) category, and a FACS level.
- The system automatically indicates whether this FACS level is eligible for support (NB: if FACS level is lower than agreed threshold for support, but intervention is agreed with your manager for prevention purposes, it can still be recorded and carried over to the Care Plan).
- It is mandatory (Check Form button will flag this) to enter **at least one completed need line** (unless Assessment Decision is Close – Assessment not Completed).
- The 'Need Detail’ text will carry forward into the Care Plan created from the FACE form, even if the Need is categorised as “Low” in terms of FACS level.
- You can enter needs that are going to be met by others or unmet here, and then just move them to the appropriate section of the Care Plan when that has been created.
- The questions on support managing **Long Term Condition**, **Self Directed Support** and **Continuing Care** are mandatory and the Check Form button will check for them.

**Consent section**

- This section is mandatory (Check Form button will flag this).
- It is also mandatory that a **Confidentiality Table** has been completed for the client before the FACE form can be completed.
If you indicate that there is a restriction to sharing information on the FACE form, you will be prompted to update the Confidentiality Table.

**Assessment Decision section**

- All fields apart from secondary diagnosis are mandatory
- The **Overall FACS level** is automatically calculated (when the form is saved), taking the highest level recorded in Health & Social Care Needs section above.

**Miscellaneous** (none of these are mandatory)

- There is scope to record **Further Action** if required.
- There is scope to enter other assessors in **Record of Completion**
- There is scope to enter where/when copies have been sent
- There is scope to reference other assessments/observations of relevance to the assessment

**4. Creating a Care Plan**

- The first Care Plan from a FACE form will only be populated with **need** details, but subsequent Care Plans will give the option whether to carry over all the values from the previous Care Plan details.

- The Care Plan will appear in date order with any other Care Plans created within the episode.

**5. Creating an attachable file for eSAP**

- To create an attachment which may then be pinned to an eSAP Overview Assessment on eSAP (if you use this system):

With the FACE form open, or by highlighting the document in the **A-Z** or **By Team/Wkr** view, click the **Print** icon:

![Print button](image)

On the resulting window **DO NOT** click OK, but click the **Printer** button:

![Printer button](image)

From the list of printers displayed select **Microsoft Office Document Image Writer** and click **OK**:
Then back on the original box click **OK** again:

A new box will appear asking you to save the document and suggesting a name:

Choose where to save the document and either keep the suggested name or enter a new one and then click the **Save** button.

The document will then appear on screen for information, it may closed by clicking the top right **X**.

Go into **eSAP** and attach the document as normal.

**Tip!** This does in fact work for **ANY** Lotus Notes document, not just the FACE form.

### 6. Care Plan Review Form – copy and pasting from the FACE form

When a Review is created you might find it handy to copy needs or other information from the FACE form. To do so:

Have the completed FACE form open on screen **but do not have it in edit mode** (i.e. **don’t** click the Edit button).

Click the **ASCC Live - User A-Z** button on the screen bar at the top of the screen:

Go to the most recent Care Plan for the person, open it and create the Review.
Click on the FACE assessment button on the screen bar at the top:

Highlight the fields you want to copy by clicking and dragging – the text will be marked in a dark colour:

<table>
<thead>
<tr>
<th>Health and Social Care Needs</th>
<th>FAC</th>
<th>Eligible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health &amp; Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs. Abrahamson needs the assistance of two nurses plus a high level of personal care needs, to include washing, dressing, feeding needs, transfers, pressure area care, and assistance with the administration of her medication. Critical Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs. Abrahamson needs access to Kosher meals - Substantial risk</td>
<td>Substantial</td>
<td></td>
</tr>
<tr>
<td><strong>Health &amp; Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs. Abrahamson needs assistance with all aspects of practical care - Substantial risk</td>
<td>Substantial</td>
<td></td>
</tr>
</tbody>
</table>

**Copy** the text using **Ctrl-C** or the **Copy** button on the tool bar, or right clicking on the text and selecting **copy**.

Click on the Review button on the screen bar at the top of the screen:

Go to the field on the document where you want to paste the text and make sure your cursor is in the field, then either do **Ctrl-V** to paste, or select **Paste** from the menu bar at the top of the screen, or right click in the field and select **paste**. The text will appear:

<table>
<thead>
<tr>
<th>The reason for the success/failure of the care package</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need Category</strong></td>
</tr>
<tr>
<td>Health &amp; Safety</td>
</tr>
<tr>
<td>Autonomy</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
</tr>
</tbody>
</table>

The text in these copied sections can now be amended if required:
<table>
<thead>
<tr>
<th>Need detail</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Abrahamson needs the assistance of two carers plus a hoist with all</td>
<td></td>
</tr>
<tr>
<td>personal care needs, to include washing, dressing, toileting needs,</td>
<td></td>
</tr>
<tr>
<td>transfers, pressure area care, and assistance with the administration of</td>
<td></td>
</tr>
<tr>
<td>her medication. Critical Risk</td>
<td></td>
</tr>
<tr>
<td>At review, it is felt that this has generally worked well</td>
<td></td>
</tr>
</tbody>
</table>