B Assessment tools

B.1 Introduction

As set out in Chapter 7, there is no universally agreed tool for assessing the care and support needs of individuals. There is however, reasonable consensus about the attributes that any assessment tool must have. These include validity, reliability and rigour.

This appendix provides further detail on the suite of assessment tools currently in use, including information about their reliability and validity.

The appendix begins by briefly reviewing the concepts and measurement of validity and reliability, and the pitfalls associated with their interpretation (section B.2). Section B.3 discusses the assessment tools outlined in table 7.1 in greater detail.

B.2 Validity and reliability

Effective assessment tools must be both valid and reliable. It is important to examine these concepts closely because the various measures of the reliability and accuracy of different assessment tools may not be comparable and need to be interpreted carefully.

Reliability

A reliable measure is one that measures a construct consistently across time, individuals, and situations. A good measure should produce consistent results when the test is repeated within a reasonably short space of time and when different assessors use the instrument to assess the same individual.

Test-retest reliability

Test-retest reliability is used to assess the consistency of a test across time. It is measured by the correlation between results from tests administered to the same

group of people over two or more periods.[1] The test assumes the stability of the underlying phenomenon being measured and that the testing context is the same.

If these assumptions do not hold, a test-retest measure may reflect confounding factors, and fail itself to provide a reliable measure of reliability. For instance, differences in test-retest results might reflect use of trained assessors at one time and untrained ones at a later time; assessment with and without an observer; or tests that are sufficiently far apart in time that the measured phenomenon has changed (for example, tests of depression or anxiety could be expected to change over a 12 month period, while that would generally not be true for intelligence tests). Accordingly, if there are confounding factors, a low test-retest score may not indicate an intrinsically unreliable test.

Moreover, a high test-retest score may be obtained for a poorly performing test for two reasons.

First, the initial test may provide a poor measure of functioning, with later tests simply finding consistent, but equally poor measures. An example is provided in box 7.2. This would produce a high test-retest level, but have poor validity.

Second, a subsequent test may be highly correlated with an initial test, but nevertheless provide a very different average measure of functioning. As an illustration, suppose that functioning were measured on a scale of 1-10 and 5 people got the scores 2, 8, 6, 4 and 10 in the first test and the scores of 1, 4, 3, 2 and 5 on the second test. The correlation measure would be 1, and therefore an indicator of 'perfect' test-retest reliability, despite the fact that the average level of functioning among this group would have halved. The implication is that measures of test-retest reliability should consider changes in averages as well as correlation between successive measures.

Finally, a test may produce high test-retest scores in trials, but fail to achieve the same degree of consistency in its actual application in the field. This may reflect differences in the quality and capabilities of the assessors and the varying contexts in which the tests apply. Some tests may be less susceptible to this problem than others, but their superiority may not be evident in the empirical studies associated with the development of the tests.

[1] It is typically measured using the Pearson product-moment correlation coefficient. A coefficient of around 0.7 is often regarded as 'good'.

Inter-rater reliability

Inter-rater reliability measures the extent to which two different assessors (or raters) agree when assessing the various degrees of a person's functional capacity and support needs. It is important to the NDIS because assessments determine resource allocation — both in terms of aggregate amounts and in particular areas. Ideally, most of the differences in resources received by people would reflect differences between their underlying needs, and not differences between the assessors rating them. Low inter-rater reliability would result in inequity and inefficiency. It may also have adverse dynamic effects if assessors change their own ratings in response to perceptions of biased testing by other assessors — with the result being excessive and misdirected resourcing. Poor inter-rater reliability would lead to significant scheme inefficiencies.

Low inter-rater reliability could arise because of particular weaknesses in a test (for example, due to many subjective items). Or it could arise because facets of the implementation and oversight of tests are poor. For example, in the absence of audits it would be possible for an assessor to change a test score because it led to a better outcome for the rated party (for example, more resources).

Inter-rater reliability is usually tested by having several assessors rate the same group of people separately, and then examine the extent to which they give the same pattern and average of scores. Whereas correlation coefficients are the most common (if deficient) measure of test-retest reliability, there are many measures of inter-rater reliability (Cohen's Kappa, Krippendorff's alpha, generalisability coefficients, correlation coefficients and the intra-class correlation coefficient), each with different advantages and disadvantages. Unfortunately, not all studies report which instrument has been used or the exact context of the tests, which makes it difficult to make comprehensive comparisons between assessments of reliability between instruments.

A key question in considering inter-rater reliability measures is the use of the test. For example:

- a test may be used as a screen for entry into the NDIS. In that instance, regardless of formal measures of inter-rater reliability based on the components of the test, the key issue is inter-rater reliability for eligibility (either a yes or a no). It is not necessarily problematic if different assessors score specific components differently, if the decisions they reach are the same
- in the case of resource allocation, the test conclusion is not dichotomous. Instead, the tests seek to determine the amount and/or makeup of support packages. This represents a particular challenge for test instruments because

higher inter-rater reliability requires assessors to provide nearly equivalent assessments for each of the dimensions of the test. This is one reason why self-directed funding has efficiency benefits beyond those described in chapter 8. It is likely that inter-rater reliability is greater for total resource allocation, than it is for components of packages. However, many assessment instruments are not tested for their consistency in measuring budget allocations despite this being the most important facet of any arrangement that gives people with disabilities significant choice

- an assessment may assist a person with a disability to plan their lives and to specify their aspirations coherently (which is useful both to the people with disabilities and to scheme managers and DSOs). This can be a different goal from eligibility or resource allocation, which would have implications for the design of the instrument.

Validity

Validity is the extent to which a test measures what it claims to measure (Goodwin 2009). The key aspect of assessing validity is to pose the question: 'what is the tool for?' and ask whether it meets that purpose. Validity is not determined by a single statistic, but by extensive research that demonstrates the relationship between the test and that which it is intended to measure. There are a number of types of validity — content, construct and criterion.

Content validity:

When a test has content validity, the items on the test represent the entire range of possible items the test should cover. An illustration is a mathematics test that only tested people's arithmetic skills and no other essential mathematical skills. The tested activities would not cover all the domains relevant to assessment of mathematical skill, and would therefore lack content validity. In the area of disability, an assessment tool that failed to measure some important areas where supports could be necessary (say mobility aids or community access), would also lack content validity.

Criterion-related validity:

This relates to the capacity of an assessment tool to:

- accurately predict some future relevant behaviour (for instance, a 'work' test that provides an accurate prediction of a person's capacity to be employed in the future, or an IQ test that measures future academic success)

- meaningfully relate to some other measure of associated behaviour (for example, a work test should produce similar results to other measures of a person's work skills).

Construct Validity:

A test has construct validity if it truly measures some theoretical construct. For instance, an intelligence test would have construct validity if it measured a person's capacity for complex cognitive tasks and problem solving.

B.3 The range of assessment tools available

The Functional Independence Measure

The Functional Independence Measure (FIM) is an outcome measure of the severity of disability in adults. Used widely in rehabilitation settings, FIM is grouped into two areas, 'motor' and 'cognitive'. 'Motor' covers:

- *self care* eating, grooming, bathing, dressing, toileting
- *sphincter control* bladder management, bowel management
- *locomotion* walking, wheelchair use, using stairs
- *transfers* from or to a bed, chair, toilet, tub or shower.

'Cognition' covers:

- *communication* comprehension and expression
- *social cognition* social interaction, problem solving and memory.

In total, 18 activities of daily living are assessed. Each is rated on a seven point scale, ranging from fully dependent to independent with no aids.

The WeeFIM is a paediatric version of the FIM. It is very similar to the adult tool, although it differs in its scoring processes to take into account the child's developmental stages.

The FIM has good psychometric properties. FIM scores differentiate between disabilities and levels of severity of impairment, correlate with the time taken for care and correlate highly with the results of other relevant measures (McKintosh 2009). The FIM is intended to be administered by trained assessors, takes around 30 minutes to complete and has been found to have high rates of inter-rater and test-retest reliability (0.95) (Ottenbacher 1996).

The FIM has been used in several countries, including the US, Canada, France, Japan, Sweden and Germany. The FIM and Wee FIM are currently used by the NSW Lifetime Care and Support Authority.

Disability Support Training and Resource Tool

The Disability Support Training and Resource Tool (D-START) is a support needs measure. It is designed to assess the needs, capabilities and aspirations of adults with different types, levels and combinations of disabilities (though its developers intend to expand D-START to cover children). In addition to identifying current support needs, D-START is intended to highlight possible changing needs. D-START can be used for generating estimates of support needs for individual planning and resource allocation purposes.

The underlying structure of D-START is compatible with the ICF framework to ensure comprehensive coverage of life domains, which include:

- *medical and health supports* medication administration, treatments, seizures
- *supports for activities of daily living* encompassing
  - daily tasks such as dressing, eating and bathing
  - community and household tasks such as shopping, housework and community travel
  - recreation and leisure activities
  - day/night supervision
- *functional skills* communication skills, motor skills, interpersonal interactions, social/emotional skills and general tasks and demands
- *behaviour supports* the nature and intensity of supports required for problem behaviours
- *personal risk factors* personal characteristics that could place the person or others at risk such as personal vulnerability, household safety, community safety, cultural background, legal issues and life stage transitions
- *environmental factors* external factors impacting on the person's independence, participation and/or well being such as products and technology, attitudes, supports and relationships, services, systems and policies.

D-START is a hierarchical tool, featuring brief, standard and supplementary assessments for different support purposes (such as eligibility, funding, individual support planning and assessing outcomes). Moreover, the tool assesses only those support needs relevant to the individual (certain scales such as medical or behaviour

are not used if not relevant). The tool incorporates a functional abilities scale to refine support need estimates and control for 'gaming'.

Validity for D-START is supported by high correlations with other support need measures such as the Inventory for Client and Agency Planning (see later) and its capacity to discriminate between sub-groups in expected ways (such as across severity of impairment and single versus multiple disabilities). As the support need construct is an emerging one, measures of support need are relatively few for the purposes of establishing construct validity, so 'expert opinion' has also been used as a form of validation (Guscia et al. 2006, Thompson et al. 2002).

The standard form takes around 45-90 minutes to complete. The developers indicated that assessors should be trained to maximise accuracy. Test-retest reliabilities for subscales and total score range from 0.80 to 0.98, while inter-rater reliabilities for subscales and total score range from 0.56 to 0.98.

I-CAN

I-CAN is a system for identifying and classifying the support needs of people with disability based on the ICF framework. Rather than measure functioning, I-CAN is intended to measure the frequency and level of *support* that a person requires. According to its developers, I-CAN can be used for a range of purposes including support needs assessment, planning, resource allocation and to predict future costs.

I-CAN is structured around two themes, health and wellbeing and activities and participation, each comprising a number of domains (figure B.1)

I-CAN has demonstrated good reliability and validity in studies to date (Arnold et al. 2008). Domain scales effectively discriminated a range of intensities of support for people with various disabilities, with highest support needs generally recorded by individuals with multiple disabilities and ageing issues. However, early studies suggested correlations between I-CAN and adaptive behaviour scales were mixed.

I-CAN involves a slightly different approach to administration. Its developers note:

> I-CAN unites person-centred and strengths based principles, by allowing the individual to direct their own assessment, in collaboration with their circle of support … A [trained] I-CAN facilitator guides a semi-structured self assessment interview process.[2]

I-CAN has been shown to have inter-rater reliability ranging from 0.96 to 1.0, though this may be attributed to the group interview assessment process itself. Test-retest reliability ranged from -0.22 to 0.51 (measured at 1 and 2 years). Those

2 (I-CAN brochure accessed at http://www.i-can.org.au).

involved with the tools development note: 'Although these generally low and non significant results could indicate poor reliability, alternatively they may indicate sensitivity to real change' (Arnold et al, 2008).

One inquiry participant suggested that there were 'significant problems' with the tool's psychometric properties (sub. DR958, p. 33). However, the tool's developers note:

> Some of the critique provided … was based on early research on the first, second and third versions of the I‑CAN. We have now been implementing the fourth version of the I‑CAN for the last four years and recently developing and testing a brief version of the I‑CAN. The brief version of the I‑CAN is most likely more suited to the specific process of resource allocation than the full version. We apologise that the latest research for the full and brief versions of the I‑CAN has not yet been published or is commercial in confidence and not currently publically available. Hence aspects of the critique presented … may be due to the lack of information on which they were basing their critique …… More recent test‑retest data have been gathered over a much shorter time period, with promising results. (Centre for Disability Studies, sub. DR1055, p. 2)

According to the tool's developers, the full version of the I-CAN takes on average 70 minutes to administer, and the Brief I-CAN takes approximately half this time.

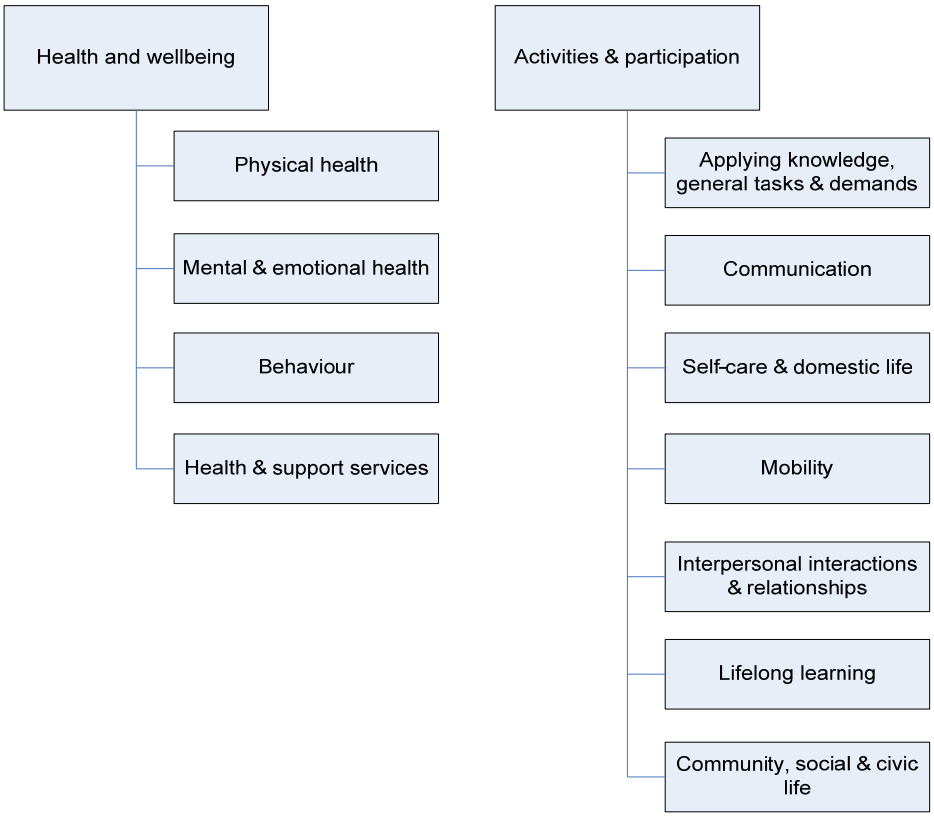
Supports Intensity Scale

The Supports Intensity Scale (SIS) is a support needs assessment designed to measure practical support requirements of adults with intellectual and developmental disabilities. It provides an objective measure of a person's need for support in medical, behavioural and life activities. Suggested uses for the SIS include individualised support planning, clinical judgements regarding support needs, resource allocation, and financial planning.

The SIS measures support requirements in 57 life activities and 28 behavioural and medical areas. Life activities encompass home living; community living; lifelong learning; employment; health and safety; social activities and protection and advocacy.

The scale ranks each activity according to frequency (such as none, at least once a month), amount (for example, none, less than 30 minutes), and type of support (monitoring, verbal gesturing). A supports intensity level is determined based on the 'total support needs index', which is a standard score generated from scores on all the items tested by the scale.

Figure B.1 **I-CAN domain structure**



Source: Arnold et al. (2008)

The developers indicated that the SIS should be administered by a professional who has completed a four year degree program and is working in the field of human services (for example, a case manager, a psychologist, or a social worker). The assessor consults with one or more people with a sound knowledge of the individual being assessed. According to the developers, the assessment process takes about one hour to complete, but can take longer if a broader range of people participate.

SIS is being used across the United States and in several other countries, including the Netherlands and Belgium. Test-retest coefficients ranged from 0.68 to 0.85 across the SIS subscales and was 0.84 for the total score (conducted after three weeks) (Morin and Cobigo 2008). Inter-rater reliability ranged from 0.51 to 0.92 across the subscales and was 0.90 for the total score (Thompson et al. 2008).

Inventory for Client and Agency Planning (ICAP)

ICAP provides information about what a person can or cannot do, as well as what type of help a person may need to go about their daily living. It can be used for determining eligibility, individualised planning, program and resource management

and statistical record keeping. ICAP can be used to assess the needs of people of all ages.

ICAP provides information on an individual's ability to function in the areas of motor, personal living, community living, and social and communication skills. Information is provided on an individual's maladaptive behaviour in a further eight areas — hurtful to self; hurtful to others; destructive to property; disruptive behaviour; unusual or repetitive habits; socially offensive behaviour; inattentive behaviour; and uncooperative behaviour.

Each item represents a statement of ability and is given a rating and associated score (does very well, does fairly well, does but not well, and never or rarely). Maladaptive behaviours are rated in terms of their frequency of occurrence and severity. Measures of adaptive and maladaptive behaviour are combined in a service score. ICAP also covers a number of other areas, including demographic information, diagnostic and functional status, residential placement, social and leisure activities, and daytime programs and support services.

According to the manual, the tool has good psychometric properties with both test-retest and inter-rater reliability for the service score of more than 0.80 to 0.90 (Harries 2005).

ICAP can be completed in approximately 20 minutes by a parent, teacher or care person who is well acquainted with the person being assessed. No specific training is recommended for its implementation other than self-study of the ICAP manual.

Service Need Assessment Profile (SNAP)

Developed in Australia, SNAP is designed to measure the support needs of individuals, with different disability types and levels of severity in accommodation and day support services. It generates an individual support profile that includes an allocated time, in hours per day, for providing support to the individual, and a night support rating (active, sleepover, or none required).

Assessments contain a series of statements to describe the support needs of individuals in relation to various aspects of daily living. The statements provide a description of the levels of support required, ranging from independence to full support. The scale measures 29 areas of functioning within 5 domains:

- *personal care* bathing, dressing, eating, meal preparation, household tasks, and self-protective skills
- *physical health* ambulation, health issues, incontinence, mobility, pressure care and epilepsy

- *behaviour support* type of behaviour, support requirements, behavioural risk, behavioural programs, and mental health issues
- *night support* safe practices, sleeping patterns, physical support needs, health and monitoring, and behavioural issues
- *social support* communication, social, leisure and money skills, day support requirements, skill development options and travel needs.

SNAP has been designed to allow primary carers to complete the assessment in the service setting. No specific detail is given in the SNAP manual with respect to training or who is best qualified to provide ratings other than the 'person completing the assessment must have a good knowledge of the individual being assessed'. The scale takes around 20 minutes to complete.

According to Guscia et al. (2006) construct and criterion validities were supported by high correlations with SIS, ICAP, and staff estimates of support needs, and by the tool's capacity to discriminate between sub-groups in expected ways. Guscia et al. (2005) report inter-rater reliability 0.61-0.91 and test-retest reliability 0.86-0.97.

SNAP has been used in New South Wales to guide the funding of accommodation and day support services and has been trialled by the South Australian Department for Families and Communities.

B.4 Some sample forms

To give people an idea of the scope of the assessment and planning process, this section includes some sample forms provided to the Commission by the NSW Lifetime care and Support Scheme. The people described below are fictitious, and any similarity to existing people is coincidental.

Sample Care Needs Assessment form

(fictitious person) Lifetime Care and Support Scheme NSW

1.1 PARTICIPANT'S DETAILS

Name	Peter	**LTCS no**	
Address			
Contact Name		**Contact Ph**	
Date of injury		**Date of birth**	

Diagnosis	☒ **TBI**	☒ **SCI** Level ASIA score	☒**Other** (specify)

CANS level*	--	
Incomplete SCI Attendant Care Assessment**	**ULMS** --	**Ambulation** --

1.2 CARE NEEDS ASSESSOR

Name	Cherish
Qualification	Various
Organisation	Best Practice SCIS
Days / hours available	Anytime **Ph**
E-mail	

1.3 LTCS COORDINATOR: Contact name xx

1.4 SCHEME PARTICIPATION STATUS

☐ **Interim**	**Date of end of interim participation period:**
☐ **Lifetime**	

For interim participants, services cannot extend beyond the interim participation period

1.5 ASSESSMENT & CARE DATES

Date of this assessment	16/10/2011	
Proposed dates of this care program (max 12 weeks for initial program)	**From** 10/04/2012	**To** 25/08/2012
Next review date (must be at least 3 weeks prior to expiration of proposed care period)	04/08/2012	
Previous approved care period	**From 07/11/2010**	**To 09/04/2011**
Previous approved paid care hours (per week/month)	**29 hours per week**	

1.6 ATTENDANT CARE PROVIDER

Has an attendant care provider been selected?

☒ **Yes** – specify provider **BetaP**
☐ **No** – has participant been provided with panel list? ☐ **Yes**
☐ **No**

Has this assessment been discussed with the care coordinator from the attendant care provider?

☐ **Yes** – name
☐ **No** – reason

1.7 OTHER OBJECTIVE MEASURES OR REPORTS ATTACHED

Details	Date
NIL	

***** Care and Needs Scale (CANS) must be completed and submitted with each Care Needs Assessment for all adult participants with brain injury

****** The Incomplete Spinal Cord Attendant Care Assessment must be completed for all participants who are ASIA C or D

2. WHAT IS THE PARTICIPANT'S CURRENT STATUS? *(Only complete this section if the care needs assessment is not being submitted with a Community Living Plan.)*

Current health and medical issues *(differentiate between accident and non-accident related health conditions or impairments)*

Current accommodation

☐ Own home / buying ☐ Private rental ☐ Public housing
☐ Other (specify)

Living arrangements

Non-injury related conditions

Care-related equipment

☐ Hoist
☐ Electric bed
☐ Respiratory
☐ Air mattress
☐ Other (specify)
☐ Communication devices
☐ Exercise equipment
☐ Power wheelchair
☐ Commode

Is this equipment in place at the participant's home? ☐ **Yes** ☐ **No**

If no, when will it be in place?

Pre accident information relevant to this assessment

3.1 Mobility

Transfers:		**Running:**	
Assessed:	Yes	Assessed:	No
Level of assistance:	None	Level of assistance:	--
Type:	--	Type:	--
Reason:	--	Reason:	--
Likely to improve:	--	Likely to improve:	--
Walking / using wheelchair:		**Other (specify):**	
Assessed:	Yes	Assessed:	--
Level of assistance:	Minimal	Level of assistance:	--
Type:	--	Type:	--
Reason:	--	Reason:	--
Likely to improve:	--	Likely to improve:	--
Climbing stairs:		**Bed mobility:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	None	Level of assistance:	None
Type:	--	Type:	--
Reason:	--	Reason:	--
Likely to improve:	--	Likely to improve:	--

Description of care needs:
Peter requires assistance with walking outdoors. He reports that he needs more self-belief to walk outdoors with carers without the use of an assistive technology. Has started walking with a walking stick with his therapist and is gaining confidence and balance skills

Currently a carer is on standby when Peter walks up and down his street and when going to appointments where he has to travel any distance from the car. (A parking permit has helped him greatly).

Rehabilitation goals:
To start walking outdoors with carers using a cane (with physiotherapy guidance). To start walking outdoors independently (using a graded program so the progress is realistic and safe). Needs special assistance to regain balance skills and to have appropriate posture while walking (currently slumps forward and is fearful)

3.2 Activities of Daily Living

Eating:		**Bathing:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	None	Level of assistance:	Moderate
Type:	--	Type:	Physical
Reason:	--	Reason:	Physical
Likely to improve:	--	Likely to improve:	No
Grooming:		**Dressing:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	Minimal	Level of assistance:	Moderate
Type:	--	Type:	Physical
Reason:	--	Reason:	Physical
Likely to improve:	--	Likely to improve:	--
Sleeping:		**Toileting:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	None	Level of assistance:	None
Type:	--	Type:	--
Reason:	--	Reason:	--
Likely to improve:	--	Likely to improve:	--
Managing medication:		**Other (specify):** bladder management	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	None	Level of assistance:	Minimal
Type:	--	Type:	Physical
Reason:	--	Reason:	Physical
Likely to improve:	--	Likely to improve:	Yes

Description of care needs:

Managing medication: Given cognitive impairments, needs carers to monitor the Webster pack to ensure all essential drugs are taken. Timing of prescribed doses are very important for adequate pain control and functioning

Bladder management: Needs daily assistance

.

Showering: Needs help with washing and drying his body (given weak arms limited ability to bend and reach his feet)

Dressing: Needs help with dressing and undressing (given above). Especial care needed to avoid pain and damage to skin

Handling objects: Requires assistance to move any heavier items (eg. a chair) or pick up larger things from the floor height (eg. a bag).

3.3 Instrumental Activities of Daily Living

Using telephone:		**Chores / housekeeping:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	None	Level of assistance:	Maximal
Type:	--	Type:	--
Reason:	--	Reason:	Physical
Likely to improve:	--	Likely to improve:	Possible
Shopping:		**Laundry:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	Moderate	Level of assistance:	Moderate
Type:	Physical	Type:	Physical
Reason:	Cognitive	Reason:	Physical
Likely to improve:	Possible	Likely to improve:	Possible
Food preparation:		**Transportation:**	
Assessed:	Yes	Assessed:	No
Level of assistance:	None	Level of assistance:	--
Type:	--	Type:	--
Reason:	--	Reason:	--
Likely to improve:	--	Likely to improve:	--
Money management:		**Computers / IT:**	
Assessed:	Yes	Assessed:	Yes
Level of assistance:	Minimal	Level of assistance:	None
Type:	--	Type:	--
Reason:	Multiple reasons	Reason:	--
Likely to improve:	Yes	Likely to improve:	Yes
Gardening:		**Other (specify):**	
Assessed:	Yes	Assessed:	--
Level of assistance:	Maximal	Level of assistance:	--
Type:	Physical	Type:	--
Reason:	Physical	Reason:	--
Likely to improve:	No	Likely to improve:	--

Description of care needs:

Shopping: Requires help to get to shops to buy food and essentials (including handling the basket/trolley, lifting heavy things into the trolley — such as a bag of rice – passing items to the shop assistant, and getting the basket/trolley to the car or bus.

Everyday jobs: Requires help with any cleaning tasks where coordination is important or where cleaning requires arm or leg strength (such as sweeping). Needs help to hang clothes on a wash line (and to retrieve them). Peter is learning how to hang some items, and the clothes line has been lowered to a more comfortable height to allow him to do so more easily. He can also hang some items on a simple wire frame indoors (but the frame must not be collapsible for OH&S reasons).

Transportation: Requires carer to provide transportation to attend appointments or visit shops.

Rehab Goals: To be able to get out and about by using public transport confidently and, over the long run, with vehicle modification and training, to obtain a driver's license. He

would like more autonomy in doing simple things, like cleaning, and needs to build up flexibility and strength so that this may be possible.

3.4 Participation

Consider: interpersonal skills, vocational activities, recreational activities / play, living in the community, family functioning, parenting skills, social interactions, day care / pre-school / school / work

Description of care needs:

Has travelled five times in the past two months to visit family in Mittagong and Picton with the assistance of his grandfather. He needs help to travel by car.

His desire to return to fishing with his friends has been put on hold, given his continued poor balance where the ground is uneven.

Return to bowling delayed due to greater leg pain, though is attending some social activities with his former club members (but needs assistance with travel). Some club members provide travel and support, but need to be contacted well in advance.

Supports required to attend medical and other appointments (eg. physiotherapist and psychologist) if Peter needs to walk any distance

4.0 Previous care goals

PREVIOUS CARE GOAL	DATE REVIEWED	OUTCOME RATING
ASSIST PETER PERFORM PERSONAL CARE TASKS WHERE HE REQUIRES STANDBY TO MODERATE ASSISTANCE, SUCH AS, SHOWERING, DRESSING AND UNDRESSING	11/01/2011	3
TO ASSIST PETER PERFORM DOMESTIC TASKS WHERE HE REQUIRES ASSISTANCE, SUCH AS SHOPPING AND CLEANING		3
TO ASSIST PETER GET OUT AND ABOUT IN HIS COMMUNITY, TO MEET HIS FRIENDS AND GO TO THE SHOPS		3
ENSURE BETTER POSTURE, BALANCE AND BODY STRENGTH THROUGH THE PHYSIOTHERAPY PROGRAM.		2

Outcome ratings 1 Goal not achieved 2 Goal partly achieved 3Goal achieved W Goal withdrawn

4.1 Current care goals

CARE GOALS RELATED TO THIS ASSESSMENT	NEXT REVIEW DATE
TO HELP PETER GAIN CONFIDENCE IN GOING OUT INTO THE COMMUNITY BY HIMSELF	08/06/2011
TO HELP PETER WALK FURTHER, WITHOUT AIDS AND WITHOUT FEAR	08/06/2011
TO HELP PETER ACCESS HIS COMMUNITY AND ATTEND SOCIAL AND LEISURE PURSUITS, SUCH AS DENTAL APPOINTMENTS, SUPERMARKET SHOPPING, GETTING TO THE BOWLING CLUB	08/06/2011
TO HELP PETER ACHIEVE HIS GOAL OF RETURNING TO INDEPENDENT DRIVING WITH SOME PREPARATORY CLASSES (BUT NO ACTUAL ON ROAD CAR USE UNTIL L5 ACHIEVEMENT TESTS HAVE BEEN PASSED). MIKE, HIS NEPHEW IS HELPING HIM HERE, SO SOME SUPPORT IN THIS AREA IS FREE	08/06/2011

5.0 Attendant care worker skills *(refer to documents: Matching client needs and support worker skills in the NSW Motor Accidents Scheme and ACiA Guideline 001 – Provision of Paid Attendant Care and Nursing in the Community)*

Skill	Required	Tasks for which required
Baseline support worker competencies	☒	Transport Peter for supermarket shopping once per week (His daugher Maria helps out once a week on her day off). Help with trips to classes and appointments
Injury related core support worker competencies	☒	Some skills in basic typing and computer use may aid job finding
Brain Injury specific support worker competencies	☐	
Spinal Cord Injury specific support worker competencies	☐	
Registered nurse	☒	Tasks vary, but once per month required
Other (specify):	☐	

5.1 Other important skills for attendant care workers (e*.g. ability to transport participant, language skills, experience with adolescents:*

Skills	Tasks for which required
Ability to transport Peter: drivers licence and vehicle required	Regularly take him to the supermarket and to local essential appointments. Must be able to allay Peter's concerns about travelling on the road (still has fears since accident)

5.2 Recommendations for participant focused training

List any essential training required that is unique to the participants needs (e.g. participant specific behaviour management techniques, physiotherapy program or use of specialised equipment).

Training required	Training hours per attendant care worker	Who will provide training? (eg OT, Physiotherapist)	Comments
Walking outdoors and walking aids	2.5 hours times 2 carers	Physiotherapist	
Fine motor (finger) skills	Once a week	Physiotherapist	For 4 weeks maximum, then reversion to software learning tool

5.3 Are there any tasks that require more than one attendant care worker?

☐ **Yes (specify below)** ☒**No**

5.4 Risk Factors

Please list any risk factors in relation to the provision of care that need to be considered. These may relate to participant or attendant care worker safety.

Peter can be fearful when travelling, and the carer must ensure he is calm at the start of any journey.

5.5 Approved travel *(travel in the attendant worker's car to meet treatment, rehabilitation & care needs)*

Task / activity requiring travel	Mode of transport	km or fares per week
As discussed above	Car/public transport	22 km
Other relevant information Direct bus to shops not available on Fridays		

6.0 Summary of overall care need

CARE NEEDS	HOURS	RECOMMENDED REVIEW DATE
TOTAL HRS OF UNPAID CARE PER WEEK	10	
TOTAL HRS OF PAID CARE PER WEEK	30 HOURS 29 PER WEEK ATTENDANT CARERS 1 HR PER WEEK FOR CLEANING	
TOTAL HRS OF CARE PER WEEK	30 HOURS PER WEEK	

6.1 Request for paid care

Care	Number	Frequency (month/week)
Attendant care worker (hours)	29 hours	week
Second attendant care worker (hours) (specify tasks in question 5.1)	0	
Inactive sleepover (number per week)	0	
Registered nurse (hours) (specify tasks in question 5.0)	1 hour	month
Approved travel (km or fares)	25 km maximum per week	27/03/2011

6.2 What alternatives to care have been considered?

6.3 Is the need for care likely to change? If so, when?

Peter is gaining confidence in his mobility and capacity to pick up objects. He may also be able to drive within the next 9 months. He will continue to need assistance in meeting his personal needs in the home, but overall hours of home support may be able to be reduced to 15 hours per week in 12 months time. Psychological therapies are required to give Peter the confidence to get out and about and CBT (up to the clinically approved limit) will be provided to do that over the next 3 months, with an effectiveness review at that time.

At the end of this care needs period this should be reviewed so that the care hours reflect these changes.

6.4 Other factors

7.0 ASSESSOR DECLARATION

Name | **Title**

Signature | **Date**

This assessment has been discussed with the participant and the participant has agreed to participate in the proposed Attendant Care program:

Yes ☐ **No** ☐

If no, please briefly outline why the participant does not agree with the request.

Plan Period From: To:

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	Tasks & who will provide the care	Tasks & who will provide the care	Tasks & who will provide the care	Tasks & who will provide the care	Tasks & who will provide the care	Tasks & who will provide the care	Tasks & who will provide the care
Week 1							
Week 2							
Week 3							
Week 4							
Kms / fares							
Total hours of paid care per day							

Plan Period From: To:

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
	Tasks & who will provide the care	**Tasks & who will provide the care**	**Tasks & who will provide the care**	**Tasks & who will provide the care**	**Tasks & who will provide the care**	**Tasks & who will provide the care**	**Tasks & who will provide the care**
early morning	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)	7am to 8am Help get out of bed, shower, dress, clean bathroom, make bed, put dirty clothes and linen in washing machine (Peter can help)
morning	8am to 9.30am. Help with physio exercises and 30 minute walk up the street and back, hanging out laundry and cleaning.	8am to 9.30am. Hydrotherapy class (attendant must bring swim suit and towel)	8am to 9.30am. Help with physio exercises and 30 minute walk up the street and back, hanging out laundry and cleaning.	8am to 9.30am. Help with physio exercises and 30 minute walk up the street and back, hanging out laundry and cleaning.	8am to 9.30am. Help with physio exercises and 30 minute walk up the street and back, hanging out laundry and cleaning.	8am to 9.30am. Help with physio exercises and 30 minute walk up the street and back, hanging out laundry and cleaning.	9am to 10am Assist with physio exercises and 30 minute walk around the block, making bed, hanging out laundry and other cleaning tasks.
lunch	9.30am to 12.00 Assist with shopping, more exercise (if not over – tired) attendance at appointment with CBT psychologist, dental repair, and/or physio as required. Bring in laundry, other cleaning tasks and some food preparation.		9.30am to 12.00 Assist with shopping, more exercise (if not over – tired) attendance at appointment with CBT psychologist, dental repair, and/or physio as required. Bring in laundry, other cleaning tasks and some food preparation.	9.30 to 12 Help to travel to and from bowling club		9.30am to 12.00 Assist with shopping, more exercise (if not over – tired) attendance at appointment with CBT psychologist, dental repair, and/or physio as required. Bring in laundry, other cleaning tasks and some food preparation.	
afternoon							

dinner							
evening	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with undressing, brushing teeth and getting into bed	8pm to 10pm Assist with settling for sleep, undressing and donning nightwear, grooming
night							
Kms / fares							
Total hrs of paid care per day	6hrs	6hrs	6hrs	6hrs	6hrs	6hrs	6hrs

Community Living Plan

Fictitious person (used for training purposes)

1.1 PARTICIPANT'S DETAILS

Name	John Silken	**LTCS no**	xxx
Address	xx		
Contact Name	AA	**Contact Ph**	xx
Date of injury	xxx	**Date of birth**	xx

Diagnosis	☒ **TBI**	☐ **SCI** Level ASIA score	☐ **Other** (specify)

CANS level*	3	**FIM/weeFIM*** (most recent)	-

1.2 PLAN DEVELOPED BY

Name	Jenny
Qualification	Speech Pathologist and Case Manager
Organisation	FBIS
Days / hours available	Mon-Fri
Ph	xxx
E-mail	

1.3 LTCS COORDINATOR: Contact name Karen De Juliis

1.4 PLAN DATES

Plan period 28/03/09 to 28/03/10

Next review date (must be at least 3 weeks prior to expiration of proposed plan period) xx

1.5 ATTACHMENTS

Forms attached: *(check relevant items)*
☐ **Equipment Request**
☐ **FIM/weeFIM*** ☐ **CANS***
☐ **Care Needs Assessment**
☐ **ASIA Scale**

Reports attached: *(please list any reports included with this plan)*

*Provide FIM/weeFIM for all participants. Provide CANS level for all participants with brain injury

2. WHAT IS THE PARTICIPANT'S CURRENT STATUS?

2.1 Current health conditions & impairments *(include any non-injury related health conditions or impairments)*

Health conditions: Sustained a severe TBI

Impairments
Physical: Bilateral instability of knee joints resulting in reduced walking endurance. John continues to experience fluctuations in his blood pressure and is awaiting a 24 hour heart monitor as recommended by his GP.

Behavioural: Interacts well and forms friendships easily.
Cognitive: Difficulties with memory, attention, reasoning, problem solving and impulse control. John is using his mobile phone for appointment reminders, a white board at home to assist with organisation and future planning, and support from his brother in planning, organising and carrying out weekly activities.

Psychological: John's brother reports some emotional upset and distress over the loss of friendships since his discharge home but John has not disclosed this himself. In recent discussions, John reported feeling positive about his decision to change his future and reported feeling OK about losing the friends who have not stood by him. He indicated he has strong friendships with several people who he previously associated with. These people know of his brain injury and reportedly support him. He wants to get a job again.

2.2 Living arrangements

John is now living in a Department of Housing property with his brother. The property is a 3 bedroom house with a yard and is close to public transport. The property is generally suited to his needs, but there is some risk of a fall when stepping over the bath and on the front steps which are worn unevenly and can be slippery when wet. An occupational therapy home assessment was conducted and a report with recommendations regarding home modifications was sent to Housing. According to John, they have installed a rail in his bathroom but have not installed a rail at the front steps

2.3 Current self management, mobility and activities of daily living

John is independent in self care and does not require equipment. He is independently mobile however he has reduced fitness. John uses his mobile phone to make appointments and set reminders. He continues to require his brother to oversee the organisation of appointments and is yet to hang the whiteboard at his new home to assist him in planning and organising his week.

2.4 Instrumental activities of daily living

John remains under the care of the protective commissioner for financial issues and the public guardian for accommodation, health care, medical and dental consents and services. John is independent in meal preparation, menu planning, light housekeeping, laundry, catching public transport and community access. His brother tends to do most of the cooking at home and assists John with grocery shopping as he is unable to carry heavy bags. John has indicated interest in investigating study options at TAFE and will be referred to the teacher consultant for neurological disabilities at the local TAFE to seek guidance and assistance in this goal. John has indicated the desire to look for employment in the near future, but is unsure of what he can physically and cognitively manage. I feel a vocational assessment through a vocational rehabilitation provider such as CRS would be beneficial to guide his future work goals.

2.5 Current participation in life roles

Housekeeping, leisure and participation in rehabilitation program. Study/work as above

2.6 Equipment used

☐ Hoist	☐ Communication devices
☐ Electric bed	☐ Exercise equipment
☐ Respiratory	☐ Power wheelchair
☐ Manual wheelchair	☐ Commode
☐ Air Johnress	☐ Other (specify)

3. GOALS OF THIS PLAN

Goal 1 **Outcome rating**

John will maximise his physical recovery by participating in a physiotherapy and exercise program		2
What steps need to be taken to achieve the goal?	**How & Who**	**Outcome rating**
John will attend hydrotherapy to improve fitness, confidence in the water, continue work on knee strength and provide social opportunities	John attended one term of Hydrotherapy	3
John will attend gym to improve strength, fitness, endurance and muscle bulk.	John attended an assessment, program development and several gym sessions but attendance was limited by distance once he moved house	2
John will continue outpatient physiotherapy through FBIS	John has attended physiotherapy as recommended. Progress report attached	3
Gym equipment to be requested in order to set up a some gym equipment in the third bedroom of John's new home.	Exercise Physiologist to recommend equipment for John's home and FBIS Case Manger to seek and submit quotes to LTCS	N
Exercise physiology assessment and home exercise program development	John will be referred to a local exercise physiologist to assess current functioning and exercise program needs	N

Outcome ratings

1 Goal / step not achieved
2 Goal / step partly achieved
3 Goal / step achieved
W Goal / step withdrawn
N New goal / step

Progress *(If a goal / step has not been achieved please outline why)*
John's attendance at the gym lessened once he moved from the boarding house in xx to the Department of Housing property in xx. In the new location, he was required to catch three forms of public transport to access the gym and the effort outweighed the benefits. We have been exploring the options for a local gym in the xx area. John's preference is for some home gym equipment where he can practice daily with no issues of access. John has decided he no longer wants to attend Hydrotherapy with FBIS, but prefers to work on his swimming and leg strength by swimming at the local swimming pool and by walking more. John has indicated he no longer feels comfortable attending the pool with a disability group and wants to be seen as normal. His physiotherapist reported limited home practice of exercises provided and does not feel further physiotherapy is needed at this stage. She feels a community or home exercise program would be beneficial and she recommends a review by physiotherapy in 4 weeks. An exercise physiologist was recommended by her to determine the most appropriate exercise equipment for the home.

Goal 2

Outcome rating

John will have an identified work or study goal for 2011 through a process of assessment of capabilities, interests, strengths and previous experience.	N

What steps need to be taken to achieve the goal?	**How & Who**	**Outcome rating**
John will undergo a repeat neuropsychological assessment to determine cognitive progress, current strengths and weaknesses and to guide future study, work and driving goals	referral to FBIS Psychologist	N
John will meet with teacher consultant for neuological disabilites at the local TAFE to learn more about courses of interest, entrance requirements and support options available for future study goals	FBIS Case Manager to refer to xx at local TAFE	N
John will undergo an initial assessment and vocational assessment with CRS to determine suitability for employment and assist him in identifying appropriate work goals	FBIS Case Manager to refer to CRS in xx for assessments	N
John will undergo a medical review with FBIS rehabilitation specialist to determine medical suitability for employment and driving	FBIS case manager to refer to xx at FBIS	N

Outcome ratings

1 Goal / step not achieved
2 Goal / step partly achieved
3 Goal / step achieved
W Goal / step withdrawn
N New goal / step

Progress (*If a goal / step has not been achieved please outline why)*

Goal 3

Outcome rating

John's new accomodation will be assessed to minimise any potential risks for falls or injury	N

What steps need to be taken to achieve the goal?	**How & Who**	**Outcome rating**
An Occupational Therapy home visit is recommended to determine the need for modifications to the existing property	Case manager to refer to FBIS Occuaptional Therapist xx to conduct the assessment and provide recommendations	N

Outcome ratings

1 Goal / step not achieved
2 Goal / step partly achieved
3 Goal / step achieved
W Goal / step withdrawn
N New goal / step

Progress *(If a goal / step has not been achieved please outline why)*
A home visit was conducted by John's case manager on xx and potential risks were identified. These risks included the tendency for John to hold onto the unstable shower screen when stepping into the bath, and uneven concrete steps at the front door which have no rail and are reported to be slippery when wet. A full Occupational Therapy assessment of the home is recommended.

Goal 4

Outcome rating

What steps need to be taken to achieve the goal?	How & Who	Outcome rating

Outcome ratings

1 Goal / step not achieved
2 Goal / step partly achieved
3 Goal / step achieved
W Goal / step withdrawn
N New goal / step

Progress *(If a goal / step has not been achieved please outline why)*

Copy and paste additional goals if required

4. ROLE OF THE CASE MANAGER

How will the case manager facilitate the participant achieving the goals in this plan?
* The case manager will continue meeting with John and his brother Peter to monitor progress, review community living plan goals and identify any changing needs or priorities. * To liaise with John's GP, protective office, public guardian, family, therapists, community services and medical specialists as required to ensure effective communication of progress and needs. *To identify any new rehabilitation needs as his program continues and to liaise with LTCS about these needs. * CM will accompany John to assessments at CRS and the meeting at TAFE to integrate information into next CLP and RTW or study plan

5. SERVICE PROVIDER DECLARATION

I have developed this plan in consultation with the participant.

Name	xx	**Title**	FBIS Speech Pathologist/Case Manager
Signature		**Date**	xx

This plan has been discussed with the participant and the participant agreed to participate:

Yes ☒ **No** ☐

If no, please briefly outline why the participant does not agree with the plan.

6. REQUEST FOR APPROVAL

List the recommended services, service providers, LTCS code, estimated hours and costs (including GST) including non-direct services such as provider travel.

Strategy (service type)	Service provider details	Code	Est hrs	Est cost (incl GST)
Physiotherapy review	FBIS Physio Dept	LTCS301	4 hrs	520
Occuaptional Therapy home assessment	FBIS –xx	LTCS102	3 hours	390
Exercise physiology assessment and recommendations re exercise equipment	xx	LTCS106	4 hours	520
Repeat Neuropsychological assessment	FBIS – xx	LTCS103	8 hours	1040
CRS initial assessment and vocational assessment (includes report)	CRS Local district	LTCS106	13 hours	1820 ($140/hr quoted by CRS)
FBIS Rehabilitation Specialist assessment	FBIS -xx	LTCS105	1 hour	225
FBIS case management	FBIS – xx	LTCS501	10 hours	1300
Reports Provider travel to client's home	FBIS case manager and OT	LTCS505 LTCS503	5 hours 2 hours	650 260
Total cost:				$6725