Allied Health Professions' Office of Queensland

COMMUNITY REHABILITATION Learner Guide

Work within a community rehabilitation environment

April 2017

Queensland Government

Community Rehabilitation Learner Guide – Work within a community rehabilitation environment

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An electronic version of this document is available at
https://www.health.qld.gov.au/ahwac/html/ahassist-modules/

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INTRODUCTION

Welcome to Work within a community rehabilitation environment.

This Learner Guide has been developed specifically for Allied Health Assistants (AHAs) to provide the necessary knowledge and foster the skills required to work with clients to support rehabilitation within the community.

The Learner Guide includes information on:

- working in community rehabilitation
- organisation practices
- holistic support

Throughout the guide, you will be given the opportunity to work through a number of activities, which will reinforce your learning and help you improve your communication and organisation skills, manual handling skills and ability to apply therapeutic exercise practices. Take time to reflect during the module on how you may be able to apply your new knowledge and skills in your role as an allied health assistant.

Learning requirements

It is important that you have an allied health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay “on track”, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials. This will be particularly important if you are having any specific learning difficulties.

Activities and assessment tasks may require access to the internet. If you do not have internet access please talk with your supervisor about your options.

Self-Completion Checklist

The Self Completion Checklist outlines the underpinning knowledge and skills contained in each of the topics for the unit of competency you will be assessed against. You will be asked to review the list and place a tick in the box if you feel you have covered this information in each section and if you feel ready to undertake further assessment. If you have any questions about this checklist, ask your supervisor.

Recognition for Prior Learning

If you subsequently enrol in the Certificate IV in Allied Health Assistance you may be able to undertake recognition assessment for the study that you have done. To enable you to gain recognition for the learning you have undertaken in this Learner Guide, it will be necessary for you to complete the Assessment Guide associated with this unit of competency. The assessment activities in this Assessment Guide must be signed off

by your supervisor**.** Copies (Word version) of the Assessment Guide can be obtained by contacting the AHPOQ team via e-mail AH_CETU@health.qld.gov.au

Please Note

Due to the varied environments in which allied health assistance is carried out, the terms 'patient' and 'client' are used interchangeably throughout this resource. Please use your organisation's preferred term when performing your duties.

Symbols

The following symbols are used throughout this Learner Guide.

Important Points – this will include information that is most relevant to you; statistics, specific information or examples applicable to the workplace.

Activities – these will require you to reflect on information and workplace requirements, talk with other learners, and participate in a role play or other simulated workplace task. You may use the space provided in the Learner Guide to write down a draft response. Record your final answer in the Assessment Guide.

Further Information – this will include information that may help you refer to other topics, complete activities, locate websites and resources or direct you to additional information located in the appendices.

Case Studies – these will include situations or problems for you to work through either on your own or as a group. They may be used as a framework for exploration of a particular topic.

Research – this refers to information that will assist you complete activities or assessment tasks, or additional research you may choose to undertake in your own time.

LEARNING OUTCOMES

As an AHA working effectively in community rehabilitation, you will be required to perform the following tasks.

1. Work within the context of community rehabilitation by:
   - Applying knowledge and implications of values and philosophies of community rehabilitation in practice
   - Identifying implication of working communities (rather than in institutions)
   - Identifying principles and applications of a range of different frameworks, approaches and models
   - Identifying and adhering to job function boundaries in community rehabilitation, including work delegated by the AHP
2. Work within a multidisciplinary team by:
   - Identifying the roles of AHPs within the multidisciplinary team
   - Identifying the range of support inputs required for the client's rehabilitation, relevant to role and responsibilities
   - In collaboration with the supervising AHP, identify the range of supervisory requirements associated with supporting the implementation of a client's rehabilitation plan
   - Clarifying the nature of supervisory relationships with all professional workers
   - Clarifying additional people to be included in communication about the implementation of a client's rehabilitation plan
   - Providing feedback to relevant others according to the rehabilitation plan, including observation of client status and progress and feedback provided by the client/significant others
3. Provide holistic support to clients within the context of the rehabilitation plan by:
   - Identifying the range of service inputs required to support a client's rehabilitation plan
   - Identifying the interrelationship between a range of service inputs and other supports
   - Identifying additional client requirements outside the rehabilitation plan and discuss with the supervising AHP
   - Providing the client with information to meet educational needs, according to the rehabilitation plan
   - Engaging professional interpreters when required to support cultural and linguistic diversity
4. Address risk identification, hygiene and infection control issues in home care and community settings by:
   - Identifying risks associated with working with the client in their home and community in accordance with local safety protocols

- Developing and implementing risk management plan in consultation with the supervising AHP and in conjunction with the client and in accordance with local protocols and procedures
- Maintaining personal hygiene and dress standard according to infection control and organisation requirements
- Wearing personal protective equipment correctly according to organisation requirements
- Safely disposing of infectious and/or hazardous waste material according to waste management policy and procedures
- Reporting or initiating action within own area of responsibility to redress any potential workplace hazards

5. Document client information by:
   - Using accepted protocols to document information relating to the rehabilitation program in line with organisation requirements
   - Providing regular feedback to the client's care team
   - Using appropriate terminology and format to document the client's progress, including any barriers or challenges to the rehabilitation plan

LEARNING TOPICS

The table below outlines the relationship between the topics presented in this Learner Guide and the Essential Knowledge required for completion of the unit of competency.

Topics	Essential Knowledge
1. Working in community rehabilitation	• Different frameworks, approaches and models of rehabilitation • Human rights in reference to community rehabilitation • International classification of functioning disability and health • Philosophy and values of community rehabilitation • Relevant national and/or state-based community services and programs such as HASS, CACPS, veteran's home care • The importance and practice of participation, social justice and equity
2. Organisation practices	• Community care service providers including managers, supervisors, coordinators, assessment officers and case managers • Importance of principles and practices to enhance sustainability in the workplace, including environmental, economic, workforce and social sustainability • Occupational health and safety (OHS) issues and requirements, risk assessment and risk management associated with working in client homes and the community • Understanding of medico-legal and legal implications of working outside the plans, specifically treatment style plan
3. Holistic support	• Awareness of cross cultural issues in a community rehabilitation context • Community advocacy groups • Importance of client's interests • Support groups and organisations within the community • The importance and meaning of home and belongings to clients and the nature and significance of working in the client's home and community settings • Understanding of importance of range of rehabilitation requirements • Understanding of principles and practices of self-management

CONTENTS

1. Working in community rehabilitation

This topic covers information about:

- Philosophy and values of community rehabilitation
- Frameworks and models of community rehabilitation
- Community rehabilitation programs

Activities in this topic address the following essential skills:

- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisation and client group:
  - This may include, for example, ability to read and comprehend a rehabilitation plan, develop and implement a risk management plan, report hazards and document client information
  - Language used may be English or a community language
- Communicate effectively with relevant people in a community rehabilitation context, including:
  - Communication that addresses specific needs of people with disabilities
  - Cross cultural communication
  - Verbal and non-verbal communication with clients and colleagues, including members of multidisciplinary teams
- Facilitate client involvement and participation in the rehabilitation process within the context of rehabilitation plans and under supervision of an identified health professional
- Work within a multidisciplinary team

1.1 Philosophy and values of community rehabilitation

Before we start talking about community rehabilitation, we have to define what is meant by the term 'rehabilitation' in the health industry. Here is one definition from Queensland Health:

Rehabilitation is the process that brings about the highest level of recovery or improvement in function following the loss of function and ability from any cause.

Compare this to the following definition from the World Health Organisation (WHO):

'Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination.'

(World Health Organisation 2010)

As you can see, the WHO definition explicitly mentions a person's functioning on a range of different levels, ensuring that the concept of rehabilitation extends beyond the physical consequences of illness or injury.

The rehabilitation process can be characterised further, as:

'Co-ordinated, multidisciplinary team-work, by a team with expertise and an interest in disability, who actively involve the client and family in the process, which is set within an explicitly recognized framework encompassing all aspects of illness.'

(Wade 2001: 230)

Further complexity in describing the rehabilitation process arises when we consider where along a client's continuum of care the rehabilitation is occurring.

What do we mean by 'Continuum of Care'?

'The provision of comprehensive care from the hospital to the home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system' (World Health Organisation 2006).

For instance, the continuum of care for rehabilitation commences with an acute presentation (which may be related to an acute illness, trauma or elective admission) and continues through discharge and referral to alternative care, including home. It is important to consider plans for discharge from the time of admission, as this would ensure a smooth and co-ordinated client journey. Along the continuum, given the client's changing needs over time, rehabilitation may take place in a number of settings including an acute unit, dedicated rehabilitation unit, as an ambulatory client into a hospital or community-based setting, or in the person's home. This is ensuring that the client is receiving the right care in the right place at the right time.

What is community rehabilitation?

Now we have defined rehabilitation, how is community rehabilitation (CR) different?

From *Establishing a Baseline for CRWP Activities*, the following definition was developed by Queensland Health's Community Rehabilitation Workforce Project (CRWP):

'Community rehabilitation is a process that seeks to equip, empower and provide education and training for rehabilitation clients, carers, family, community members and the community sector to take on appropriate roles in the delivery of health and rehabilitation services to achieve enhanced and sustainable client outcomes'.

'It is, therefore, a broad and diverse area which generally encompasses:

- the physical, social and attitudinal environment in which services are delivered
- the use of networks to create a complete response to consumer needs
- the engagement of consumers in their own rehabilitation'

(Queensland Health 2008)

Put very simply, CR is a process to help people 'get on with life' after illness or injury even if they have not made a complete recovery.

CR services could be classified in a number of ways:

1. By speciality. Speciality teams, such as spinal cord injury or stroke teams, exist to provide services to a particular diagnostic group. Modelling services according to diagnosis results in a high level of expertise and specialist skills in the area; however, they are only appropriate where a large number of people with that diagnosis exist in an area. It would not be feasible, for example, for health services to provide speciality teams for Huntington's Disease or Motor Neurone Disease. Often these teams need to provide more of a consultancy role; for example, in Queensland, the spinal outreach team provides statewide assessment and case management and often relies on local services to provide actual treatment to clients and their families.

2. By location or by the management providing the service. In Queensland, state government funded community rehabilitation teams are provided in geographical areas linked to health service districts. These services treat a wide range of often non-specific conditions. It could be argued that these teams are specialised in:
   - Assessing and managing common, usually not disease-specific problems, that affect a large number of people in the community, such as pain secondary to poor posture, skin problems associated with immobility, impairments and disabilities associated with arthritis, minor problems in personal or domestic activities etc.
   - Monitoring a client's disability, specifically to avoid or treat complications, such as joint contractures, pressure sores, weight gain etc.

- Encouraging a client back into a range of social roles locally including activities, such as going out shopping, going to clubs and day centres, and doing voluntary work
- Knowing all the resources available locally
- Knowing when to refer clients back to other specialised services appropriately
- Providing on-going support, for example through answering clients' and families' questions, and providing practical and emotional support

(Wade 2003: 879)

You can see that there are no consistent definitions of rehabilitation in general or community rehabilitation in particular. There is also variation in the terminology used to describe the end 'user' of rehabilitation services: the terms *client, client* and *consumer* are used interchangeably for the purposes of this guide.

The lack of consistent definition of CR means that CR services are not all the same in the range and delivery of services offered. While some teams offer only specialist services such as stroke rehabilitation; other teams deliver services to people with a wide range of issues, such as those associated with ageing including frailty, falls, osteoporotic fractures and other neurological conditions (Hillier 2010).

Not all CR services offer 'treatment' in the way it is generally understood. We will look at the different types of interventions that sit under the umbrella of CR in the section about Models of Care.

Regardless of where they are placed along the continuum of care or what model of service they use, all CR services are underpinned by common philosophies and values.

Activity 1: What is disability?

1. Reflect on people with disability you know or have worked with as well as the use of the word 'disability' in the descriptions of rehabilitation on pages 21 to 24 of the learner guide. What does 'disability' mean to you?

2. Compare your reflections with what the WHO says about disability: '…every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity.' (World Health Organisation 2011)

Activity continues on the next page.

Activity 1: What is disability? (continued)

3. List three common disabilities that occur as people grow older, even without any specific illness or injury, and how each disability can affect the client and their family/carer. You may wish to discuss your answer with your supervising AHP.

Philosophy and values underlying community rehabilitation

Health services have long been involved in the business of treating health conditions. Regardless of the quality of services provided, the fact remains that not everyone makes a full recovery. Some people will be left with temporary or permanent disabilities, and many of these will be referred to CR services.

As part of a range of services provided by Queensland Health, CR is influenced by the philosophies and values of the WHO. Consider the following vision statement from the WHO's *Disability and Rehabilitation: WHO Action Plan 2006–2011*:

'All persons with disabilities live in dignity, with equal rights and opportunities'

(World Health Organisation: 1)

Human rights

Some of the human rights Australians are entitled to include the right to:

- live with our families
- a basic education
- be treated equally by the law
- think what we like and practise any religion
- say what we like (without inciting hatred or violence)
- an adequate standard of living, including adequate food, clothing and housing
- access to appropriate health care
- maintain our culture and language
- freedom of movement
- privacy
- freedom from discrimination

(Human Rights and Equal Opportunity Commission 2009: 2)

Social justice

Hand in hand with human rights is the concept of social justice; that is to say, ensuring that human rights are upheld for everyone, especially for the most vulnerable members of our society who may be unable to speak up for themselves.

'Social justice can be defined as the responsibility to care for the dignity of the human person and the search for the common good. Social justice seeks to reduce gaps in opportunities (for example, access and entitlements, allocation of resources) between individuals and groups, and so begins to address some underlying social issues such as homelessness, hunger and unemployment.

'Social justice is about relationships between people, and relationships between people and their environments; it is the responsibility of everyone. It is about taking action to redress inequalities, it is about respect and it is about human rights.'

(Department of Education and Training 2003)

Human rights also encompass freedom of choice, including the freedom to accept or reject treatment or intervention. In CR, the rehabilitation worker steps back from the role of ‘expert’, and takes on the role of ‘resource’. This involves handing over power to the client, respecting and accepting their values and culture, and helping them to find and access support in order to meet their needs and achieve their goals. The client is central in the process, and should be involved in all aspects of service delivery including:

- goal setting
- program planning
- decision-making about interventions
- evaluation of program outcomes

Activity 2: Reflection

Imagine you have had stroke (interruption of blood supply to the brain). Your stroke has left you with high support needs: you are unable to walk; and you need help with bathing, eating and drinking, personal hygiene and communication. You are very aware of your surroundings and recognise all the members of your family and your friends. The time is coming for you to be discharged from hospital. You have not made any significant improvement and your doctor has suggested there are two options open to you:

1. You can return home and be cared for, full-time, by your spouse. Your spouse would have to give up work but would be eligible to receive a carer's pension.
2. You can move into a nursing home.

You are 32 years old, with two young children, and your spouse is now the sole breadwinner for your family.

a) Review the human rights for Australians listed on page 14 of this guide.

b) What are the human rights implications for the two options you have been given: for you; your spouse and your children?

1. _____
_____
_____
_____
_____
_____
_____

2. _____
_____
_____
_____
_____
_____
_____

You may wish to discuss your answers with your supervising AHP.

1.2 Frameworks and models of community rehabilitation

There is more than one way to deliver rehabilitation services. Different models of care will be more suitable at different points along the rehabilitation continuum as clients' needs change, thus changing the focus of rehabilitation.

Models of care

'Model of Care' is a term used to describe the way a service is delivered and includes:

- what types of services are provided
- who provides the service (what profession, or type of worker)
- when the service is provided
- how the service is provided

(Queensland Health, *Models of Care*)

In the acute hospital setting, for example, treatment focuses on the health condition and is commonly 'impairment based'; that is, the restoration of function lost through illness or injury. This generally involves a range of professionals:

- medical specialists and other doctors
- nurses
- AHPs from various backgrounds

As people recover and become medically stable, they are either discharged with outpatient follow-up appointments, or transferred from the acute wards to inpatient rehabilitation units. There usually remains a focus on reduction of impairments, or on adaptation to impairment for those who will not regain full function. Services at this point are provided largely by nursing and allied health disciplines. There is generally greater family involvement at this stage as the client prepares to return to the community environment, and greater consideration of barriers to functioning in the home and community setting, including:

- equipment and home modifications required
- accommodation and transport issues
- family and carer education on manual handling, transfers, and supporting the client
- adjustment to disability counselling

Discharge from the inpatient or outpatient rehabilitation setting typically occurs when the client's recovery has slowed or 'plateaued'. This is where CR starts.

In CR, while there may be some potential for further reduction of impairment, this is likely to be slow, and the client, now more commonly referred to as the 'client' or the 'consumer', generally has some remaining level of long-term or permanent impairment.

CR services, even within Queensland Health, are not all the same. The model of care adopted will depend on the client's position along the continuum of care. The following are some of the terms you will hear describing CR services:

- transitional rehabilitation/care – this generally refers to services provided to assist client transition from hospital to the community
- time-limited – clients are offered a set number of weeks or months of service
- whole-of-life – clients may enter and re-enter the service as their needs and goals change over time
- community-based – providing services to people living in the local community either in a clinic setting or in the client's home
- outreach – the provision of services in the clients own community setting, including in more distant communities, often statewide
- specialist – provides services to one specific diagnostic client group (such as stroke or spinal cord injury)
- generalist – provides services to people with a range of different conditions

Types of CR services provided by Queensland Health may include:

- slow-stream rehabilitation – the less intensive provision of therapies, when some further recovery is anticipated
- case management – coordination of a range of services and supports, including services outside of health (accommodation or financial support, transport, personal care, home help, etc.) to support client functioning within home and community settings
- advocacy – 'speaking up' for people with disability either at an individual client level or for groups of clients with similar needs
- training and consultancy – providing training advice to families carers or other service providers on how to assist a person with a disability
- chronic disease self-management – equipping clients and carers with the skills for managing their own health conditions or stresses associated with the carer role

Community rehabilitation services may offer one or a combination of these services.

Activity 3: Models of care

Think about the CR team you are currently working in (or one which you know of) and answer the following questions. You may wish to refer to your service brochure and attach it.

1. Which types of clients are eligible for the team's services? (Is the service generalist or specialist?)

2. How do clients access the service? (referral processes/eligibility)

3. What types of services are provided?

4. Who provides the services (what professions, or types of worker)?

Activity continues on the next page.

Activity 3: Models of care (continued)

5. When is the service provided? (At what point along the continuum of care? Time-limited? Whole of life?)

6. How is the service provided? (Individual or group programs?)

7. Where is the service provided? (clinic/client's home/community) Several answers may apply

8. How would you describe the Model of Care adopted by your service? (Brochures and fact sheets about your service will often contain a description.)

You may wish to discuss your answers with your supervising AHP.

Community rehabilitation framework

An audit commissioned by Queensland Health's Community Rehabilitation Workforce Project (CRWP) in 2005, identified that for a multidisciplinary team to function well, all team members need to speak a 'common language' and use a 'common framework' when talking about, thinking about, and approaching the provision of rehabilitation services.

What is a framework?

There are many different definitions of this word. As you will appreciate, humans are very complex beings and when things go wrong with our health the rehabilitation process can also be complex. The following definition, therefore, seems appropriate:

'A hypothetical description of a complex entity or process.'

(The Free Dictionary 2010)

The International Classification of Functioning, Disability and Health (ICF) was identified by the CRWP as providing both the common language and the common framework needed for teams, clients, carers, families and communities to work effectively together.

The International Classification of Functioning, Disability and Health

The ICF is an international classification system developed and endorsed by the WHO. You may have heard of the International Classification of Diseases (ICD-10), which is used for recording data on admissions in all Queensland Health hospitals. The ICF and the ICD-10 are both members of the same family of international classifications.

The ICF was added to this family in 2005, and fulfils two main functions:

1. A classification system which captures information describing how a health condition impacts on a person's ability to function and participate in life, and allows for the comparison of data across communities and populations worldwide.

2. A common language and framework for health and rehabilitation professionals to use when planning, implementing and evaluating health and rehabilitation services.

We will not be discussing the ICF as a classification system in this Learner Guide, but will focus on the second function; a common language framework.

The diagram on the next page illustrates the major components of the ICF, and how they relate to each other.

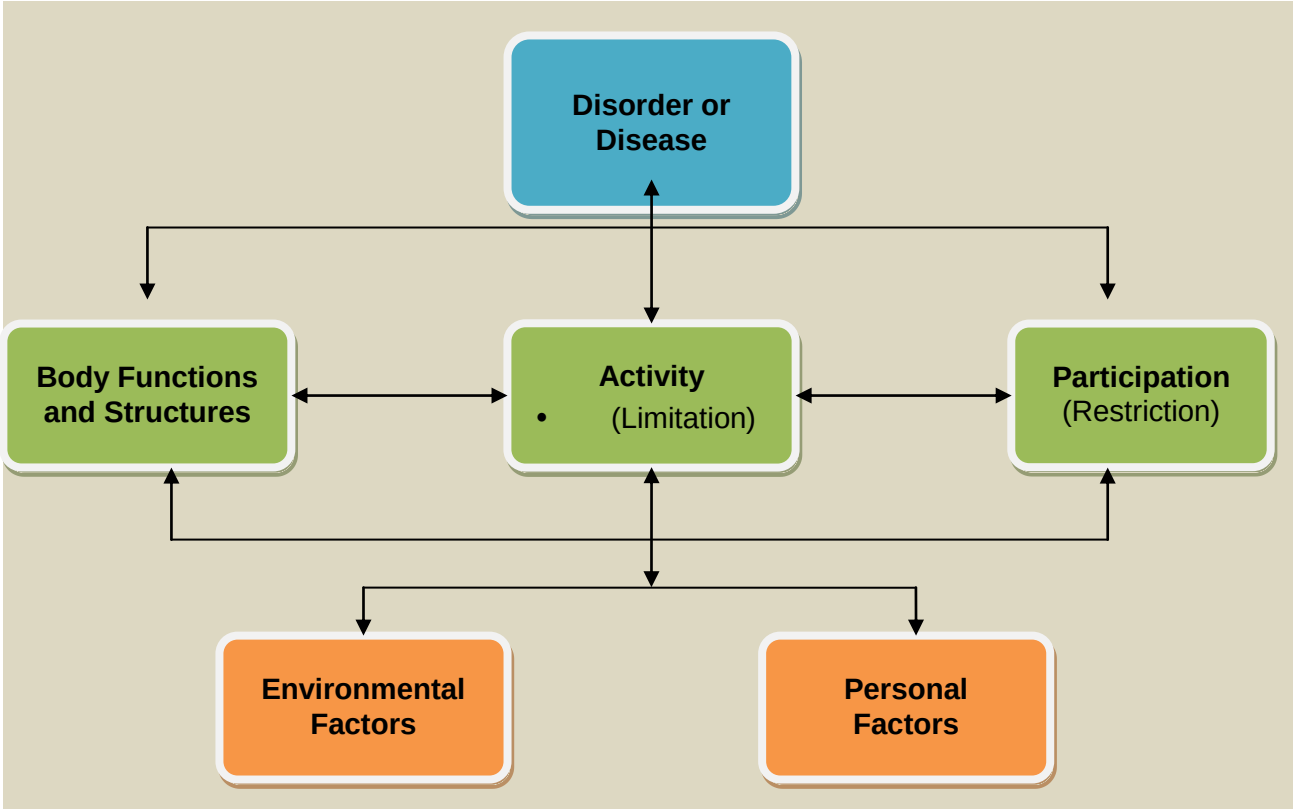

Figure 1 **Interactions between components of ICF (Adapted from Towards a Common Language for Functioning, Disability and Health: ICF 2002: 9)**

At the top of the diagram is the health condition, and at the bottom of the diagram are the personal and environmental factors which together form the context or background on which the health condition has occurred.

The middle line of the diagram represents the client outcomes that result from the interaction between the health condition and contextual factors:

- At the level of body (degree of impairment in body structures and functions)
- At the level of the individual (what activities the person can and cannot perform)
- At the level of society (in what roles a person is able or unable to participate)

The health condition and the context interact in a dynamic way, represented by all the arrows in the diagram.

Put very simply, what this diagram depicts is that every illness or injury has different outcomes, because it happens to a unique and complex person, living in a unique and complex social environment.

Components of the ICF

Body functions are the physiological functions of body systems (including psychological functions) and can include:

- physical functions such as muscle contraction
- cognitive (thinking) functions, such as remembering and concentrating
- psychological functions, such as self-awareness, insight or adjustment

Body structures are anatomical parts of the body, such as organs, limbs and their components: eyes, ears, nose, mouth, brain, liver, kidneys, skin and so on.

Impairments of body structure and functions can include such diverse things as:

- paralysis or weakness in muscles
- skin breakdown or lesions
- loss or deformity of limbs
- inability to feel touch or pain
- changes in sexual function
- changes in memory and other cognitive or 'thinking' functions
- changes in ability to regulate one's own behaviour
- changes in ability to regulate one's own body temperature

Activity refers to those actions performed at the individual level, for example:

- walking
- speaking
- swallowing
- seeing
- making decisions

Activity limitations would therefore include such things as:

- difficulties walking on rough ground/slopes/without a walking aid
- having slurred speech, or word-finding difficulties
- difficulties swallowing thin fluids or chunky foods
- difficulties reading fine print
- difficulties understanding the nature of decisions or their consequences

Participation is a person's involvement in social and life roles, for example:

- caring for a family
- deciding where to live and with whom

Participation restrictions are barriers to participation, for example:

- can walk but can't get to the shops due to transport problems so is unable to do grocery shopping
- has the ability to make decisions, but is not being consulted or involved in decision making
- has the ability to cook, but is prevented from doing so by a parent or spouse worried about stove safety

We can see that a person with various impairments may have abilities to perform certain activities, but can still experience barriers to participation. Often, these barriers are contextual, which in the ICF, as we mentioned earlier, includes both environmental and personal factors.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These are either barriers to or facilitators of the person's functioning and are included in the ICF under the following headings:

- products and technology
- natural environment and human-made changes to environment
- support and relationships
- attitudes
- services, systems and policies

Products and technology includes such things as:

- equipment, which can include disability specific/adaptive equipment, such as cutlery with built-up handles, voice-operated computer software, wheelchair accessible taxis, or simply items generally available, like mobile phones, computers or diaries
- home modifications such as ramps, rails and lifts
- medications to control or manage symptoms

Natural environment and human made changes to the environment includes things like:

- terrain – a person in a manual wheelchair might find it hard to get up a steep driveway
- climate/weather – a person who is unable to regulate their own body temperature could become dangerously over-heated on a hot day
- presence of allergens/toxins in the air water or soil – a person with asthma may be unable to exercise outdoors in spring when certain trees or grasses are flowering

Support and relationships can include:

- family members
- carers
- friends
- domestic animals or pets
- neighbours
- clubs and societies
- church groups
- informal or unpaid supports in a person's environment
- relationships with individual workers in formal support services

Attitudes

This refers to the attitudes of other people towards the person with disability. Attitudes of health and rehabilitation workers are included in this and can be an important influence in either a positive or negative way. Let's take, as an example, the influence of a health professional when decisions are made about accommodation options after discharge from hospital. If health professionals focus merely on getting people out of hospital to free up beds, rather than focussing on what the client wants, clients can end up in unsuitable and depressing living situations (for example, young people in aged care facilities).

Services, systems and policies

Health and non-health, government and non-government services across a range of different areas, such as:

- accommodation
- respite
- medical aids and equipment
- transport
- counselling
- lifestyle support and personal care
- 'Meals on Wheels'
- household maintenance
- employment
- education

Policies include such things as:

- Disability Services Act
- Guardianship and Administration Act,
- Anti-Discrimination legislation
- Equal Employment Opportunities legislation

All of these and more are important legislative underpinnings that support the rights of people with disability to choice and to full participation in society (ICF Australian User Guide, 2003).

Personal factors include:

- gender
- cultural background
- age
- other health conditions
- fitness
- lifestyle habits
- upbringing
- coping styles
- social background
- education
- profession
- past and current life experience
- overall behaviour pattern and character style
- individual psychological assets

Some personal factors are able to be influenced or changed, for example education, profession, fitness, lifestyle habits. Others, such as age, gender and cultural background, are not. Either way, they are factors which can act as facilitators or barriers to functioning and need to be considered when working out how best to support clients to meet their needs and reach their goals.

Activity 4: The impact of personal factors on client outcomes

Let's look at how a personal factor such as age can impact on client functioning after illness or injury. Consider a person who has had a stroke, causing paralysis down one side of their body, some speech and communication impairments, and some memory impairment.

What might this mean for a person who is?

1. 8 years old and at primary school

2. 28 years old and the breadwinner in a family

3. 78 years old and caring for a spouse with dementia

You may wish to discuss your answers with a supervising AHP.

Environmental and personal factors can act as either facilitators or barriers - meaning they can either help or hinder attainment of goals. Read the case study below to see what this means in practice.

Case Study: George

George has had a spinal cord injury (health condition) resulting in quadriplegia. At the time of his injury, he worked as a truck driver, was married and was planning to start a family (personal factors). He lived in a high set house in the country (environmental factors).

At the level of body structures and function his injury has resulted in:

- paralysis of his legs, trunk, and some muscle groups in his arms (his shoulder, elbow and some wrist muscles are not impaired)
- impaired sensation below the level of the injury
- impaired bladder and bowel function
- impaired sexual function

At the level of the individual this means he:

- cannot walk or use stairs
- cannot grip things with his hands
- cannot feel his legs, trunk or most of his arms and is at risk of developing pressure sores
- cannot pass urine and cannot feel when his bowels are moving
- cannot engage in sexual intercourse

At the level of society this might mean he:

- cannot get into his own house or some other buildings in his local community
- cannot participate in his former work as a truck driver
- will not go to the movies or out to dinner in case his bowels move unexpectedly
- cannot participate in the conception of a child through sexual intercourse

With environmental interventions (for example, products and technology), George is able to participate in many roles in his family and in his community. Interventions might include:

- a manual or power wheelchair
- hand splints to assist with gripping objects
- lifts or wheelchair ramps into buildings
- catheters and bags for management of urine, suppositories to ensure bowel movements occur at predictable times
- assisted fertility by way of sperm harvesting and IVF

George cannot return to truck driving, as he cannot physically load or unload a vehicle, or sit for long periods due to risk of pressure sores. With interventions at the level of personal factors (education), George may be able to retrain for a different type of work for example in information technology, accounting or teaching, and resume his valued role as a wage earner.

The above case study illustrates how important contextual factors can be. The ultimate aim of rehabilitation is participation in all aspects of life, regardless of residual activity limitations or impairments. CR addresses not only the health condition, but environmental and personal factors as well. Sometimes, especially when impairments are permanent, contextual factors may be the main focus of CR.

 Follow this link for a copy of the WHO ICF Checklist for Clinicians:

http://www.who.int/classifications/icf/training/icfchecklist.pdf

Note that everything on the checklist, except for personal factors, can be ‘coded’ into a series of letters or numbers, thus permitting ease of comparison of data across different cultural and language groups from all over the world.

Activity 5: ICF and the environment

What is the 'ICF' and what is it used for?

_____

_____

_____

_____

_____

_____

Below is a list of categories or domains listed as environmental factors in the ICF:

A. Products and technology
B. Natural environment and human-made changes to the environment
C. Attitudes
D. Support and relationships
E. Services systems and policies

In which category is each of the following?

Place the letter A, B, C, D, or E in the space provided.

1. Meals on Wheels ___
2. Neighbours who bring in the paper ___
3. Set of crutches ___
4. Bathroom grab rails ___
5. Disability Services Act ___
6. A heat wave ___
7. Herbal medicine ___
8. Electric scooter ___
9. Day respite centre ___
10. Shopkeeper who ignores person with disability ___

(Answers: E, D, A, A, E, B, A, A, E, C)

How the ICF is different from other health and rehabilitation frameworks

One of the most important features of the ICF is that it is applicable to everyone. It recognises that all of us may experience barriers to participation regardless of our health condition.

'ICF thus "mainstreams" the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing allowing them to be compared using a common metric – the ruler of health and disability.'

(World Health Organisation 2002: 3)

Furthermore, the ICF takes into account the social aspects of disability and does not see disability only as a 'medical' or 'biological' dysfunction. By including the Contextual Factors, in which environmental factors are listed, ICF allows the recording of the impact of the environment on the person's functioning.

What is meant by 'mainstreams'?

1. Most of us would experience barriers to participation as a competitor in the Olympic games, not because we have a health condition or a disability, but because of personal factors such as level of fitness, motivation, or just the wrong body type.
2. A perfectly healthy person might be excluded from participation in paid employment, not because they are unable to do the job, but because of environmental factors such as employer attitudes like prejudice about their gender or the colour of their skin.

The ICF as a classification system is capable of capturing and describing both of these situations.

The ICF can also describe situations where a person with very high levels of disability is able to participate in life situations, despite extremely high levels of impairment and significant activity limitations as illustrated by the following case study.

Case Study: John

John is a man with a brain stem injury, which has resulted in 'locked-in syndrome'. This means he is unable to move any part of his body except his left eyelid. He is unable to communicate either verbally or through gesture, but his cognitive (thinking) functions are fine.

By addressing environmental barriers; devising a system such as blinking when someone points to the right letter on an alphabet board, John is able to spell out words and thus communicate his choices - about his medical treatment, what to wear, when he wishes to go to bed, what he wants to watch on TV etc. He is also able to communicate with his friends and loved ones.

Further Reading

If you would like to see how a person like John, the man described in the case study above, can participate in and contribute to society, read about the book and film entitled 'The Diving Bell and The Butterfly' by Jean-Dominique Bauby:

http://en.wikipedia.org/wiki/The_Diving_Bell_and_the_Butterfly

With these factors to consider, you can see why CR tends to be a 'team effort' involving workers from a range of different backgrounds; no single discipline is able to provide every service needed by CR clients.

To work effectively together, team members need to be able to understand each other and CR teams are no exception. Specialised terminology, abbreviations and acronyms can make conversations between health professionals difficult to understand, even to professionals from other disciplines.

ICF as common language

The ICF provides a common language for health and rehabilitation professionals, but there is another, perhaps more important feature of ICF language: it is comprehensible to clients, carers, family, and friends. ICF moves away from the use of specialist medical 'jargon', and uses terms easily understood by all.

Case Study: Ruby

Ruby is in hospital after a stroke, which has affected her vision, speech, and communication, and has caused some paralysis down one side of her body. She is able to eat a normal diet and is able to feed herself using modified cutlery. In a family conference before Ruby is discharged, the occupational therapist (OT) reports that Ruby has 'left homonymous hemianopia'.

Ruby's husband David reports that he has been encouraging Ruby to eat everything on her plate when he has been with her at hospital mealtimes, but she still leaves half of her meals untouched.

The OT explains to Ruby and David that homonymous hemianopia is a visual impairment in both eyes, in Ruby's case affecting her ability to see the left side of her plate. She shows Ruby how to 'scan' her dinner plate and see the food she has left behind and shows David how he can prompt Ruby to scan if she forgets.

The above case study illustrates how the use of medical jargon can impact negatively on communication and can exclude the most important members of the rehabilitation team: clients and their families.

Communication with clients

There is a lot more to communication than merely the spoken or written word; non-verbal communication is also extremely important. Various estimates place 60% or more of our communication as non-verbal, another 30% or more of communication is in our 'tone' (it's not what you said, it's the way you said it), leaving 10% or less of our communication to what is actually said.

Non-verbal communication can include:

- posture – whether we seem tense or relaxed, interested or distracted, whether our arms or legs are crossed (this is called closed posture and can be a barrier to communication)
- gesture – putting our finger to our lips to indicate 'sshhh', or holding up three fingers to represent the number three
- facial expressions – many of these are common across cultures, for example happiness, sadness, fear, anger, surprise
- spatial relations – the distance between us, whether we sit beside someone or on the other side of a desk
- touch – may be used to gain attention or to indicate a body part
- display – presentation, for example whether we wear a uniform or regular clothes

(Beer 2003)

Communication impairments

Some health conditions, for example stroke, Parkinson's disease or dementia, may result in specific communication impairments; the ability to understand the spoken or written word, to find the right words to respond, or even to move the muscles of the face and tongue to form clear speech.

These and other health conditions can also affect a person's conversational skills, including:

- taking turns in speaking
- being able to read the other person's body language, for example understanding when a person wants the conversation to end
- concentrating on what is being said
- 'blocking out' unnecessary environmental sounds and attending to what is being said

There are many different conditions that may lead to different communication impairments in clients. Follow this link for tips on how to communicate effectively with a person with dementia:
https://www.alz.org/national/documents/brochure_communication.pdf

This Learner Guide will not cover all the skills required to work with all clients with communication impairments. If your CR service has clients with specific impairments you will need additional training from a speech and language pathologist.

Further Information

You will find a fact sheet with more information about specific communication impairmentsthat may occur with certain health conditions, "Communication Impairment in Australia" on the Speech Pathology Australia website at:

https://www.speechpathologyaustralia.org.au/spaweb/Document_Management/Public/Fact_Sheets.aspx#anchor_impair

Activity 6: Communicating with clients

In the following situations, do you think effective communication is happening? How might the client feel in these situations? What is one strategy that might assist?

1. You are talking to a person in a wheelchair. You are standing and there are no chairs around.

2. A client with dementia doesn't respond when you say hello.

Activity continues on the next page.

Activity 6: Communicating with clients (continued)

3. Your client has had a stroke and his speech is slurred and difficult to understand. You ask his wife how he is getting on with his home therapies.

1.3 Community rehabilitation programs

Rehabilitation services

Service providers comprise a mix of government (commonwealth and state) and private sector providers. Current funding arrangements have led to a mix of publicly- and privately-provided services for clients. Not all geographical areas are covered by all services. Some areas are well covered with a choice of providers for clients, whereas other areas will have only one provider who may not provide services to all types of clients or have a full range of services to provide.

Queensland Health funded services

- Aged Care Assessment Teams (ACAT)
  - provide assessment only to older people
  - assess for eligibility for EACH or Home Care packages (see below)
  - generally, teams include Nurses, Physiotherapists, Occupational Therapists, and Social Workers
- Transition Care Teams
  - provide 'slow stream' rehabilitation and case management for clients over 65 who are eligible for an ACAT package and who have had a hospital admission
  - aim to reduce unnecessary placement in residential aged care, or to reduce the level of care required (for example, from high care or nursing home level, to medium or low care or hostel level)
  - teams may consist of Registered Nurses, Enrolled Nurses, Occupational Therapists, Physiotherapists, Speech Pathologists, Dieticians, Social Workers, Case Managers, Community Health Aides (CHAs), and Team Leaders
- Community Adult Rehabilitation Services (CARS)
  - generally targeted at the older population and those with stroke and other neurological conditions
  - generally, teams include Physiotherapists, Occupational Therapists, Speech Pathologists, and AHAs, and may also include Psychologists, Social Workers, Dieticians, Nutritionists, and Nurses
  - operate throughout Queensland
  - provide rehabilitation for a wide variety of clients with neurological conditions
  - interventions provided within the community or home setting or centre-based, as required

State-wide specialist services

- QLD Spinal Cord Injury Services (QSCIS)
  - Transitional Rehabilitation Program (TRP) assists people affected by spinal cord injury to transition from hospital rehabilitation to community living. It offers a flexible rehabilitation service focussed on individual goals and enables earlier discharge from hospital. TRP assists people to consolidate and build on

skills developed in the Spinal Injuries Unit with the support of an experienced team of health professionals.

- Spinal Outreach Team (SPOT) is an ‘all of life’ service that supports people affected by spinal cord injury throughout Queensland by providing quality, timely and client focussed consultancy, early intervention and education services in the areas of Social Work, Physiotherapy, Occupational Therapy and Nursing.
- Acquired Brain Injury Outreach Service (ABIOS)
  - A specialist whole of life community-based rehabilitation service providing case management, training and consultancy for adults who have had an acquired brain injury living in the community, their families and the services that support them.
- STEPS Program (Skills To Enable People and Communities)
  - An information and skills group program for adults aged 18-65 with stroke and acquired brain injury (ABI), their families and friends. It aims to establish sustainable networks of support in people’s local communities throughout Queensland. It is a service arm of the ABIOS best suited for people who had their brain injury or stroke at least one year ago.
- Paediatric Rehabilitation Services
  - Queensland Health Lady Cilento Children’s Hospital includes a Department of Paediatric Rehabilitation which comprises a range of services and clinics, for example
    - Queensland Cerebral Palsy Health Program
    - Queensland Clinical Motion Analysis Service
- Other Support Services
  - There are a variety of programs and funding packages to assist people to live independently in the community. These programs, funded by the Australian or Queensland governments aim to assist Australians to live in their own homes.

Home Care Packages Program

Individually planned and coordinated packages of community aged care services designed to meet older people’s daily care needs in the community. It is a care option for older people with complex care needs who prefer to remain living in the community rather than enter residential care.

The packages are flexible and designed to help with individual care needs. The types of services that may be provided as part of a package include:

- personal care
- support services
- nursing, allied health and other clinical services
- home help
- care coordination and case management

Extended Aged Care at Home (EACH)

EACH packages provide high levels of support to assist frail older Australians to remain living in their own homes. These packages offer a higher level of support than a CACP

They also require a person to have been assessed by an ACAT as requiring high level care.

These packages may be used to fund services like those provided under a CACP and in addition a person receiving an EACH package may also receive these services:

- registered nursing care
- care by an Allied Health Professional such as a Physiotherapist, Podiatrist or other type of allied health care
- assistance with home oxygen and enteral feeding supplies

Extended Aged Care at Home Dementia (EACHD)

EACHD packages provide high-level care to people who experience difficulties in their daily life because of behavioural and psychological symptoms associated with dementia.

CACP or EACH approved providers deliver the care funded by these packages. Providers could include government organisations like HACC (see below) or non-government organisations such as Bluecare or Spiritus.

Home and Community Care (HACC)

The HACC program is jointly funded by the Australian, State and Territory Governments, with the Australian Government providing around 60 percent of the funding.

The HACC program provides services to support older Australians, younger people with a disability and their carers to function at home and in the community and to reduce unnecessary admission to residential care, for example, nursing homes.

Some of the services funded through the HACC program include:

- nursing care
- allied health care
- meals and other food services
- domestic assistance
- personal care
- home modification and maintenance
- transport
- respite care
- counselling, support, information and advocacy
- assessment

Veteran's Home Care

This program is managed by the Department of Veterans' Affairs to help veterans and war widows or widowers enjoy a healthier lifestyle and remain living at home longer. The services through Veterans' Home Care are similar to HACC services and include help in the home, personal care, home maintenance, and respite care.

Disability and Community Care Services Queensland (DCCSQ) formerly Disability Services Queensland (DSQ)

DCCSQ provides various services for people with a disability and service providers. These include programs, funding and grants, and access to a complaints process.

One example of DCCSQ funding is the **Adult Lifestyle Support** program, which assists adults with a disability to live and participate in their local community. This program contributes funding and support to help meet the disability support needs of individuals to complement informal (unpaid) networks and to promote access to other general community services. The funds provided through the Adult Lifestyle Support program can be used by adults with a disability in a variety of ways.

Including purchasing support to:

- live at home and manage their household
- take part in recreation and leisure activities
- strengthen personal and family relationships and networks
- purchase necessary aids and equipment that cannot be provided by other agencies or government departments

An adult support package is available to those who live in Queensland and have disability that:

- is attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of impairments
- results in a substantial reduction of capacity in one or more of the following areas; communication, social interaction, learning, mobility or self care/management
- results in needing support **and**
- is permanent or is likely to be permanent (and may or may not be of chronic episodic nature) **and**
- manifests itself before the age of 65

(Department of Communities 2011)

 Further Reading

There are also family and early childhood programs, respite services and family support programs provided by Disability and Community Care Services. For further information refer to the website.

http://www.communities.qld.gov.au/disability/support-and-services/our-services

 Depending on your workplace you may want to research these programs further.

- Aged and Community Care Information Line on 1800 500 853
- Commonwealth Respite and Carelink Centres on 1800 052 222 or via

https://www.dss.gov.au/disability-and-carers/programmes-services/for-carers/commonwealth-respite-and-carelink-centres

More information about services available for veterans, war widows and widowers, is available from the Department of Veterans Affairs:

http://www.dva.gov.au/Pages/home.aspx or 1800 555 254

Community organisations and peak bodies

There are also community organisations dedicated to specific conditions, such as Multiple Sclerosis Queensland, Parkinson's Queensland Inc, and Arthritis Queensland. Many of these Queensland-based peak bodies have a national organisation as well.

Some peak bodies provide therapy services; however, others provide information and education only. Most of these organisations provide advocacy support for their client base.

Private not-for-profit providers, such as Bluecare, Spiritus and Anglicare, also provide domiciliary nursing, personal care and therapy services in the home for eligible clients. These are usually funded through commonwealth government programs such as HACC or EACH and therefore have eligibility criteria the client must meet in order to receive services.

There are also private rehabilitation providers operating in specific areas, for example Montrose Access, providing support for people with degenerative neuromuscular disorders throughout Queensland.

As an AHA you may be involved in compiling and maintaining a database of information about services available and of relevance to the client group of your community rehabilitation service. This involves gathering information about each service including:

- referral and eligibility criteria and processes
- types of services provided
- any costs to clients
- transport options
- contact details

AHAs may also be involved in arranging, on behalf of a delegating AHP, referrals of community rehabilitation clients to other services. It is the AHP's responsibility to decide which is the most appropriate service for referral.

Activity 7: Researching other services in the community

Select an organisation outside of Queensland Health that is relevant to the client group of your CR service

Locate their website or contact details and research the following

Type of organisation (for example, accommodation or equipment provider)	
Services provided	
Staff mix	
Geographical area covered	
Referral sources	
Eligibility	
Funding (how is the service funded: federal or state government or non-government)	
Client demographics (what types and ages of clients are able to access the service)	
Cost to clients	

Key points

This section of the Learner Guide has covered information related to the topic of working in CR. You should now:

- understand that rehabilitation takes place along a continuum from acute episode to the community setting

- understand that CR is about the client - the client is central to the process and is empowered to participate in roles and activities which they value

- understand that the philosophy of CR is centred in human rights and social justice

- have a basic understanding of International Classification of Disability Functioning and Health (ICF) as a useful framework for community rehabilitation:
  - the ICF allows for consideration of all of the factors impacting on a person's ability to function - their health condition, their personal factors and environmental factors
  - disability is mainstreamed, and people with disability have the right to support to enable them to participate in valued and necessary roles in their personal, family and social lives
  - the person is seen as a whole
  - the environment is not seen as something to be considered after rehabilitation has occurred; it is an integral part of rehabilitation to work towards removing environmental barriers to participation
  - ICF is consistent with social justice and human rights

All people have the right to be included in all aspects of life

2. Organisation practices

This topic covers information about:

- Roles and responsibilities
- Occupational Health and Safety

Activities in this topic cover the following essential skills:

- Facilitate client involvement and participation in the rehabilitation process within the context of rehabilitation plans and under supervision of an identified health professional
- Communicate effectively with relevant people in a CR context, including:
  - verbal and non-verbal communication with clients and colleagues, including
  - members of multidisciplinary teams
  - cross-cultural communication
  - communication that addresses specific needs of people with disability
- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisation and client group. This may include:
  - ability to read and comprehend a rehabilitation plan, develop and implement a risk management plan, report hazards and document client information
  - language used may be English or a community language
- Work within a multidisciplinary team
- Apply OHS knowledge in home and community settings

2.1 Roles and responsibilities

If we think of sports like netball or football teams, we can see how important it is for each member of the team to know their own role and also the roles of every other member of their team. The same is true in a CR team. People you will meet working in CR have different titles although their roles may be similar or overlap.

Managers or team leaders are responsible for the overall direction and running of a team. They are also usually responsible for a budget and employing staff. Depending on the type of team, your manager could be from an allied health background or they could be a nurse or a doctor.

Supervisors are the people directly responsible for your work. As an AHA working in community rehabilitation, your supervisor could be a:

- Physiotherapist
- Occupational Therapist
- Speech Pathologist
- Dietitian or Nutritionist
- Podiatrist
- Social Worker
- Psychologist
- Cardiac Rehabilitation Nurse
- Diabetes Educator
- General Practitioner
- Registered Nurse
- Medical Specialist

Assessment officers usually work in specialised teams like the Aged Care Assessment Team. They assess a client's suitability and eligibility for other services or funded packages of care.

Co-ordinators and case managers are responsible for co-ordinating different strategies to help the client achieve their goals and make sure the appropriate services are involved. It is good for the client as they only have to liaise with one person from the team to ensure all their concerns are taken care of.


Most teams in the community are multi-disciplinary so you will be working with people from lots of different professional backgrounds**.**

Medico-legal implications and legal implications of working outside a plan

As an AHA you are employed to work in a specific role. This is sometimes called a 'scope of practice'. The requirements of your role should be clearly listed in your role description (RD). Some tasks you will be expected to undertake **independently**, for example:

- ordering stock
- equipment inventory
- equipment maintenance
- preparation of treatment areas

Your role will also include working directly with clients on clinical tasks **delegated** to you by AHPs. The AHP is legally responsible for delegated clinical tasks, so it is essential that you are aware of your own scope of practice and do not undertake any tasks which are outside this scope.

 If you are delegated a task which you believe is out of scope for your role or for which you believe you do not have adequate training, it is your responsibility to raise this with the delegating professional or with your line manager.

If you are assisting across a range of professions, which is common in CR, you will have a range of professionals delegating tasks to you. Each one of these professionals will be responsible for delegating clinical tasks specific to their discipline; a Physiotherapist can only delegate Physiotherapy tasks, a Speech Pathologist is the only professional who can delegate Speech Pathology tasks, and so on. You can see why it is important to know the roles of all the professionals on the team as well as your own.

Duties which are **not** part of your role as an AHA (roles that are 'out of scope') include:

- diagnosis
- independent administration and interpretation of assessments*
- independent referral to a provider or service outside the team
- interpretation of information provided to staff, clients, their families, and carers
- independent development or modification of a rehabilitation plan
- decisions about discharging clients from the service

*In some professions and with appropriate training, AHAs may administer certain standardised screening tools or assessments and provide the results to supervising AHPs for interpretation. If this is part of your role, training will be provided locally to ensure that you have the appropriate skills.

Activity 8: Delegation to allied health assistants in a multidisciplinary team

1. Make a list of five professions represented in your community rehabilitation team and list their roles and responsibilities. You may wish to make time to speak with team members and check that your list is complete.

2. What tasks might each AHP delegate to you? Again, you may wish to arrange an informal discussion with each AHP in your team.

If you do not have a clear understanding of the role of any of the people you work with make some time to talk with them to learn more.

Role descriptions also contain information about **governance**. This refers to reporting and supervision lines. You may have several different people to report to: for line management (for example, a manager in the operational stream) and for clinical supervision (for example, an AHP in your workplace).

It is important that you are aware of reporting and supervision arrangements for your AHA position and comply with these requirements to uphold the legal and medical obligations of Queensland Health to its clients.

Governance Guidelines for AHAs have been developed by the AHPOQ. They can be viewed by following this link to the website

Governance Guidelines for Allied Health Assistants:

http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahagovguide.pdf

You may wish to discuss this document with your line manager and clinical supervisor to be sure that you are clear about the governance of your role.

There are also requirements in terms of **documentation** that you must follow. It is important to follow the required procedures in your work unit. AHPOQ has also developed documentation guidelines for AHAs. *Guideline for Allied Health Assistants Documenting in Health Records:*
http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf

Activity 9: Documentation

With a clinical supervisor, work through scenario 4 from the : *Guideline for Allied Health Assistants Documenting in Health Records*

http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf

Case Study: Mrs Singh

Mrs Singh is a 72-year-old female who had a mild stroke resulting in mildly slurred speech. She was discharged from hospital earlier this week. She lives independently at home and appears highly motivated to improve her clarity of speech. Her stated goal is to feel comfortable with her speech when interacting socially with her friends.

After the Speech Pathologist reviews Mrs Singh, she asks you to carry out speech drills focusing on multi-syllabic words as per the handouts the Speech Pathologist provides.

Mrs Singh reports compliance with her home exercise program and her husband notes that her speech has already improved.

During the session you work with Mrs Singh through two pages of speech drills focussing on increasing complexity in multi-syllabic words. She participates well, however you note she has difficulties when the words contain four syllables or more. Mrs Singh reports being aware of this.

Mrs Singh is booked in for her next review in three days' time, and the Speech Pathologist has asked you to reinforce that she do her home exercise program twice daily.

Activity continues on the next page.

Activity 9: Documentation (continued)

2.2 Occupational Health and Safety

When you work in the community, your work space is at times someone else's home. Private homes are not always safe or well maintained. There can be environmental hazards such as poorly maintained paths and steps. In addition, there can be other hazards such as dogs, a history of violence or substance abuse and clients or other family members who have psychological, emotional or mental health issues.

Your organisation will have a policy and procedure on home visiting. Before you undertake a home or community visit, a **risk assessment** is conducted. This is to screen for Occupational Health and Safety issues and to ensure a safe and healthy work environment.

The link below takes you to a sample risk assessment tool, Darling Downs Hospital and Health Service Home Visit Risk Screen
http://qheps.health.qld.gov.au/darlingdowns/pdf/forms/mr31.pdf

To undertake a home visit successfully it is also important to have a plan. This can include the following items:

- health rehabilitation or support services to be provided
- resources to be allocated
- equipment required to undertake the home or community visit

It is your responsibility to make sure you know the safety procedures and concerns of your industry and work in a safe manner in your organisation and in people's homes.

 The link below will take you to an example Procedure for Home Visiting and Personal Safety from the Darling Downs Hospital and Health Service.
http://qheps.health.qld.gov.au/darlingdowns/pdf/procedure/4-04-001.pdf

Ask your supervisor to help you locate your local policy or procedure for Home Visiting.

It is an Occupational Health and Safety requirement that you take reasonable action to make sure that:

- accidents are prevented
- clients and staff are protected from injury
- hazards are removed, reported, or controlled
- injuries and 'near misses' are reported

Queensland Health runs orientation programmes and mandatory annual training programs that cover relevant Occupational Health and Safety training such as:

- manual handling
- working with hazardous substances
- electrical safety
- cultural awareness
- infection control
- personal safety
- aggressive behaviour management
- driver safety (transport to the home or community environment)
- fire safety

Activity 10: Home visits

Consider this scenario in reference to your local or the DDHHS Procedure for Home Visiting and Personal Safety

You are going on a home visit. A risk assessment was undertaken and no safety concerns were identified. As you enter the yard a large snarling dog runs towards you. Your client has a visitor who dropped in unexpectedly and it is the visitor's dog. The visitor calls out to you, 'don't worry; his bark is worse than his bite.'

1. What would be the appropriate action for you to take in this situation?

2. How could this situation have been avoided?

Discuss your responses with a clinical supervisor.

Remember

- Before you go out to someone's home for the first time be sure a risk assessment has been conducted.
- Make sure someone knows when you are going, where you are going (exact address), and the time you are expected back.
- Call if your return to the office is delayed for any reason.
- Take a charged mobile phone into the house with you – it is no good in the car.
- Make sure you have an exit strategy in case something goes wrong (for example, it is a good idea to sit where no one can block your exit)
- Make sure you look after yourself – if, *for any reason*, you feel unsafe entering or remaining in a client's home or other community setting, you should leave the situation immediately and report to your team leader, clinical supervisor, or line manager.
- Expect the unexpected and know what to do about it.
- If in doubt, ask a supervisor.

Activity 11: Minimising risk in the community setting

1. What strategies are in place in your workplace to maximise your safety during home or community visits? You may consider strategies for Occupational Health and Safety, manual handling, infection control, personal safety, and driver safety.

2. What strategies are in place at your workplace, or could be put in place, to enable staff to inform others of their whereabouts?

Key points

This section of the Learner Guide has covered information related to the topic of organisation practices. You should now:

- know that there are many different organisations providing support and rehabilitation within the community
- understand that there are medical and legal obligations associated with your position - ensure you know what they are and observe them
- read and understand the risk assessment of the client - it should be in their file, if it is not, make sure one is done before the home visit
- understand that working in the home brings its own OHS issues; safety, both for you and the client, is important
- follow the home visiting policy of your work unit - your safety is your responsibility

3. Holistic support

This topic covers information about:

- Client needs
- Providing support
- Chronic Disease Self-Management

Activities in this topic cover the following essential skills:

- Motivate client and build self esteem
- Provide effective and sensitive support to people in CR settings
- Facilitate client involvement and participation in the rehabilitation process within the context of rehabilitation plans and under the supervision of an identified health professional
- Communicate effectively with relevant people in a CR context, including:
  - verbal and non-verbal communication with clients and colleagues, including
  - members of multidisciplinary teams
  - cross-cultural communication
  - communication that addresses specific needs of people with disabilities

3.1 Client needs

Holistic health care is ‘a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs’

(The Free Dictionary, 2011)

In health and rehabilitation, this means a focus on the ‘whole person’; not on ‘bits and pieces’ such as an injured leg or arm.

Case Study: Peter

Peter has broken his leg. It is now in plaster and Peter has been ordered to use ‘non-weight bearing’ crutches. If we focus only on the leg, we might teach him how to use the crutches and send him on his way.

Taking the holistic approach, we would ask Peter about the impact this will have on his life.

For example, if he drives a manual car, he will not be able to drive, so we may need to help him with alternate travel to attend his appointments. If he works as bartender, he will not be able to return to work, so he may need help arranging income support for example through Centrelink. If he is caring for an ageing parent who needs help getting in and out of bed, we might need to arrange for an emergency carer for his parent.

Clients are generally the best source of information about what they need to function in their various individual family and community roles. Family members and carers are also well placed to contribute to any discussions about the needs of the client, provided they have the client’s permission to do so.

Family members and carers of a CR client will have needs of their own and if these needs are not met they may not be able to continue to provide care and support to the client. In CR services, therefore, the provision or coordination of support for family and carers should be seen as part of the rehabilitation program (Doig 2006).

Sometimes the family is the client, as illustrated in the case study below.

Case Study: Jane

Jane is a girl with an intellectual impairment. She also has behavioural impairments and can sometimes behave aggressively towards her mother. Managing this is very time-consuming. Jane's mother Jenny is a single parent with three other children, who she is worried will 'miss out' because of the demands of caring for Jane. Jenny is finding it really difficult to cope and is experiencing carer 'burn-out' as she never gets a break.

Arranging some regular in-home respite care for Jane allows Jenny to go out twice a week to the gym and to socialise with friends. Arranging centre-based residential respite care for Jane for a few weeks each year allows Jenny to give her other children some 'special time with mum' when she can also 'recharge her batteries' enabling her to continue providing support to all her children.

Working in a person's home

Working in CR often means working in a client's home. This is a very personal space. People organise their homes with objects that are special and important to them. Everyone has a different perspective on what is important and what is not. Sometimes people collect things that you might consider unnecessary or useless, but these objects may have significance for that person.

CR professionals may be involved in providing advice or recommendations on changes that would benefit the client's safety and function, for example:

- taking up loose mats that could pose a falls risk
- installing grab rails in showers or toilets to aid with transfers
- removing unnecessary furniture and objects to minimise housework
- installing whiteboards to assist people with memory impairments

As an AHA you may be required to follow up on whether professional recommendations have been acted on.

Remember that CR clients may not live alone; everyone who lives in the home may wish to be involved in decisions about suggested or recommended changes. It is important that you are empathetic in your approach and respect client and family choices.

The five core values of the Queensland Public Service are:

- Customers first
- Ideas into action
- Unleash potential
- Be courageous
- Empower people

(Queensland Government, *Our Values*)

Advantages of working in the home have been identified as:

- seeing the person in their own environment and understanding what they wish to achieve
- creating a relationship with family, friends and carers allowing greater communication
- increasing collaboration with the family and the community and voluntary sectors
- clearer identification and assessment of goals
- increased ownership of goals
- increased motivation for achievement of goals
- increased achievement of goals
- increased ability to see the impact of subtle changes of the environment
- knowledge that each person and their issues are unique
- increasing self awareness and reflection of own practice

Case Study: Mrs Thomas

Mrs Thomas is an elderly client using your service who uses a four-wheeled walker to help her to get about. She is a widow who lives alone. Her children and their families all live in various cities around Australia. Although she and her children are close and keep in touch by phone regularly, she does not get to see them very often and generally just for a few days or weeks during school holidays.

Last time you visited her with the OT it was recommended that many of the objects in the entry and hallway of her home be moved in order to make the house safe to navigate. The objects in question are rugs, large pieces of pottery and sculptures she collected on trips with her husband when he was still alive and similar items her children have given her to add to her collection over the years.

Activity 12: Working in a client's home

Refer to the Case Study about Mrs Thomas on the previous page. On your next visit you notice that the OT's recommendations have not been acted on. Compare these two approaches to follow-up.

Approach 1: 'The OT said you need to get rid of all that clutter.'

How do you think this might make Mrs Thomas feel?

Approach 2: 'These are very interesting? How did you come to collect them? Have you thought any more about what the OT recommended? With your walker, it seems quite difficult to get through your hallway, so moving some of these objects should make it safer for you and there is a chance you might knock something over and break it. Are you happy for me to help you move them to a safer spot?

How do you think you might respond to an approach like this if you were Mrs Thomas?

Impaired decision-making capacity

A worker may go against the client's wishes if the client has impaired capacity to make decisions and they are putting themselves or others at risk. For example, if you attended a client's home and noticed that much of the food in the house was mouldy or smelled 'off' and the person was doing nothing about it you might suspect they had impaired capacity for decision making about food safety.

Impaired decision-making capacity is the inability to go through the process of reaching a decision and putting it into effect. There are three elements to making a decision:

1. understanding the nature and effect of the decision
2. freely and voluntarily making a decision
3. communicating the decision in some way

If an adult is unable to carry out any part of this process for decision-making, the adult is said to have 'impaired decision-making capacity'. This is not ignorance, eccentricity, different ethical views, cultural diversity, poor communication, poor judgement or poor decision making (Department of Justice and the Attorney-General 2011).

It is **not** your role as an AHA to decide if a person has impaired capacity to make decisions. It is not even the role of the health professionals in your team. It is the role of the Queensland Civil and Administrative Tribunal (QCAT). If you are in a situation where you are concerned about the person's capacity to make decisions for themselves, you need to report this immediately to your supervisor who may then choose to refer the matter to QCAT.

You can read more about QCAT by following this link:

http://www.qcat.qld.gov.au/matter-types/decision-making-for-adults

It is important to note that all adults who are the subject of an application before QCAT are **presumed to have capacity** until QCAT determines otherwise (Department of Justice and the Attorney-General 2011).

Impact of culture

People who live in Queensland come from diverse social, political, cultural and economic backgrounds; have a wide range of experiences, behaviours, beliefs, and attitudes in relation to health and illness. Depending on their backgrounds they may

have different perceptions of health, illness, symptoms, or disease as well as varying notions and expectations of treatment.

When these different perceptions come together in a health care encounter, care should be taken to ensure that services are respectful of potential differences in knowledge and perceptions.

The following factors may impact on the health and illness experiences of all people, but may also differ depending on cultural backgrounds, as shown by the examples provided:

- language and communication styles
  - eye contact with person of authority is sometimes not culturally appropriate
  - asking direct questions may be considered rude in some cultures
- explanatory models of health and illness
  - clients from some cultures may have the belief that illness/disability is a punishment or a curse and is therefore something to be ashamed of
- knowledge and familiarity with health system and procedures within health services
  - in some countries relatives stay in hospital with their family member and may find the idea of ‘visiting hours’ hard to understand
- use and belief in medicines including traditional medicines
  - in some cultures medication may not be taken as it is thought to be ‘wrong’ to poison the body
  - clients may not think to report on traditional medicines they are using, not being aware that even so-called ‘natural’ medicines may interfere with the effectiveness of prescribed medications
- spirituality and religion
  - some religions do not agree with practices such as blood transfusions or organ transplant
  - not all people from the same religious background will have the same beliefs and practices; this will vary sometimes on what branch of the religion the person adheres to, and whether they are practising or non-practising
- family and community
  - some cultures might see it as shameful to accept outside help when caring for a family member, seeing it as a family responsibility
- gender and modesty
  - dress codes may mean people cannot show certain parts of their bodies to workers of a different gender
- diet and food preferences
  - some people elect to follow vegetarian diets, because of religious or personal convictions about eating meat
  - medicines may be unacceptable to the client if they are developed from products of animals considered ‘unclean’ within that client’s culture or religion

- pain and disability
  - admitting to pain may be perceived as a sign of weakness
  - disability may be a source of shame or stigma and something to be hidden away
- impact of trauma
  - people such as political refugees who have experienced torture by guards in refugee camps may fear and mistrust anyone wearing a uniform

(Queensland Health, *Multicultural Clinical Support Resource*)

Cross-cultural capabilities resources and training are available within Queensland Health. You may wish to investigate this further by following the link below:

http://qheps.health.qld.gov.au/multicultural/

Activity 13: Cultural considerations

Follow the link below to find information on religious practices and health care:

http://qheps.health.qld.gov.au/multicultural/support_tools/8MCRS_hlth_relgn.pdf

And, read through the 'dietary needs' column for the section on Islam and also the section entitled 'religious restrictions and medication'.

How do you think coming from an Islamic background might affect the following?

1. A client's acceptance of 'Meals on Wheels'?

_____

_____

_____

_____

2. How might you adapt rehabilitation programs for retraining cooking skills to suit the client?

_____

_____

_____

_____

3. A client's compliance with prescribed medications?

_____

_____

_____

_____

Discuss your answers with your allied health supervisor.

3.2 Providing support

The type of support a client may need is dependent on many different factors, including:

- type and severity of the illness or injury
- degree of recovery - abilities as well as impairments
- presence or absence of natural supports (for example, family or friends and unpaid carers)
- location of the client along the continuum of care
- client's personal goals

In the early or acute stage of rehabilitation for example there is a primary focus on reducing impairments: **regaining or retraining functions and abilities** affected by the health condition.

As the client recovers and moves into the inpatient or outpatient rehabilitation setting, residual impairments become evident and the focus of rehabilitation widens to include adaptation to impairment and the prescription, trial, and training in the use of adaptive equipment.

At the transition stage of rehabilitation as the client prepares to leave hospital, the focus again widens to include **modification of the environment** in which the client will be living after discharge.

CR starts here and this is generally a time when recovery has usually slowed or 'plateaued'. In CR the primary focus of intervention is on assisting the client to resume his or her chosen roles and lifestyle, often in the presence of long-term or permanent impairments. Lifestyles vary greatly from individual to individual and are influenced by many different factors, either in a positive way (as facilitators) or in a negative way (as barriers).

The ICF framework assists CR workers and their clients to identify these facilitators and barriers and to determine where intervention should be directed to be most effective.

The MAGPIE process

Project officers in the Community Rehabilitation Workforce Project (Qld Health, 2007) described a client-centred community rehabilitation process which uses the ICF as its underlying framework. Most CR services will use a variation of this process, which may be summarised by the acronym 'MAGPIE':

Meet

Assess

Goal set

Plan

Implement

Evaluate

As an AHA, you may not be involved in all phases of the MAGPIE process, but it will be helpful for you to know the phases and the potential involvement of an AHA at each phase.

1. Meet

This first phase is a very important one, especially when the CR program is occurring in the client's own home or community environment, and may involve family members, carers, and friends.

It is a time to establish rapport and can include activities such as:

- introducing CR workers and nature of referral - sometimes clients are referred to a range of different services on discharge and they may find it hard to work out who is who
- identifying and addressing any transcultural issues - this could include communication styles, beliefs about health and disability, customs, and spiritual practices
- explaining services you are able to provide or arrange
- outlining rights and responsibilities including complaints procedures - both the rights and responsibilities of the client and CR workers
- obtaining consent from the client, for example to use their information for service statistics or outcome measures when referring to other services

The location is often, where possible, in the client's own environment; much information can be gained from observation of the home and community environment and how the client functions within it.

AHAs may be involved in various preparation activities for the initial meeting:

- obtaining relevant medical files or charts, for use by the AHP to gain background clinical information
- sourcing transcultural information and resources for the AHP
- preparing for the home visit

2. Assess

Assessment in CR is generally very holistic, and covers most or all of the domains of the ICF.

- Illness or injury factors
  - impairment to body structures and functions
  - activity and limitations
  - participation and restrictions
- contextual factors
  - personal
  - environmental

Background clinical information on the health condition and impairments is generally gained from the referral and medical charts, but information about client activities, participation, and contextual factors is often best obtained directly from the client and family or carer.

Initial assessment is generally performed by an AHP, Nursing Professional or Case Manager, but in some CR services suitably trained AHAs may administer standardised screening tools.

3. Goal Set

Collaborative goal setting or needs identification is a vital step in the CR process. Clients are the experts on what is important or necessary for them to achieve in order to live as they choose.

Depending on the nature of your CR service, goal setting may include identification of one or all of the following:

- short term client goals or needs
- long term client goals or needs
- family or carer goals or needs

Goal setting is not within the scope of the AHA role. AHA involvement in this step may be making sure that all the correct paperwork and forms are available for use by the CR professional.

4. Plan

Planning is a collaborative process undertaken by the CR professional in conjunction with the client, family or carers.

The ‘Plan’ phase is facilitated by the CR professional and there is generally limited AHA involvement. You may, however, be able to contribute suggestions for consideration by the client and the CR professional, particularly if you have been involved in managing a database about ‘other services’ as part of your AHA role.

5. Implement

This phase involves implementing the strategies identified and endorsed in the ‘Plan’ phase.

Implementation could include:

- discipline specific assessment and intervention from a range of professionals
- case management intervention
- advocacy (individual or systems)
- chronic disease self management

In this phase of MAGPIE, AHAs will be most involved.

Working from the list above, AHAs might be involved in activities such as:

- providing and monitoring slow stream therapy services according to treatment plans devised by CR professionals on the team, including group therapy programs
- following up on applications for funding packages for equipment, transport subsidies, home modifications etc.
- organising referrals to other services, as decided by the CR professional and the client
- researching relevant advocacy services on behalf of the CR professional
- co-facilitating Chronic Disease Self-Management group programs

Your role as an AHA will vary depending on:

- the model of service of your CR team
- composition of your CR team (disciplines represented)
- location of your CR team along the continuum of care

6. Evaluate

CR services generally undertake evaluation of the effectiveness of the programs they offer, often by using standardised outcome measures. These may be:

- quantitative: outcomes which can be measured objectively, like client's range of movement, grip strength, or distance walked in a set time
- qualitative: more subjective measures like a client's perception of their quality of life, or a carer's perception of the strain they are feeling as a result of their caring role

Evaluations are generally linked to the client or carer goals.

Evaluation of client outcomes is largely the responsibility of the CR professional. Only they can undertake discipline specific re-assessments to determine the effectiveness of the treatment program.

AHAs may be involved in administering and gathering data from client satisfaction surveys or standardised measures such as Quality of Life or Carer Strain, but will not be involved in any interpretation of information obtained.

(Queensland Health, *Community Rehabilitation Student Handbook* 2008)

Activity 14: Implementing a program plan

Obtain a copy of the treatment or program plan used by your CR service and answer the following questions. Please attach the de-identified risk assessment.

Alternatively, you can also use the example care plan included in Appendix B of your Learner Guide.

1. What type of information is in the plan? List ten of its key features.

2. Are AHAs involved in delivery of any of the services included in the program plan? Why or why not?

CR is sometimes a circular or cyclical process, and client goals may be changed or modified over time. In some services the client may be able to enter and re-enter the service as their needs change, but in time-limited services the client may be discharged or referred elsewhere once their CR program has been completed.

Diagrammatic representation of the MAGPIE process

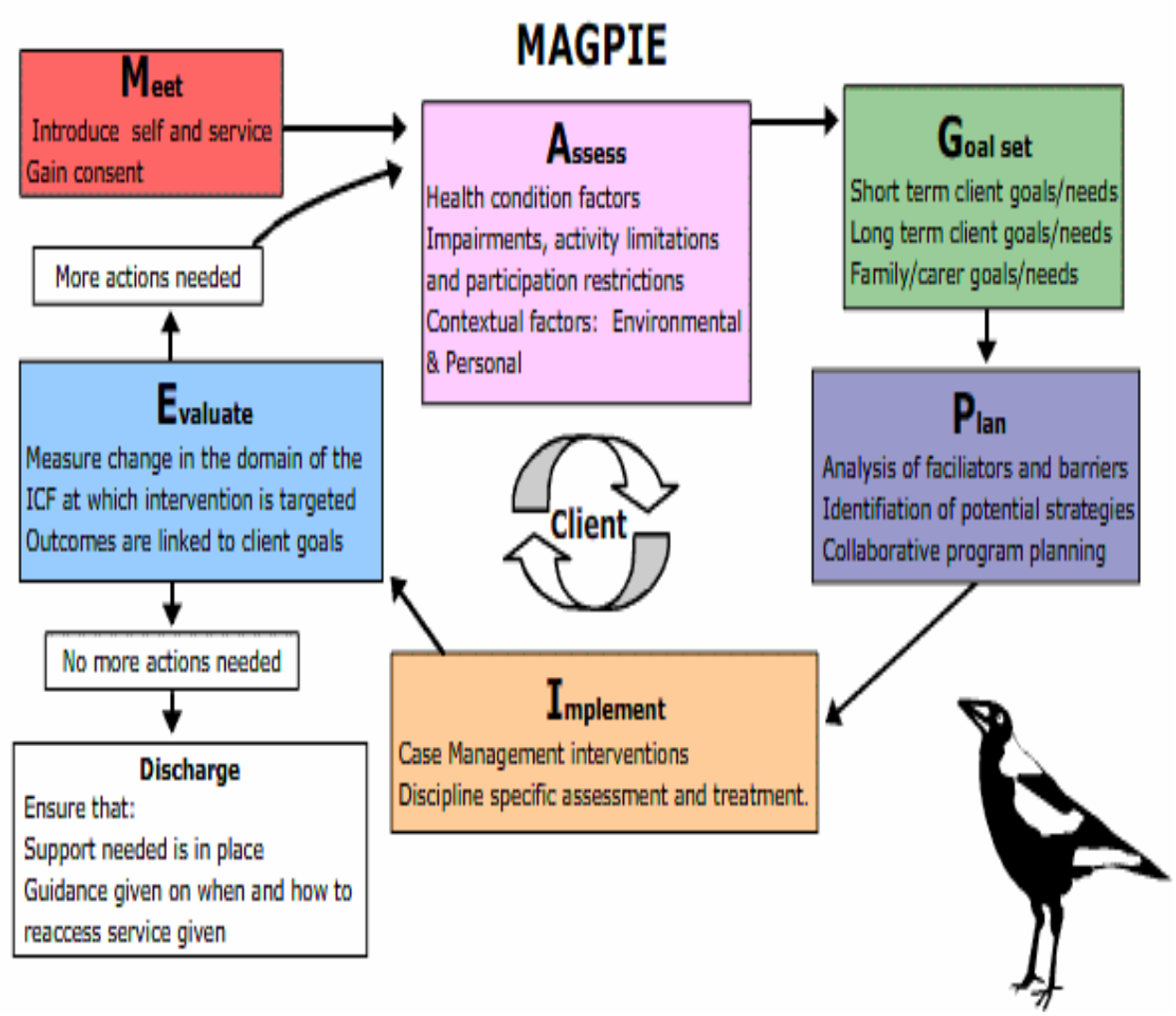

Diagram 2: MAGPIE Process

(Adapted from Wade, DT 2005: p114)

REMEMBER

If you do not feel confident in your ability to perform any tasks delegated to you by a CR professional, it is your responsibility to let your clinical supervisor know.

Case Study: Marianne

Marianne is 82 years old and has had a stroke affecting her right side and some loss of speech function. She has been discharged home with support from a transition care team. Her goals are to:

resume knitting and sewing

do her own shopping

improve her ability to communicate

start reading books again

increase socialisation

These goals have been worked on by the Transition Care Team for a three month period. The review of her care plan showed good outcomes on all goals. Solutions were achieved as follows:

1. OT assessment for hand function, followed by introduction to knitting. A local craft group was identified. Marianne was introduced to the group and now attends weekly.
2. To go shopping it was necessary to ensure Marianne could get there and that she could communicate her needs. Marianne was assisted to apply for a CACPwhich she now receives. Marianne goes shopping once a week with a worker. The Speech Pathologist worked on a series of communication cards that allow Marianne to let her worker know what she wants to buy.
3. To improve communication, the Speech Pathologist also prescribed a therapy program that was conducted by the AHA with reviews fortnightly by the Speech Pathologist and discussions after each session. Marianne now has a vocabulary of 30 words.
4. Reading has proved difficult and Marianne's goal has changed. In conjunction with the local library, a volunteer from Volunteering Queensland and the Australian Aphasia Association (AAA) different talking books have been trialled.
5. All of the above lead to a great deal of increased socialisation. Marianne also goes to a coffee morning with the AAA once a month.

Activity 15: Community rehabilitation in practice

Read the case study above and answer the following questions.

1. How has a holistic approach been taken with Marianne?

2. How have the values and philosophy of CR been upheld?

3. Which support groups and organisations outside Queensland Health were used?

3.3 Chronic Disease Self-Management

The rising incidence of acquired and chronic health conditions in our population presents many challenges to our health services.

The National Chronic Disease Strategy has defined chronic disease as:

- having complex and multiple causes
- usually has a gradual onset
- can occur across the lifecycle (more prevalent with old age)
- can compromise quality of life through physical limitations and disability
- long term and persistent leading to a deterioration of health
- most leading cause of premature mortality

(Commonwealth Department of Health and Ageing 2006: 1)

Some of the more common chronic diseases are:

- asthma
- cancer
- cardio vascular diseases
- chronic obstructive pulmonary disease
- diabetes
- haemoglobin disorders
- HIV/AIDS
- mental illness, including depression
- musculoskeletal disorders
- obesity
- osteoarthritis, rheumatoid arthritis
- physical disability
- stroke

Activity 16: The impact of chronic disease

Look at the list of common chronic diseases on the previous page. Choose three chronic diseases and describe the impact they might have on a person's quality of life. You may wish to choose conditions common among clients in the CR service where you work.

1.

2.

3.

Self-management is the active participation by people in their own health care. Self-management incorporates:

- health promotion and risk reduction
- informed decision making
- care planning
- medication management
- working with health care providers to attain the best possible care and to effectively negotiate the health system

(Community Services and Health Industry Skills Council 2009: 9)

Principles of chronic disease self-management

There are six key principles of chronic disease self-management that underpin good practice for AHAs. They are:

1. client-centred practice
2. holistic practice
3. accurate, comprehensible, timely, and appropriate information
4. partnership and participation
5. strengths-based practice
6. coordination of support

1. Client-centred practice

Client-centred practice requires working with clients with respect to build on their strengths and build resilience and behaviours that support the self-management of chronic disease. In order to achieve successful chronic disease self-management, support and care must be centred on the unique needs, characteristics, and circumstances of the client. This includes:

- working within the client's context (including motivation, individual and community beliefs, values, and language)
- working within the client's access constraints (including financial, travel, language, and cultural)
- working according to informed client choices and preferences
- working according to client's pace and timing requirements
- working with regard for the client's pain, suffering, and impact of the condition on life circumstances

2. Holistic practice

Chronic disease self-management requires support and care across a range of issues other than clinical treatment. The application of this principle requires information and support across all aspects of the client's life that could have an impact on the management of a chronic disease, including:

- providing direct support for positive lifestyle and wellbeing (including information, kits, education, nutrition support, exercise support, and other support services)
- providing indirect support for positive lifestyle and wellbeing (including preparation of food, policy, and staff development)
- supporting the client to implement, monitor, and evaluate treatments, including medication use
- supporting appropriate client coping skills and behaviour
- supporting family and other networks' capacity to support the client

3. Accurate, comprehensible, timely, and appropriate information

Successful self-management of chronic disease relies on the client being an active partner in the management of chronic disease. Accurate, comprehensive, timely, and appropriate information is essential for active participation. Some applications of this principle include:

- supporting client understanding of the nature of the condition
- supporting client psychosocial wellbeing
- supporting client understanding of treatment, care, and behavioural responses to the condition

4. Partnership and participation

Client partnership and participation underpins the self-management of chronic disease. This occurs through care planning and monitoring, and decision making and problem solving. The application of the partnership and participation principle requires collaboration with the client as an equal partner with AHAs in the management of chronic disease. Practices that support partnership and participation include:

- supporting the client to actively participate in planning and monitoring
- supporting client decision making and problem solving
- supporting client self-management practices and priorities

5. Strengths-based practice

Traditional health and community service provision has focused on 'doing for' rather than 'doing with'. Working within a strengths-based perspective requires the identification of and building on coping skills, competencies, and positive aspects of the client in order to facilitate the knowledge and skills required to self-manage chronic disease.

Practices that support this principle include:

- supporting the client to identify and mobilise strengths
- supporting the client in solution-focused self-management strategies
- providing feedback to the client to validate decisions and actions

- providing information and support to clients to access and use compensatory equipment, aids, and procedures

6. Coordination of support

People with chronic disease may be required to negotiate a complex service system. Wherever possible and within the client's context assistance and support with coordination or integration of services on a local level and in a culturally sensitive manner, is a priority to the facilitation of the capacity to self-manage chronic disease. Supporting practices include:

- supporting contact and use of appropriate services and resources
- providing information to appropriate personnel about variations to client wellbeing
- utilising information technology to effectively communicate with the client and other services as appropriate

(Community Services and Health Industry Skills Council 2009)

Practices of Chronic Disease Self-Management

There are many different approaches to the management of chronic conditions: the Stanford Chronic Disease Self-Management program, Flinders Chronic Care Management Program, and Wagner Chronic Care Model are some of the more commonly encountered. While approaches may vary, for example group versus individual programs, factors impacting on client ability to self-manage are fairly consistently identified as:

- goal setting
- motivation
- knowledge of the condition
- pain and symptom management
- other conditions that can occur
- cultural, religious, and family beliefs
- ability to manage independently
- family dynamics
- access to services and support of health professionals

If, as part of your role as an AHA, you are involved directly in the running of chronic disease self-management group programs (for example, as a co-facilitator) specific training will be required.

 For more information about the prevention and management of chronic conditions in Australia refer to the Queensland Government's Chronic Conditions Manual:

https://publications.qld.gov.au/dataset/ef6d9f9e-e8aa-445e-a345-02a016e7251b/resource/bbe5439c-be87-45b6-b704-3b557fbee1e0/download/chronicconditionsmanual1stedition.pdf

Activity 17: Self-management

List five things that might help a client manage their own care:

1. _____
2. _____
3. _____
4. _____
5. _____

List five things that might prevent a client from managing their own care:

1. _____
2. _____
3. _____
4. _____
5. _____

List some support strategies that you could use to help a client through their illness.

_____

_____

_____

_____

_____

_____

_____

_____

Key Points

This section of the Learner Guide has covered information related to the topic of holistic support. On completion of this section you should understand:

- the client is central to the rehabilitation process
-
- needs and goals as identified by the client are the major consideration when developing a program plan
-
- the ICF assists in identifying facilitators and barriers to meeting needs and reaching goals
-
- the importance of culture and language considerations
-
- working in the community and/or home allows us to understand better the client's needs and goals
-
- CR as a holistic process which involves working in all domains of the ICF, not just at the level of the disease or disorder or the body structures and functions

SELF-COMPLETION CHECKLIST

Congratulations, you have completed the topics for HLTCR401B Work effectively in community rehabilitation.

Please review the following list of knowledge and skills for the unit of competency you have just completed. Indicate by ticking the box if you believe that you have covered this information and that you are ready to undertake assessment.

Work effectively in community rehabilitation

Essential Knowledge	Covered in topic
Awareness of cross-cultural issues in a community rehabilitation context	☐ Yes
Community advocacy group	☐ Yes
Community care service providers including managers, supervisors, coordinators, assessment officers and case managers	☐ Yes
Different frameworks, approaches and models of rehabilitation	☐ Yes
Human rights in reference to community rehabilitation	☐ Yes
Importance of client's interests	☐ Yes
Importance of client's networks in the rehabilitation process	☐ Yes
Importance of principles and practices to enhance sustainability in the workplace, including environmental, economic, workforce and social sustainability	☐ Yes
International classification of functioning, disability and health	☐ Yes
Occupational health and safety (OHS) issues and requirements, risk and risk management associated with working in client homes and the community	☐ Yes
Philosophy and values of community rehabilitation	☐ Yes
Relevant national and/or state-based community services and programs such as HASS, CAPS, veteran's home care	☐ Yes
Support groups and organisations within the community	☐ Yes

The importance and meaning of home and belongings to clients and the nature and significance of working in the client's home and community settings	□ Yes
The importance and practice of participation, social justice and equity	□ Yes
Understanding of importance of range of rehabilitation requirements	□ Yes
Understanding of medico-legal and legal implications of working outside the plans, specifically treatment style plan	□ Yes
Understanding of principles and practices of self-management	□ Yes

Activity 18: Questions

For this task you are required to answer questions that relate to your work as an Allied Health Assistant working in community rehabilitation.

6. What are some of the different frameworks or models used in community rehabilitation?

7. Why is it important to follow OHS procedures when working in the community?

Activity continues on the next page.

Activity 18: Questions (continued)

Draw a map, or flow chart, or the team members involved in a client's community rehabilitation.

Activity 19: Scenario

For this task you are required to read and respond to the scenario provided.

Scenario

You are visiting a client who lives alone. When you arrive at the client's house, you discover that the client has not been attending to self-care tasks, has had several falls, and is not eating proper meals.

How do you manage the situation? Who would you communicate with about this client? What do you think they would do about the situation? Consider the services they would organise? Describe what you would document?

Activity continues on the next page

Activity 19: Scenario (continued)

You will be observed working with clients to support community rehabilitation in the community.

Examples include:

- Providing home based therapy (e.g. self care retraining, complex cooking)
- Mobility and community access
- Community integration/leisure tasks (e.g. community groups, community colleges, sport)

You will need to assist with the rehabilitation of clients on at least two occasions to demonstrate competence.

4. WORKPLACE OBSERVATION CHECKLIST

Assessor to date and sign (draft only, please record in the Assessment Guide)

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initial	2nd observation date & initial	Comments	*FER
Work within the context of community rehabilitation				
• Demonstrates understanding of community rehabilitation				
• Identifies potential difficulties when working in the community				
• Demonstrates an understanding of your role within the community setting				
• Demonstrates an understanding of different models/frameworks used in community rehabilitation				
Work within a multidisciplinary team				
• Demonstrates an understanding of different team members roles with the team				
• Identifies appropriate personal/team members who need to be involved in the client's rehabilitation plan and discuss with professional				
• Communicates with team members (including attending team meetings and individual discussions) to discuss the client's progress/rehabilitation program				
Provide holistic support to clients within the context of the rehabilitation plan				
• Identifies the client's needs				
• Liaises with professional regarding need for further input from other/external services				
• Assists with the referrals to appropriate services/team members				

• Provides client/significant others with ongoing education				
• Considers client's cultural/religious beliefs and organises interpreters if required				
• Encourages and supports client's involvement and participation in their rehabilitation program				
Address risk identification, hygiene and infection control issue				
• Demonstrates awareness into potential safety concerns when working in the community				
• Demonstrates familiarly with risk management plans/strategies of how to manage the situation if a risk occurs				
• Works with professional to develop risk assessments and risk management plans				
• Follows OHS guidelines at all times (including maintain adequate level of personal hygiene, use safety/protection equipment as required, report any incidents/broken equipment)				
Complete documentation				
• Documents all interactions with the client/family/significant others in case notes/medical records				
• Documents and report any broken devices				

*FER – Further Evidence Required

Appendices

Appendix 1 : Example of a Care Plan

Confidential – Client Profiles and Support Plan		
Client Name: Liam	Date of Birth: 1986	
Today's Date: 28/07/2010 *Complex Y* ☒ *N* ☐	Next Review Date 28/01/2011	
This form to be completed by Care Manager for Complex Care Clients, Service Coordinators for Non-Complex Care Clients. Fields will expand as you type. **If issue is not applicable, then N/A should be entered in this field.** For guidance refer to AHCS5141 Client Profile & Support Plan - Guide for Completion – use 'Tab' key to move through the form		
Address:	26 Smith Street	
Next of Kin	Mr and Mrs X Name Mr and Mrs X Significant other present: Yes ☒ No ☐	
Dates of last risk assessment (existing client) AHCS9160 Home Risk Assessment Form – 25/07/2010 & 28/07/2010 AHCS9095 Client Manual Handling Risk Assessment Checklist - 25/07/2010 & 28/07/ 2010	6 Month Evaluation Change / No	
Clinical Management Framework Personnel	Occupational Therapist: Spinal Cord Injury Rehabilitation Consultant: Spinal Cord Injury Outreach Nurse: Continence Nurse Specialist: Physiotherapist: G. P.	
Language Spoken at Home	English	
Form of Communication	Verbal	
Interpreter Required: Yes ☐ No ☒	Specify dialect if relevant:	

Confidential – Client Profiles and Support Plan		
Disability: Client Abilities/Limitations	Liam experiences C5/6 incomplete quadriplegia. This has resulted in altered/ limited upper limb function i.e. reduced movement and strength in his arms and altered hand function. Liam relies on a grip for many activities of daily living. Liam is able to stand for short periods of time with assistance, however, is unable to walk for more than 3-5 steps depending upon fatigue levels. Liam has altered respiratory function and needs to be reminded to carryout his deep breathing and coughing exercises. Liam experiences severe spasm in his lower limbs, along with altered sensation in his body from the nipple line down. Liam also has a supra-pubic catheter.	
Medical conditions (Fact sheets attached: Yes /1 No ❑)	Related to the level of injury Liam is predisposed to experiencing autonomic dysreflexia. He has not experienced this to date.	

Confidential – Client Profiles and Support Plan		
Cultural Requirements/Special requisites	Liam has an extremely supportive family where independence is very important and the notion of extended family living is not an expectation. Liam will continue to receive services in the custom built annexe of the family home to ensure privacy and alone time is maintained.	
Living Arrangements	Liam will move into the family home to live with his mother and father. Liam has lived independently for over 5 years. The family home has been modified to ensure that it is wheelchair accessible, and suitable for Liam to promote his independence and privacy,	
Other Relevant Information	Liam had a partner and strong social network prior to his accident. Liam always went to the pub or parties on the weekend and played football at the local football club.	
Client Goals 1. To be able to go to the local football on Saturday afternoons. 2. To be able to go out with his work mates on Friday nights.		**6 month evaluation –** achieved/not achieved?
Rehabilitation /Care Goals 1. To increase independence with his personal care routine. 2. To increase muscle strength and endurance by implementing exercise routine. 3. To reduce muscle spasm and pain in legs by implementing stretching routine. 4. To increase overall stamina and reduce fatigue levels by implementing an independent support routine suitable to Liam's current needs.		**6 month evaluation –** at discretion of therapist to evaluate program

Treating Therapist	Therapy Goal	Therapy Commencement Date	Therapy Review Date
Occupational Therapist	To increase independence with personal care routine To increase overall stamina and reduce fatigue levels by implementing an independence support routine suitable to Liam's current needs	28/07/2010	28/01/2011
Physiotherapist	To increase muscle strength and endurance by implementing exercise routine. To reduced muscle spasm and pain in legs by implementing stretching routine	28/07/2011	28/01/2011
Continence Nurse	To maintain faecal continence by implementing current bowel management plan	28/07/2010	28/01/2011

Alerts and Medical Requirements		
Coordinators must consult with Care Manager if any of the following care related conditions are part of the client care program		6 month evaluation Change / No Change
Allergies	No Known Allergies	
Neurological Conditions e.g. *seizures*	Autonomic Dysreflexia risk- Emergency. Call an ambulance ph:000 Liam has not experienced this to date. However, some typical signs may include: 1. Pounding headache 2. Rash on neck 3. Goose bumps 4. Sweating 5. Pallor. Whilst waiting for an ambulance the support worker should try to work out what might be causing this. 1. Check catheter and empty bag 2. Check skin for cuts, prickles, stones in shoes. 3. Loosen clothing, particularly belts 4. Check if Liam has used his bowels during the previous 24 hours. Stay with Liam and reassure him until the ambulance arrives.	
Respiratory Management *e.g. Asthma*	Liam has reduced ability to inflate his lungs related to his spinal cord injury. This means that Liam needs to be reminded to take deep breaths and cough on a regular basis. Liam has a deep breathing and coughing exercise routine that needs to be implemented twice per day. Liam will take responsibility for this, but may require prompting to perform this, particularly at night when he is tired.	

Alerts and Medical Requirements		
Medication	Assistance with medication. Medication is kept in the Webster pack which is located on the top shelf of the kitchen cupboard.	
Emergency Management (Ring 000 + Coordinator unless otherwise stated)	Support Worker to dial 000 and ask for an ambulance. Explain that Liam has a C5/6 Spinal Cord Injury and may experience autonomic dysreflexia. Liam has an emergency pendant alarm	*Service Advisor consulted Yes* ☒
Behaviour Management	Not applicable	*Service Advisor consulted Yes* ☒
Family Members as Direct Care Staff for Program		
Family members employed as paid carers yes ☐ no ☒ How many N/A		

Daily Routine		6 Months
Day/Times	**Actions**	**Safe Operating Procedures**
Personal Care routine Mon- Fri 0700-0900 Sat- Sun 0900-1100	Greet Liam and enquire about his night. Personal Care routine: breakfast medication assistance bowel care urinary catheter management showering/ drying dressing	Ensure that the bed is raised to the hip height of the support worker so that Back attack principles can be used. Ensure that the brakes are on the commode chair prior to the transfer. Ensure that the ceiling hoist is in working order and the battery is charged before commencing the transfer.

Daily Routine		6 Months
Therapy Support Mon- Fri 0900- 1100 Sat- Sun 1100-1300	Stretching routine Exercise routine Standing Machine Deep breathing and coughing routine	Ensure that the bed is raised to ensure that the height enables the use of back attack principles. Follow the routines as demonstrated in client specific training sessions. Encourage Liam to participate in the actions he can perform independently.
Community Access Monday 1200 – 1500 Wednesday 1300 – 1500	Liam is supported to attend the local shops, which are around the corner to buy small grocery items, personal items, clothing and go into the music shop which he loves. The Support Worker walks with Liam whilst he controls his electric wheelchair. Liam will direct where he would like to go and when. He often likes to meet friends for coffee during this time at a local café where his friend works. Liam also likes to eat lunch out at a café. Liam uses this time to go in his wheelchair with the independence Support Worker to the local park which has good accessibility – he enjoys going out into the fresh air. Liam might decide to go for a walk in the neighbourhood as he takes a strong interest in the building developments in his local area, and follows real estate closely.	Ensure that IIam has his safety belt doen up when in the wheelchair. Liam will control the wheelchair; however ensure that manual override instructions are clear before going out. Ensure Liam has his mobile phone with him at all times. If the weather is extremely cold and or wet, Liam will not go outdoors. A maxi taxi can be used. His parents keep cab vouchers which are stored in Liam's bed side drawer. Support Worker not to consume alcohol whilst working with Liam. Ensure that he is comfortable with the situation and be ready to take him home when he decides to go. Ensure Liam's mobile phone is with him.

Daily Routine		6 Months
Community Access Cont. Friday 1600 – 1900 Saturday 1300 - 1700	Liam usually likes to go with the Support Worker to the local pub to meet with his Trade mates after work on a Friday. A core group of work friends attend, and Liam requires support with his urinary catheter bag, pressure area care during this time. Liam likes the Support Worker to be part of this social gathering. Liam may ask to go home after a short period depending on his fatigue levels at the end of the week. He might request that a pizza is ordered for home delivery whilst on his way home. The phone number is in his mobile phone.	Liam will go to the local football along the path, as the ground is within 0.6km from his home. If the weather is poor a maxi taxi will be ordered and this can be booked in advance.
Personal Care Mon, Tue, Thurs, Fri 1500 – 1600 Wed, Sun 1200 – 1300 Sat 1700 – 1800	Assist Liam to transfer from chair to bed. Empty urinary drainage bag and check stoma site Check skin integrity Assist with positioning and pressure area care Place wheelchair on charger Offer Liam a drink Ensure that Liam is set up with the computer, television, music or book Liam might like to rest for this time Assist Liam with his meal on Saturday night as he is usually tired after his day out.	Apply backattack principles for all personal care tasks, particularly transfers and positioning. Liam's family members return home after work and other commitments at approximately 5:00pm at the latest. This is the time the family would prefer not to have support workers in the home. The Support Worker should leave Liam unattended at the end of the shift, ensuring his is comfortable and has access to his phone and his emergency alarm pendant.

Daily Routine		6 Months
Therapy Support Mon – Fri and Sun 2000 - 2100	Stretching routine Deep breathing and coughing routine Liam has chosen not to perform stretching routine on Saturdays (to be reviewed)	Apply back attack principals when supporting Liam to complete his exercise and stretching routine. Use backattack stances and raise Liam's bed to hip height.
Personal Care Mon – Sun 2100 - 2300	Assist Liam with oral hygiene, face and hand washing Assist Liam to transfer into bed using hoist. Assist with medication administration Assist Liam with undressing/removal of antiembolic stockings Assist Liam to change into night attire Provide urinary catheter care and attach night bag. Assist with hand hygiene, washing, drying and applying hand cream. Offer Liam a drink Assist with position on his left side.	Apply backattack prinicpals when supporting Liam with his hygiene needs Elevate bed whilst preforming personal care tasks whilst Liam is in the bed Encourage Liam to participate in all activities to promote independence.
Inactive Overnight Care. Mon – Sun 2300 – 0700	Liam does not usually require intervention overnight. Liam will call out if he needs assistance with reposition, or stretching to assist with spasms. The Support Worker has a monitor in their bedroom so they can hear Liam when he calls. There is also a backup doorbell that will ring in the Support Worker's room	

Care/Support Detail		6 month evaluation Change/No Change
Hygiene Bath/Shower	Liam showers daily on a commode chair with a safety belt in place. Ensure the bathroom is warm prior to commencing the shower routine. Adjust the running water and check that the temperature is safe as Liam has altered sensation in his truck and lower limbs. Ensure that Liam is wheeled into the shower recess safely and that his legs are safely placed on the foot plates of his commode chair. Liam does not use soap as his dries out his skin. He likes to use a soap free shower gel. Encourage Liam to wash the areas he can manage, these are face, trunk arms, hands, between fingers and legs. Liam requires assistance to wash his lower legs, back and bottom. Liam washes his hair every second day and will direct the Support Worker as to when this is to be completed. Liam likes to have a few minutes without the Support Workers involved in his shower routine. Respect his privacy and use this time to change linen and place dry towels on his bed to be used once routine is completed. Ensure Liam washes the stoma site of the supra pubic catheter and rinse well. Liam will turn off the shower.	

Care/Support Detail		6 month evaluation Change/No Change
	Support Worker to provide Liam with 2 towels to keep him warm and commence the drying routine. Liam will dry his own pace, upper-arms, underarms, chest, stomach, groin, upper legs and S.P.C. stoma site. Assist Liam to dry his lower legs, back, and check under his arms. Liam will clean his teeth at the basin prior to being transferred back to bed to complete the drying routine. Transfer Liam onto the bed using the ceiling hoist. Once on the bed Support Worker to assist Liam to roll onto his left side to continue drying his back, bottom and using this time to look at his skin and report any red areas, or skin breakdown to Liam immediately. Roll Liam onto his back once completed and dry under his arms and between his fingers. Ensure Liam's privacy is maintained during this process and he is kept warm.	
Dressing/Grooming	Liam chooses his own clothing and prefers to wear loose comfortable clothing. Liam is able to put on upper body clothing, but will need assistance with his boxer shorts and tracksuit pants. Liam needs full assistance to put on anti-embolic stockings that assist with the swelling in his lower legs. Ensure these are not	

Care/Support Detail		6 month evaluation Change/No Change
	too tight and applied smoothly without creases. Support Worker to ensure that there are no creases or rolled over waistbands in his clothing that might cause pressure areas. Assist Liam to put on his shoes, ensuring they are inspected for creases and small objects prior inside them prior to assisting Liam to put these on. Liam prefers to shave later in the morning and will perform this task. Liam will request that the electric shaver is given to him by the Support Worker. Liam might request the Support Worker to clean the razor. Liam will apply deodorant, and to do his *Oral Hygiene* hair once his is transferred back into the wheelchair.	
Oral Hygiene	Liam will brush his own teeth at the basin once the shower/dressing routine is completed. Liam attends dental appointments annually.	

Care/Support Detail		6 month evaluation Change/No Change
Urinary Continence Management	Liam has a supra pubic catheter. The Continence Nurse manages the supra pubic catheter (SPC) changes. Support Workers must empty the urinary drainage bag if requested to do so. Standard precautions are to be used for assisting Liam with	
	catheter care. Ensure that gloves are worn prior to emptying the drainage bag. A jug is kept in the bathroom next to the toilet, use this to empty the urine out of the bag and discard into the toilet. Rinse the jug and empty the contents into the toilet. Flush the toilet, remove and discard gloves. Wash hands. The SPC site is to be inspected twice each day, report any concerns such as: redness, inflammation, discharge to Liam for monitoring and follow up with the health professionals. Liam might experience problems with catheter blockages. If this occurs call the Continence Nurse and or an ambulance. Liam will assess his urine for increased sediment, debris and blood. Report any noted changes to Liam. The Continence Nurse will manage the catheter changes which occur every 6-8 weeks.	

Care/Support Detail		6 month evaluation Change/No Change
Bowel management	Liam has a bowel management plan which has been developed by the Spinal Cord Injury Nurse. Liam takes Senokot tablets every night before going to bed and has assisted bowel care every second morning. Liam will direct this. Bowel Care: Assist Liam to roll onto his left side and insert a Durolax	
	suppository into his rectum with a lubricated gloved index finger. Once completed, remove and discard glove, roll Liam onto his back with a bluey/protective sheet underneath his bottom and wash hands. Liam will have breakfast whilst waiting for the suppository to work. Liam will direct the Support Worker when it is time to be transferred onto the commode chair. This occurs approximately 30 minutes after breakfast. Transfer Liam onto the commode chair using the ceiling hoist. Wheel Liam over the toilet for him to open his bowels. This may take up to 30 minutes. Encourage Liam to assess the amount of faeces that has been passed into the toilet. Liam does not require a rectal check. Assist Liam to clean his bottom prior to the showering routine commencing.	

Care/Support Detail		6 month evaluation Change/No Change
Pressure Care	Liam is responsible for his own pressure area care. He will perform his pressure relieving techniques when sitting in the wheelchair. However, he might ask for assistance and a change in position. Liam has a custom-made pressure relieving cushion on his wheelchair at all times. Support	
	Worker to ensure that this is clean, intact and placed in the correct position prior to transferring Liam into the wheel chair. When Liam is resting in bed he has a pressure relieving mattress, and may require one turn overnight. Liam will request when it is necessary for the support worker to assist him with this	

Care/Support Detail		6 month evaluation Change/No Change
Mobility/Positioning	Liam experiences incomplete quadriplegia so has some limited movement in his legs. Liam is able to move his legs using his arms as a lever to change pressure points and can move out of the wheelchair to stand for a few minutes on a good day. Liam will direct when this is possible. Liam sits in the electric wheelchair most of the time when sitting out of bed as he finds this most comfortable. Liam requires assistance with positioning in the bed, particularly when settling for the night. Liam also requires assistance with a position change overnight, particularly if he is experiencing leg and abdominal spasms.	
Manual Handling/ Transfers	Liam transfers using a sling and ceiling hoist. The sling is kept on a hook on the back of his bedroom door. Liam requires the 2 red loops to be attached to the hoist and the 2 blue loops. Check that the loops are securely attached to the hoist prior to	

Care/Support Detail		6 month evaluation Change/No Change
	commencing the transfer. Liam will use the hand controls to move the hoist. The Support Worker needs to supervise the transfer and assist Liam with correct positioning when he is lowered into the commode chair or wheelchair. Liam also has a standing frame to promote weight bearing which is used as part of his exercise routine. Liam requires assistance and supervision with all transfers - refer to the client manual handling risk assessment for more detail.	
Supervision/Safety Issues	Liam requires supervision with all transfers and particularly when he experiences spasms. Liam had one situation in hospital when the leg spasms made him fall out of bed. This has resulted in Liam requiring reassurance and confidence in relation to his safety during these episodes. Liam can be left alone for 1-2 hours if he is in bed, comfortably positioned, has access to the phone and emergency alarm.	
Meal Preparation/ Dietary Preferences/ Meal Assistance	Liam likes to supervise meal preparation. His mother likes to cook the evening meal however, Support Worker might need to assist Liam to prepare snacks, make hot drinks as requested. The Support Worker prepares breakfast. Liam likes to have a cup of tea when he wakes up	

Care/Support Detail		6 month evaluation Change/No Change
	followed by cereal and fruit. Liam may ask for a cup of coffee before he commences his personal care routine. This is useful to stimulate his gastrocolic reflex which assists with the bowel routine. Liam prefers to eat meat and vegetables, fruit, etc. However, on Friday nights he prefers pizza after he has been out with his friends. He also likes to drink soft drinks. Liam dislikes spicy food and dislikes fish. Liam uses adaptive equipment to assist him with meal preparation. Assistance might be required related to fatigue.	
Community Access/ Transport	Community access is an important part of Liam's Independence Support Plan. Liam uses his electric wheelchair to travel to the local shops, football club, etc. However, if transport is required for longer distances or related to poor weather maxi taxis are to be booked and the Support Worker travels with him. The taxi vouchers are managed by Liam and stored in his bed side drawer. Liam is awaiting funding for a modified vehicle.	

Care/Support Detail		6 month evaluation Change/No Change
Household Tasks	Wash dishes Clean bathroom Change bed linen and Liam's clothes Hang washing out onto the clothes line	
Shopping	Assist Liam to purchase small grocery items during community access shifts, personal items. Liam's mother does the food shopping. Assist Liam to shop for clothes, shoes as directed by him.	
Financial Dealings – description of tasks receipt/process	Liam is responsible for all his financial affairs. If assistance is required, his father will support him with this.	
Other	Liam likes to have some down time when support workers are present but not directly with him. During these times, household tasks can be performed as per the home care checklist.	
Name	Jane Smith	
Position	Service Advisor	
Date	28/07/2010	
Signature		

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