# Care Needs Assessment Report (CNAR)

Use this report form for complex and standard assessments for the Lifetime Care scheme and the Workers Care program

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| --- |
| Once completed please e-mail this form to: Care-Requests@icare.nsw.gov.au An Attendant Care Service Request (ACSR) should also be submitted with the CNAR if requesting attendant care services |
| **The person** |
| **Name** | **Participant No. or Claim No.** |
|       |       |

## **Care needs assessor**

|  |  |
| --- | --- |
| **Name** | **Role/Position** |
|       |       |
| **Organisation** | **Qualification** |
|       |       |
| **Phone** | **Email** |
|       |       |

## **Dates**

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| --- |
| **Date of assessment** |
|       |
| **\*Proposed dates for this care period** |
| **From** | **To** | **Number of weeks** |
| Click or tap to enter a date. | Click or tap to enter a date. |       |

\*the care period should be however long the assessor can reasonably predict that the care need is likely to remain unchanged

## **The person’s current situation**

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| **Provide a summary of the person’s health, social circumstances and living arrangements, including who lives in the household and their roles and responsibilities** |
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## **Feedback on current attendant care program**

**Provide a summary of feedback on the current care arrangement from each of the following (where applicable)**

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| **Participant** |
|       |
| **Family/Guardian** |
|       |
| **Attendant Care Provider (if applicable)** |
|       |
| **Case Manager** |
|       |
| **Treating team** |
|       |

\*Assessors should seek feedback from the Care Coordinators, not individual support workers, to obtain information on the attendant care program as a whole

## **Injury information**

### SCI Level & ASIA

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| --- |
| **As provided in referral – state SCI level and ASIA score for all adults with SCI** |
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## Descriptors of SCI

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| --- |
| **Complete this description for all adults with incomplete SCI (reference: Guidance on the support needs of adults with spinal cord injury 2017 3rd edition, p 45-71)**  |

|  |  |  |  |
| --- | --- | --- | --- |
| Upper Limb / Shoulder function |  [ ]  None - Poor |  [ ]  Good – Full |  |
| **Hand function** |  [ ] None - Poor |  [ ] Some – Good | [ ]  Very good - Full |
| **Ambulation description** |  [ ] Non-walker | [ ] Household walker | [ ]  Community walker |

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| **CANS Level**  |
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As provided in the referral - state CANS level OR complete a new CANS for adults with a brain injury only when this has been requested in the referral.

## Other injuries

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| **Provide a brief description including body areas affected** |
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## Non-injury-related health conditions impacting care

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## Care program aims

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| **What does the person wish to achieve from their attendant care?** |
|       |

## **Moving Around**

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| --- | --- | --- |
| **Task observed** | **Moving around support required**Provide a description of the type and level of support the person requires to move around and an indication of what that looks like throughout the day and night as they go about their activities. Include information where there is a difference in internal home mobility and community mobility care needs and any resulting difference in time allocations for the same task.  | **Equipment required**List any items of equipment the person uses to move around and a description of the support they require to use these items |
| **Walking, climbing stairs, using wheelchair** |       |       |
| **Transfers** |       |       |
| **Bed Mobility** |       |       |
| **Other**(including any additional functional assessments) |       |       |

### **Third party report** [ ]  **Self report** [ ]

|  |
| --- |
| **Comment if any task/s is not directly observed and a third party or self-report is used** |
|       |
| What alternatives to care have been considered and what was the outcome?**This includes realistic alternatives such as equipment, monitoring devices and personal alarms** |
|       |

|  |
| --- |
| Changes since last assessmentHas the person’s functional capacity changed? If so, comment on the nature of these changes |
|       |
| What changes could be expected and when?This may be related to the provision of equipment, home modifications or a change in the person’s functional ability. The assessor should take into account the current rehabilitation goals detailed in the person’s current My Plan and any functional changes anticipated which may have an impact on the support they require to move around |
|       |
| Other factorsAre there any other factors or considerations that impact on the person’s care in this domain?E.g.: Cognitive / physical fatigue, parenting responsibilities, rehabilitation program, behavior and communication etc |
|       |

## **Self-Care**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Task observed** | **Self-care support required**Provide a description of the type and level of support the person requires for self-care tasks and an indication of what that looks like throughout the day and night as they go about their activities.  | **Equipment required**Describe the support required to use each item  | **Time required**Each time task is performed | **Time required** *Hours per week* |
| **Eating and Nutrition** |       |       |       |       |
| **Grooming, bathing and dressing** |       |       |       |       |
| **Toileting** |       |       |       |       |
| **Medication** |       |       |       |       |
| **Other** |       |       |       |       |
| **Total support required for self-care** |       |       | **Total hours per week**      |

### **Third party report** [ ]  **Self- report** [ ]

|  |
| --- |
| **Comment if any task/s is not directly observed and a third party or self-report is used** |
|       |
| What alternatives to care have been considered and what was the outcome?**This includes realistic alternatives such as equipment, monitoring devices and personal alarms** |
|       |
| Changes since last assessmentHas the person’s functional capacity in the areas above changed? If so, comment on the nature of these changes |
|       |
| What changes could be expected and when?This may be related to the provision of equipment, home modifications or a change in the person’s functional ability. The assessor should consider the current rehabilitation goals detailed in the person’s current My Plan and any functional changes anticipated which may have an impact on the support they require for self-care |
|       |
| Other factorsAre there any other factors or considerations that impact on the person’s care in this domain? |
|       |

## **Day to day activities and responsibilities**

|  |  |  |
| --- | --- | --- |
| **Task observed** | **Day to day activities and responsibilities support required***Provide a description of the type and level of support the person requires to manage their day to day activities and responsibilities in the context of their current circumstances i.e. with other members of the household completing the tasks that are their own responsibility. Include information on the tasks to be completed and an indication of what that looks like throughout the day and night as they go about their activities. For example, does the person require prompting and supervision or do they require physical assistance? Is two-person support required for any of the tasks associated with the areas below?* | **Time required (hours per week)** |
| **Shopping** |       |       |
| **Money management** |       |       |
| **Food preparation**  |       |       |
| **Laundry** |       |       |
| **Household cleaning** |       |       |
| **Transport and accessing the community** |       |       |
| **Communication and household management** |       |       |
| **Pets or icare funded assistance animals** |       |       |
| **Other** |       |       |
| **Total support required****For day to day routine and home responsibilities** |  | **Total hours per week:**      |
| **Other support required** |  | **Total hours** |
| **Car cleaning (periodic)** |        |       |
| **Home maintenance** |       |       |
| **Garden/lawn care** |       |       |

### **Third party report** [ ]  **Self- report** [ ]

|  |
| --- |
| **Comment if any task/s is not directly observed and a third party or self-report is used** |
|       |
| What alternatives to care have been considered and what was the outcome?**This includes realistic alternatives such as equipment, monitoring devices and personal alarms** |
|       |
| Changes since last assessmentHas the person’s functional capacity in the areas above changed? If so, comment on the nature of these changes |
|       |
| What changes could be expected and when?This may be related to the provision of equipment, home modifications or a change in the person’s functional ability. The assessor should consider the current rehabilitation goals detailed in the person’s current My Plan and any functional changes anticipated which may have an impact on the support they require for self-care |
|       |
| Other factorsAre there any other factors or considerations that impact on the person’s care in this domain? |
|       |

## **Current rehabilitation program activities**

|  |  |  |
| --- | --- | --- |
| **Activity** | **Current rehabilitation program activities to support required****Provide a description of the type and level of support the person requires to manage their current rehabilitation program activities in the context of their current circumstances. Include information on the tasks to be completed and an indication of what that looks like as they complete their rehabilitation activities. For example, does the person require prompting and supervision or do they require physical assistance? Is two-person support required for any of the tasks associated with the areas below?** | **Time required (hours per week)** |
| **1.** |       |       |
| **2.** |       |       |
| **3.** |       |       |
| **4.** |       |       |

### **Third party report** [ ]  **Self- report** [ ]

|  |
| --- |
| **Comment if any task/s is not directly observed and a third party or self-report is used** |
|       |
| What alternatives to care have been considered and what was the outcome? |
|       |
| What changes could be expected and when?The assessor should consider the current rehabilitation goals detailed in the person’s current My Plan and any functional changes anticipated which may have an impact on the support they require for their current rehabilitation program activities |
|       |
| Other factorsAre there any other factors or considerations that impact on the person’s care in this domain? |
|       |

## **Life and relationships**

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| --- | --- | --- |
| **Task observed** | **Life and relationships support required***Provide a description of the type and level of support the person requires for major life areas and relationships, as well as an indication of what that looks like throughout the day and week as they go about their activities. For example, does the person require prompting and supervision or do they require physical assistance? Also consider the activities described in the person’s My Plan and whether there could be a need for attendant care support to assist with the achievement of their goals?* | **Time required (hours per week)** |
| **Vocational or other programs, education, work** |       |       |
| **Recreational activities** |       |       |
| **Parenting or caring responsibilities** |       |       |
| **Social relationships** |       |       |
| **Personal safety and independent living** |       |       |
| **Other** |       |       |
| **Total support required****For major life areas and relationships** |  | **Total hours per week:**      |

### **Third party report** [ ]  **Self- report** [ ]

|  |
| --- |
| **Comment if any task/s is not directly observed and a third party or self-report is used** |
|       |
| Other factorsAre there any other factors or considerations that impact on the person’s care need in this area of support? |
|       |

## **Overnight Care**

Is overnight care required? [ ]  **Yes** [ ]  **No**

|  |  |  |
| --- | --- | --- |
| **If active** | **Description of scheduled tasks and frequency** | **Time required (hours per week)** |
|       |       |

|  |
| --- |
| What alternatives to care have been considered and what was the outcome? |
|       |
| What are the risks to the participant if overnight care is not provided? What is the likelihood of these risks occurring? |
|       |

|  |  |  |
| --- | --- | --- |
| **If sleepover** | **Reasons** | **Number of sleepovers per week** |
|       |       |

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| Why is the sleepover support required? |
|       |
| What are the risks to the participant if sleepover support is not provided? What other options were considered? Why weren’t these appropriate? |
|       |

## **Two-person service**

Are there any tasks that require support from more than one person? [ ]  **Yes** [ ]  **No**
For information on guidelines for 2 person services including exploring alternatives see [Two person assessment](http://managingrisk.living-with-attendant-care.info/Content/Two_Person_Service_Assessment_a_Introduction.html)

|  |
| --- |
| If yes, list these tasks |
|       |
| Why is a second person required for these tasks and what are the risks to the participant and/or their support workers if a second person is not available? |
|       |
| **What alternatives have been considered and/or trialled?** |
|       |
| **What was the outcome?** |
|       |

## **Registered Nursing**

Please note that icare adheres to ACIA guidelines regarding tasks that require a Registered Nurse. The guidelines are available at [www.acia.net.au](http://www.acia.net.au)

Is the Registered Nursing Care required? [ ]  **Yes** [ ]  **No**

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| --- |
| **If yes, list the tasks to be completed, including the time taken and frequency across the day/week** |
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## **Behaviour support**

Is a behavior support plan in place or any authorized restrictive practices? [ ]  **Yes** [ ]  **No**

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| --- |
| **If yes, what is the review date and the impact if any, on the care program?** |
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## **Gardening and home maintenance**

Does the person have a care need related to gardening or home maintenance? [ ]  **Yes** [ ]  **No**

|  |
| --- |
| **If yes, list the tasks to be completed, (regular and periodic) including the time taken and frequency. Provide a description of the size of the house, garden and lawn. Consider the need for support for routine or periodic maintenance such as external window cleaning, gutter cleaning or spring cleaning. List any environmental risk factors associated with the property** |
|       |

## **Personal preferences, cultural and religious considerations**

|  |
| --- |
| **Provide information on any personal preferences, cultural or religious beliefs that impact on how the person’s support is delivered and by whom?**  |
|       |

## **Environmental considerations**

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| --- |
| **Provide information on any risks that the person’s home and community may present to support workers?** |
|       |

## **Other considerations/risks**

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| --- |
| **Any other comments such as WHS issues, emergency situations and plans if needed** |
|       |

## **Recommendations from the assessor (if applicable)**

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| **Recommendations may include training needs for support workers, any specific monitoring required, medical/specialist/other services recommended, considerations around non-injury related needs and how these are met** |
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## **Additional comments/observations**

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| --- |
| **Provide any additional comments or observations that may assist with the safe delivery of care** |
|       |

## Support Summary

|  |  |
| --- | --- |
|  | **Care need (hours per week)** |
| **Total attendant care needed per week (excluding sleepovers)** |       |
| **Total attendant care needed per week for 2nd support worker** |       |
| **Sleepovers** | Sleepovers per week      |
| **Registered Nursing** |       |
| **Garden and home maintenance** |       |

### **Other irregular and periodic hours required in the period – specify how often and duration**

|  |
| --- |
| **E.g. school holiday periods or one-off appointments** |
|       |

## **Category of attendant care required**

|  |
| --- |
| **Attendant care service providers are approved across all or some of the categories below. Based on your review and clinical judgement, please indicate the category of service the person requires****Physical Support** [ ]  **Yes** [ ]  **No****Cognitive and behavioral support** [ ]  **Yes** [ ]  **No****Clinical / high level support** [ ]  **Yes** [ ]  **No** |
|  |

## **Assessor declaration**

|  |
| --- |
| **The following people were contacted in relation to this Care Needs Assessment (list name and role)** |
| 1.
 |
| 1.
 |
| 1.
 |
| 1.
 |

Based on my clinical review and judgement, this report documents the person’s care needs related to the motor accident injury or accepted workers compensation claim

|  |  |
| --- | --- |
| **Name**  | **Signature** |
|       |       |
| **Title** | **Date** |
|       |       |