

**Participant Needs Assessment Report**

**(PNAR)**



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| **Completing this form*** A Participant Needs Assessment Report (PNAR) must provide clarity on the participant’s current functional profile, their care needs and living situation.
* It is expected that the assessor observes the participant completing tasks within their home context and limits the use of “third party report” or “self-report”.
* Please complete the Attendant Care and Support Service Request (ACSR) on page 12 if you are submitting a service request for attendant care and support on the participant’s behalf.
* Please refer to the “Completing NIISQ participant needs assessments” guideline for further details.
* Please send all completed request forms to requests@niis.qld.gov.au.
 |

SECTION 1

PARTICIPANT INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Participant Case Number** |  |
| **Address** |  |
| **Contact Name** |  | **Contact Phone** |  |
| **Injury** | [ ] **TBI**  [ ] **SCI** [ ] **Amputation** [ ] **Burns** [ ] **Blindness** [ ] **Brachial Plexus** |

FORM COMPLETED BY

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

DECLARATION

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| The participant has been involved as much as possible in the development of this request, in collaboration with their family member or nominated participant if necessary. The participant (and family member or nominated participant) agrees with this request.  |
| **Name:** |  | **Date:** |  |

SECTION 2

INJURY INFORMATION

Traumatic Brain Injury

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| **CANS level****Please provide a copy of CANS Ax. Form** |  |

Spinal Cord Injury

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

Other injuries:

*Provide a brief description including body areas affected.*

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Non- injury-related health conditions impacting care:

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The participant’s current situation:

*Provide a summary of the participant’s health, social circumstances and living arrangements, including who lives in the household and their roles and responsibilities. Include information on formal and informal supports.*

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Feedback on current attendant care program (if applicable)

*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** |  |
| **Treating Team** |  |

SECTION 3

FUNCTIONAL ASSESSMENT1,2

Moving around

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| Pre- Injury level of Function: |  |

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| **Task observed** | **Moving around support required***Provide a description of the type and level of support the participant 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 participant uses to move around and a description of the support they require to use these items* | **Time required** **(hours per week)** |
| **Walking, climbing stairs, using wheelchair1,2** |  |  |  |
| **Transfers1,2** |  |  |  |
| **Bed Mobility1,2** |  |  |  |
| **Other** |  |  | **Total hours per week** |

What alternatives to attendant care and support have been considered and what was the outcome?

*This includes realistic alternatives such as equipment, monitoring devices and personal alarms.*

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Changes since last assessment

Has the participant’s functional capacity in the areas above changed? If so, comment on the nature of these changes.

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What changes could be expected and when?

This may be related to the provision of equipment, home modifications or a change in the participant’s functional ability. The assessor should consider the current rehabilitation goals detailed in the participant’s current support plan and any functional changes anticipated which may have an impact on the support they require to move around.

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Other factors

Are there any other factors or considerations that impact on the participant’s care in this domain?

e.g.: Cognitive / physical fatigue, parenting responsibilities, rehabilitation program, behaviour and communication etc.

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SECTION 4

SELF-CARE1,2

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| Pre- Injury level of Function: |  |

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| **Task observed** | **Self-care support required***Provide a description of the type and level of support the participant requires for self-care tasks and an indication of what that looks like throughout the day and night as they go about their activities. For example, does the participant 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?* | **Equipment required***List any items of equipment the participant requires to move around and provide a description of the support they require to use them.* | **Time required***Provide an indication of the time the task takes each time it’s performed.* | **Time required (hours per week)** |
| **Eating and Nutrition1** |  |  |  |  |
| **Grooming, bathing and dressing1,2** |  |  |  |  |
| **Toileting1,2** |  |  |  |  |
| **Medication1** |  |  |  |  |
| **Other** |  |  |  |  |
| **Total support required for self-care:** |  |  | **Total hours per week:** |  |

What alternatives to care have been considered and what was the outcome?

This includes realistic alternatives such as equipment, monitoring devices and personal alarms.

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Changes since last assessment

Has the participant’s functional capacity in the areas above changed? If so, comment on the nature of these changes.

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What changes could be expected and when?

This may be related to the provision of equipment, home modifications or a change in the participant’s functional ability. The assessor should consider the current rehabilitation goals detailed in the participant’s current support plan and any functional changes anticipated which may have an impact on the support they require for self-care.

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Other factors

Are there any other factors or considerations that impact on the participant’s care in this domain?

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SECTION 5

DAY TO DAY ACTIVITIES AND RESPONSIBILITIES1,5,9,10,11

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| --- | --- |
| Pre-I Injury level of Function: |  |

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| **Task observed** | **Day to day activities and responsibilities support required***Provide a description of the type and level of support the participant 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 participant 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)** |
| **Shopping1,5** |  |  |
| **Food preparation10** |  |  |
| **Laundry10** |  |  |
| **Home maintenance11** |  |  |
| **Transport and accessing the community9** |  |  |
| **Communication and household management1** |  |  |
| **Car cleaning (periodic) 11** |  |  |
| **Garden/lawn care11** |  |  |
| **Other** |  |  |
| **Total support required for day to day routine and home responsibilities** |  | **Total hours per week:** |  |

Changes since last assessment

Has the participant’s functional capacity in the areas above changed? If so, comment on the nature of these changes.

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What changes could be expected and when?

*This may be related to the provision of equipment, home modifications or a change in the participant’s functional ability. The assessor should consider the current rehabilitation goals detailed in the participant’s current Support plan and any functional changes anticipated which may have an impact on the support they require for day to day routines and home responsibilities.*

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Other factors

*Are there any other factors or considerations that impact on the participant’s care in this domain?*

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SECTION 6

CURRENT REHABILITATION PROGRAM ACTIVITIES1

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| Pre-I Injury level of Function: |  |

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| **Activity** | **Current rehabilitation program activities to support required***Provide a description of the type and level of support the participant 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 participant 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.** |  |  |

What alternatives to care have been considered and what was the outcome?

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What changes could be expected and when?

The assessor should consider the current rehabilitation goals detailed in the participant’s current Support plan and any functional changes anticipated which may have an impact on the support they require for their current rehabilitation program activities.

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Other factors

Are there any other factors or considerations that impact on the participant’s care in this domain?

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SECTION 7

LIFE AND RELATIONSHIPS1,5,6,7,8

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| Pre-I Injury level of Function: |  |

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| **Task observed** | **Life and relationships support required***Provide a description of the type and level of support the participant 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 participant require prompting and supervision or do they require physical assistance? Also consider the activities described in the participant’s Support 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 /education/ work programs5,7** |  |  |
| **Recreational activities5,6,8** |  |  |
| **Parenting or caring responsibilities7** |  |  |
| **Social relationships5,6,8** |  |  |
| **Personal safety and independent living1,6,7** |  |  |
| **Other** |  |  |
| **Total support required for major life areas and relationships** |  | **Total hours per week:** |  |

Other factors

Are there any other factors or considerations that impact on the participant’s care need in this area of support?

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SECTION 8

OVERNIGHT CARE1,3

Is overnight care required? [ ] Yes [ ] No Active overnight care [ ]  Inactive overnight care [ ]

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| **Description of scheduled tasks and frequency** | **Time required (hours per week)** |
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What alternatives to care have been considered and what was the outcome?

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What are the risks to the participant if active overnight care is not provided? What is the likelihood of these risks occurring?

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SECTION 9

TWO-PARTICIPANT SERVICE2

Are there any tasks that require support from more than one participant? [ ]  Yes [ ]  No

If yes, list these tasks:

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Why is a second participant required for these tasks and what are the risks to the participant and/or their support workers if a second participant is not available?

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What alternatives have been considered and/or trialled? What was the outcome?

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SECTION 10

NURSING CARE4

Is a Registered Nursing Care required? [ ]  Yes [ ]  No

If yes, list the tasks to be completed, including the time taken and frequency across the day/week:

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SECTION 11

BEHAVIOUR SUPPORT1,5

Is a behaviour support plan in place or any authorised restrictive practices? [ ]  Yes [ ]  No

If yes, what is the review date and the impact if any, on the care program:

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SECTION 12

OTHER CONSIDERATIONS

## Participant preferences, cultural and religious considerations

Provide information on any participant preferences, cultural or religious beliefs that impact on how the participant’s support is delivered and by whom?

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Environmental considerations

Provide information on any risks that the participant’s home and community may present to support workers?

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Other considerations/risks

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

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Additional comments / observations

Provide any additional comments or observations that may assist with the safe delivery of care:

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Summary of Participant’s Assessed Needs

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| --- | --- |
| **Attendant Care and Support Service Type** | **Hours per week** |
| Personal Care - Support worker hours (excluding inactive sleepovers) 1 |  |
| Personal Care - Second support worker (hours) 2 |  |
| Personal Care - Inactive sleepover (number of nights per week) 3 |  |
| Nursing Care4 |  |
| Community Access Support5 |  |
| Respite services (in-home / facility) 6 | *Please note frequency (may be monthly/3monthly etc.)* |
| Family Unit Support7 |  |
| Day Program8 |  |
| Transport for treatment and rehabilitation (km or fares) 9 |  |
| Domestic Assistance10 |  |
| Home / Garden maintenance11 | *Please note frequency (may be monthly/3monthly etc.)* |
| **TOTAL Weekly Hours:** |  |

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**Attendant Care and Support Service
Request (ACSR)**

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| **Completing a NIISQ Attendant Care and Support Service Request (ACSR):*** Please complete this section if attendant care and support (AC&S) services are being requested.
* Services should only be requested following consultation and agreement from the participant (and/or family member/guardian).
* Please note, the ACSR may request less hours than the participant’s assessed need (i.e. informal supports are in place), however, the ACSR request must not exceed the participant’s assessed need.
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| **Date of this request:** |  |
| **Proposed dates:** | **From:** | **To:** | **Number of weeks:** |
|  |  |  |

AC&S Service Type Breakdown

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| --- | --- | --- | --- |
| **Attendant Care and Support Service Type** | **Details of care**e.g.: days of the week, tasks & hours | **Total Hours**(per week) | **Provider**(if known) |
| Personal Care - Support worker hours (excluding inactive sleepovers) | *i.e. 12hours/day Mon – Sat (7am-7pm)* | *72hrs* |  |
| Personal Care - Second support worker (hours) |  |  |  |
| Personal Care - Inactive sleepover (number of nights per week) |  |  |  |
| Nursing Care |  |  |  |
| Community Access Support |  |  |  |
| Respite Care (in-home / facility) |  |  |  |
| Family Unit Support  |  |  |  |
| Day Program |  |  |  |
| Transport for treatment and rehabilitation (km or fares) (incurs GST) | *i.e.* *Participant’s home to Physio Plus Buderim: 25 km return/week**Participant’s home to GP practice: 15km return/month* | *Total kms/week* |  |
| Supported Accommodation  | *Include ratios* |  |  |
| Domestic Assistance |  |  |  |
| Home/Garden Maintenance |  |  |  |

Service request for training attendant care and support staff

**Support Worker skills**

|  |  |  |
| --- | --- | --- |
| **Skill** | **Required**  | **Tasks for which required**  |
| Injury related core support worker competencies |[ ]   |
| Brain injury specific support worker competencies |[ ]   |
| Spinal cord injury specific support worker competencies |[ ]   |
| Registered nurse |[ ]   |
| Other *(specify i.e. language skills, exp. with children:*      ) |[ ]   |

**Recommendations for participant specific training**

List any essential training that is unique to the participant’s needs (e.g. specific support strategies, therapy program or use of specialised equipment).

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| --- | --- | --- | --- | --- |
| **Training required** | **Training hours** **per support worker** | **Number of workers** | **Who will provide training?***(e.g. OT, physio, PBSP)* | **Quote obtained****Y/N** |
|  |  |  |  |[ ]
|  |  |  |  |[ ]
|  |  |  |  |[ ]

Weekly care plan table

Please complete this table to assist attendant care and support providers in understanding the participant’s specific needs. Sufficient detail should be provided to enable support workers to understand the context and tasks to be performed each shift.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** |
| **Early morning** |  |  |  |  |  |  |  |
| **Morning** |  |  |  |  |  |  |  |
| **Afternoon** |  |  |  |  |  |  |  |
| **Evening** |  |  |  |  |  |  |  |
| **Overnight** |  |  |  |  |  |  |  |
| **Total hours of care per day** |  |  |  |  |  |  |  |
| **Non-weekly tasks and time required:** |
|  |