# Care needs assessment report (CNAR) – child or young person

Use this report form for children 0 - 18 years in Lifetime Care

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| Once completed please e-mail this form to: care-requests@icare.nsw.gov.au A completed PCANS-2 should be submitted with this report for children 5-15 years and is recommended to be used for 16-18 year olds who are at school. An Attendant Care Service Request (ACSR) should also be submitted with the CNAR if requesting attendant care services |
| The child / young person’s details |
|  |
| **Name** | **Participant No.** |
|  |  |
| Care needs assessor |
| **Name** | **Role / Position** |
|  |  |
| **Organisation** | **Qualification** |
|  |  |
| **Phone** | **Email** |
|  |  |
| **Dates** |
| **Date of assessment** | Proposed dates for this period of care  |  | **Number of weeks**  |
| Click or tap to enter a date. | **From:** Click or tap to enter a date. | **To:** 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 child / young person’s current situation** |
| **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** |
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\*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 child / young person (as per eligibility criteria)** |
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## Descriptors of SCI

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| --- |
| **Complete this description for child / young person 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 |  [ ]  Very good - Full |  |
| **Hand function** |  [ ] None - Poor |  [ ] Some – Good | [ ]  Very good - Full |
| **Ambulation description** |  [ ] Non-walker | [ ] Household walker | [ ]  Community walker |

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| **PCANS-2 summary**Date of previous PCANS-2 assessment: Click or tap to enter a date.Brief explanation of current assessment findings (intensity and extent of support needs for physical assistance and supervision) |
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## 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

**What does the child/young person/family wish to achieve from their attendant care?**

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What are the assessor’s recommended care program aims? (eg independence, safety)

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Care related equipment

List all equipment currently used/prescribed

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Is this equipment in place at the child / young person’s home? [ ]  **Yes** [ ]  **No**

**If no, when will it be in place?**

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## **Behaviour support**

Is a behaviour support plan in place or any authorised 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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24-hour care required [ ]  **No** [ ]  **Yes**

Complete sections below with reference to PCANS-2 domains where applicable

## **High level needs**

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| --- | --- | --- | --- |
| **Task observed** | **Support required***Describe the type and level of support the child / young person requires. Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age.*  | **Equipment required**Describe the support required  | **Time required across the week***Hours per week* |
| **Tracheostomy management** | PCANS Domain I  |   |   |
| **Feeding / Eating (including nasogastric / PEG feeding** | PCANS Domain I  |   |   |
| **Bed Mobility** | PCANS Domain I  |   |   |
| **Communicating basic needs** | PCANS Domain I  |   |   |
|  **Wandering or harmful behaviours** | PCANS Domain I  |   |   |
| **Other observations of high-level needs** | PCANS Domain I  |   |   |
| **Total support required for high level needs** |   |   |

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| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes. |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child / young 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.  |
|  |
| **Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI. |
|  |

## **Moving Around**

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| **Task observed** | **Moving around support required***Describe the type and level of support the child / young person requires to move around and an indication of what that looks like throughout the day and night as they go about their activities. Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age.* *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** |   |   |
| **Other** |   |   |

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| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes. |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child / young 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  |
|  |
| **Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI. |
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## **Self-Care**

|  |  |  |  |
| --- | --- | --- | --- |
| **Task observed** | **Self-care support required***Describe the type and level of support the child / young person requires for self-care tasks and whether this changes throughout the day /night as they go about their activities. Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age.* **Include care allocation required to support each task** | **Equipment required**Describe the support required to use each item  | **Time required across the week***Hours per week* |
|  **Toileting** | PCANS Domain II   |   |   |
| **Grooming, bathing/showering and dressing** | PCANS Domain II  |   |   |
| **Eating and nutrition** | PCANS Domain IV   |   |   |
| **Sleep** |   |   |   |
| **Other** |   |   |   |
| **Total support required for self-care** |   |   |

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| --- |
| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes. |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child / young 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.  |
|  |
| **Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI. |
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## **Day to day activities and responsibilities**

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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 child / young 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 child / young 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? Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age.*  | **Time required (hours per week)** |
| **Food preparation** | PCANS Domain IV   |   |
| **Shopping/money management** | PCANS Domain V   |   |
| **Household chores (including laundry and other chores)** | PCANS Domain VI   |   |
| **Medication**  | PCANS Domain VII   |   |
| **Everyday device use/****Technology** | PCANS Domain IX   |   |
| **Transport and accessing the community** | PCANS Domain X   |   |
| **Other**  |   |   |
| **Total support required for day to day routine and home responsibilities** |  |   |

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| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child / young 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.  |
|  |
| **Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI. |
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## **Current rehabilitation program activities**

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| --- | --- | --- |
| **Activity** | **Current rehabilitation program activities & therapy appointments - support required****Provide a description of the type and level of the support the child/young person requires to manage their current rehabilitation program activities in the context of their current circumstances (for example assistance with homework, home exercise programs)**Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age.  | **Time required (hours per week)** |
| **1.** |   |   |
| **2.** |   |   |
| **3.** |   |   |
| **4.** |   |   |
| **Total support required for rehabilitation activities** |  |   |

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| --- |
| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes. |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child / young 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. |
|  |
| **Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI. |
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## **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 child / young person require prompting and supervision or do they require physical assistance?* *Explain why supports are required when care is needed (beyond normal parental responsibilities) for emerging skills in a child / young person of this age. Also consider the activities described in the child / young 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)** |
| **Personal safety and independent living** | PCANS Domain VII   |   |
| **Social relationships** | PCANS Domain XI   |   |
| **Recreational / leisure activities** | PCANS Domain XII   |   |
| **Vocational or other programs, education, work** | PCANS Domain XIII   |   |
| **Other** |   |   |
| **Total support required for major life areas and relationships** |  |   |

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| --- |
| **Has the child / young person’s functional capacity in the areas above changed since the last assessment?** If so, comment on the nature of these changes |
|  |
| **What further changes could be expected and when?** This may be related to the provision of equipment, home modifications or a change in the child/ person’s functional ability. The assessor should consider the current rehabilitation goals detailed in the child / young person’s current My Plan and any functional changes anticipated which may have an impact on the support they require.

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**Are there any other factors or considerations that impact on the child / young person’s care in this domain?** Consider, cultural beliefs or habits, non-TBI factors such as fractures, spinal cord injury occurring concurrently to the TBI, pre-existing health, medical, learning or developmental problems and / or other influences, e.g. medical conditions occurring since the TBI.

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## **Overnight Care**

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

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| --- | --- | --- |
| **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 child / young person if overnight care is not provided? What is the likelihood of these risks occurring? |
|  |

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

|  |
| --- |
| Why is the sleepover support required? |
|  |
| What are the risks to the child / young person 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 child / young person 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**

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

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

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

## **Environmental and other considerations / risks**

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

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

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

Is the family requesting any care?[ ]  **Yes** [ ]  **No**

## **Category of attendant care required**

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| --- |
| **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 child / young person requires****Physical Support** [ ]  **Yes** [ ]  **No****Cognitive and behavioural 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)** |
|  |
|  |
|  |

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

|  |  |
| --- | --- |
| **Name**  | **Signature** |
|  |  |
| **Title** | **Date** |
|  | Click or tap to enter a date. |