

## Guide to completing Care Needs Assessment Reports (CNAR – Adults)

The Care Needs Assessment Report (CNAR) is used by icare in assessing a participant’s care need. This guide aims to assist assessors in completing a CNAR, in addition to the prompts included in the report templates.

Categories of Care Need Assessment and who they should be used for are outlined below. This guide relates to completing the CNAR (Complex or Standard) for adults. Separate guidance is available for the Care Needs Review report.

Category	
<p><b>Care Needs Assessment – Complex</b></p>	<p>Includes the first home-based Care Needs Assessment following discharge from in-patient hospital or rehabilitation facility.</p> <p>Includes all Care Needs Assessments for children (including PCANS).</p> <p>For participants/workers with:</p> <ul style="list-style-type: none"> <li>• multiple injury types (more than 2 domains of function that need detailed observational assessment)</li> <li>• complex functional impairments</li> <li>• multiple activity/participation locations to be considered (in home, local community, workplace, holidays, other)</li> <li>• multiple and complex environmental and/or personal barriers to be considered</li> <li>• rapidly and significantly changing or fluctuating functional capability &amp;/or other circumstances requiring detailed re-assessment</li> <li>• information &amp; feedback to be obtained from multiple stakeholders</li> </ul> <p>Includes Care Needs Assessments where there is a history throughout the preceding care period of multiple complaints or issues identified by any stakeholder regarding the care program.</p>
	<p><b>Hours claimable:</b> 10 hours plus travel</p> <p><b>Inclusions:</b></p> <ul style="list-style-type: none"> <li>• review of referral documentation including last CNA if available</li> <li>• liaison with stakeholders (any or all of participant, family, informal carers, Attendant care Provider, health professionals, icare)</li> <li>• clinical assessment on-site (single visit per site)</li> <li>• completion of the Care and Needs Scale (CANS)</li> <li>• report preparation</li> <li>• completion of the Attendant Care Service Request (ACSR) if required</li> <li>• providing any clarification or additional information to assist icare to make a decision</li> </ul>
<p>Care Needs Assessment (Standard)</p>	<p>For participants with:</p> <ul style="list-style-type: none"> <li>• single injury type (may include some minor co-morbidities if they don't significantly impact care needs)</li> <li>• consideration of care needs in the home and local community</li> <li>• injury-related functional impairments</li> <li>• environmental and/or personal barriers need to be considered</li> </ul>

Category	Applications
	<ul style="list-style-type: none"> <li>changing functional capability in response to rehab or to a deteriorating condition requiring detailed re-assessment of care needs</li> <li>information and feedback to be obtained from multiple stakeholders</li> </ul> <p>OR</p> <p>Intermittent re-assessment of participants who have a stable care program and have had two previous consecutive Care Needs Reviews</p>
	<p><b>Hours claimable:</b> 7 hours plus travel</p> <p><b>Inclusions:</b></p> <ul style="list-style-type: none"> <li>review of referral documentation including last CNAR if available</li> <li>liaison with stakeholders (any or all of participant, family, informal carers, Attendant care Provider, health professionals, icare)</li> <li>clinical assessment on-site (single visit)</li> <li>completion of the Care and Needs Scale (CANS)</li> <li>report preparation</li> <li>completion of the ACSR if required</li> <li>providing any clarification or additional information to assist icare to make a decision</li> </ul>

## General Notes

- Care needs assessors will be sent a referral form with background information to assist in completing the care needs assessment. The referral will indicate the category of assessment being requested.
- The difference between a standard and complex care needs assessment is outlined in the table on page 2. The resulting report should reflect the level of complexity.
- If a field is not relevant to a participant, either leave it blank or write N/A.
- It is assumed that the assessor has observed the participant completing the listed tasks onsite unless the “third party report” or “self-report” box is checked, or an alternative information source is noted.
- Assessors should focus on the care need that exists in the person’s current circumstances and note both informal care that is provided by family and friends, and care provided by other funded services, under relevant individual tasks. This can be summarised in the section titled ‘The Person’s Current Situation’. icare will arrange for an updated care needs assessment should the person’s circumstances change substantially during a care period.
- Locating providers and sourcing quotes for domestic services and home/garden maintenance is not considered to be the role of a care needs assessor unless this is requested in the referral form. The case manager or icare contact will assist in obtaining this information.
- An ACSR must be submitted with a CNAR if care services are being requested by the participant or their family. Requests for funded care may differ from the assessed care need.
- icare will determine funding support based on the information provided in the CNAR and ACSR.
- In determining hours required for support, assessors should take into consideration that some support worker tasks can be completed concurrently.

# Completing the CNAR

## Date

- the proposed care period should be the length of time the assessor can reasonably predict that the care need is likely to remain unchanged.
- care periods can range from a minimum of 16 weeks in the initial post discharge Discharge Services Notification (DSN) period up to 2 years for a participant with stable care needs. Once a person's care needs are stable, icare will determine whether a Care Needs Assessment or a Care Needs Review is required.
- the referral for a care needs assessment will specify the date that the care needs assessment report is due.
- Care needs assessors should only accept a care needs assessment referral if they can deliver the service in the required time frame.

## The person's current situation

- provide a summary of information which impacts on care needs or care provision.
- relevant information may include who lives in the household, their roles and responsibilities, and other relevant information which may impact on care.
- include a summary of current care supports where these are not funded by icare.

## Feedback on current care program

- include feedback on the impact of current care arrangements on family members where relevant, as well as what care family members may be providing.
- this section should highlight what is working well and what is causing difficulties.
- Care needs assessors should seek feedback from Care Coordinators, rather than approaching individual support workers, as Care Coordinators can provide more comprehensive information on the attendant care program.

# Injury Information

## Spinal Cord Injury (SCI)

- The person's SCI level and ASIA score should be provided to the assessor on the referral form. To ensure that the report can stand alone, please note these scores on the report form.
- For participants with incomplete SCI, assessors should complete the upper limb and ambulation categories based on the *Guidance on the support needs of adults with spinal cord injury* (2017 3rd edition, p 45-71). This upper body functioning and revised mobility tool replaces the Upper Limb assessment tool in the 2007 edition of the Guidelines on levels of attendant care for people with SCI.

## Traumatic Brain Injury (TBI)

- The person's last recorded CANS level should be provided to the assessor on the referral form.
- A new CANS should be completed by the assessor for all adults with brain injury.

## Other injury types

Summarise the injury and affected limbs or body systems.

## Non-injury – related health conditions

These conditions impacting care should be documented to facilitate a comprehensive assessment of a person's care needs. Non-injury related care needs should be clearly outlined in the report and not included in the support hours required.

## Moving around

- Note whether the person requires prompting and supervision or physical assistance. Is two-person support required for any of the tasks? Please note, it is not necessary to estimate the number of support hours the person requires for this domain.
- The terms and definitions of household walker and community walker in the *Guidance on provisions of support workers for adults with spinal cord injury (2017)* provide useful definitions for people with a traumatic brain injury who have subsequent mobility limitations.

## Self-care

- Time required - Provide an indication of the time the task takes each time it is performed.
- Time required (hours per week)- indicate total hours over a week for the noted tasks.

## Day-to-day activities and responsibilities

- Communication and household management may include periodic tasks and regular tasks include budgeting, developing a shopping list, paying bills, mail, set up for devices, use of telephone and computer etc.
- Use the "Other" section to include any additional tasks specific to the participant.
- Home maintenance may include assistance required for cleaning external windows, gutters, routine household maintenance etc.

## Current rehabilitation program activities

- Frequency of current and planned rehabilitation activity attendance in the nominated care period should be included to help clarify care required for injury related transport support and assistance with completing therapy tasks/home programs
- Do not include additional support hours if already this is already covered under another domain such as Self Care or Moving around
- Assessors should peruse the current My Plan to assist identifying current rehabilitation commitments.

## Life and relationships

This section refers to activities that enable participants to manage different aspects of their life e.g., time management, respond to changes in routine, problem solving and planning etc.

In the case of support required to attend school/TAFE/University, it is important to identify only care needs and not include learning support needs.

## Overnight care

- Alternatives to overnight care should always be explored. Remember to consider the potential impact of overnight care on the person and their family.
- Where the person has a need for overnight care, indicate whether the person requires sleepover or active support during the night. Clear justification is required for either recommendation.
- Active support is an overnight shift of 8 hours where the support worker does not sleep as they must be available to provide support at any time during the shift. For active support, provide a description of the specific support the person requires including the tasks performed throughout the night and estimated duration/frequency.
- Sleepover support is where a support worker sleeps over and is on-call. It is a continuous period of 8 hours which may incorporate up to two 30-minute wake ups. People can be assessed as needing either 0 or 7 inactive sleepovers.

## Two-person service

The following factors should be considered when reviewing the need for two-person services:

- upper body control
- the presence of spasms or contractures
- height and/or weight
- body shape, brittleness of bones or skin integrity
- a need for positioning or repositioning
- behaviour
- continence

## Registered nursing

icare adheres to the ACIA guidelines regarding care tasks that require a Registered Nurse. Refer to link in 'useful references' below.

## Gardening and home maintenance

Include both regular maintenance support needs and any anticipated non-routine support anticipated over the recommended care period e.g., a one-off spring-cleaning service.

## Other considerations/risks

Include whether there are any WHS issues, whether an equipment maintenance plan in place, is there an emergency plan for specific situations, when and who should review these.

Note: Lifetime Care will only pay for regular and routine tasks as outlined in Part 8 of the Lifetime Care and Support Guidelines (2018).

## Recommendations from the assessor

Indicate any additional recommendations for follow up or consideration by the icare staff member such as:

- identified training needs for support workers
- exploration of new equipment needs
- identification of equipment maintenance needs
- medical/specialist follow up

- engagement of a positive behavior support practitioner
- authorisation for observed or recommended restrictive practices

## Summary of overall care need related to the person's injury

The total care hours per week for a person requiring one attendant support worker should not exceed:

- 168 hours for a person requiring 24hrs active care = 24hrs x 7days.
- 112 hours + 7 sleepovers for a person requiring 24 hr care with only inactive sleepover = 16hrs per day x 7 days + 7 inactive sleepovers

Where additional hours are assessed for a two-person service, this need should be explained under Two-person service heading in the report template, and the total number of second support worker hours should be outlined on the Support summary table.

Additional irregular hours– includes anticipated irregular care needs such as during school holiday periods or for one-off planned appointments, or where care is anticipated to fluctuate due to specific known factors.

## Category of attendant care support required

Select and explain the required categories of support to assist in optimal match with an attendant care provider.

## Useful references for completion of CNA reports

The Lifetime Care and Support Guidelines 2018 - Issued under the Motor Accidents (Lifetime Care and Support) Act 2006.

Guidance on the Support Needs of Adults with Spinal Injury (3rd ed, 2017) - Best practice tool to inform and guide people around why a person with a spinal cord injury needs assistance from support workers.

Care and Needs Scale (V2, July 2017) - Tool designed to measure the level of support needs of older adolescents and adults (16 years and older) with traumatic brain injury.

PCANS-2 - Paediatric Care and Needs Scale (PCANS-2).

My Plan and Planning Modules - The participant's current My Plan.

Living with Attendant Care - Information about living and working with attendant care services including a resource about two-person care activities.


Current treating team reports - Any reports by treating practitioners which might impact activities, participation, functional capability, potential or expected improvements. Key reports should be provided with referral or be available from the icare contact.

ACIA Guidelines - icare adheres to the Australian Community Industry Alliance (ACIA) guidelines regarding care tasks that require a Registered Nurse.

Modified Care Giver Strain Index - screens for caregiver strain with long-term family caregivers.

TAC guidelines - Guidelines for providers - Standard Outcome Measures.

Other Tools - Other assessment/outcome measurement tools considered useful and appropriate by the care needs assessor to support their reasoning to establish the participant's care needs, either completed as part of the CNA or provided by others. E.g., Mayo-Portland Adaptability Inventory (MPAI) which includes an adjustment scale.



icare  
GPO Box 4052, Sydney, NSW 2001  
Ph: 1300 738 586  
Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au)  
[www.icare.nsw.gov.au](http://www.icare.nsw.gov.au)