COMMUNITY REHABILITATION WORKFORCE PROJECT

Community Rehabilitation Student Workbook
2008
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Compiled and developed for Queensland Health by CRWP Project Officers including Kathy Acutt, Elizabeth Aire, Delena Amsters, Paul Barber, Tracey Comans, Ruth Cox, Margaret MacDonald, Judith Nance, Joshua Simmons, Jane Watts and Angela Wood.

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INTRODUCTION

A growing and aging population, an aging workforce, advancing technology and increasing consumer expectations have resulted in the need to investigate new models for delivery of healthcare services. The Community Rehabilitation Workforce project (CRWP), funded through the Commonwealth Government’s Pathways Home Program, was developed with the aim to optimise the capability of the current and future workforce to provide Community Rehabilitation (CR) services to meet the current and emerging health needs of the Queensland community.

Some of the main objectives of the CRWP were associated with influencing and supporting the integration of community rehabilitation coursework offered at an undergraduate level to allied health and nursing students; and developing a cost effective and sustainable interdisciplinary student placement model which improved workforce preparation in community rehabilitation and met student, university and clinical educator needs.

The result was the development and implementation of an Interdisciplinary Student Placement (ISP) model in Community Rehabilitation. In order to facilitate future implementation of a modified version of this model, the following *Community Rehabilitation Student Workbook* has been developed to assist service providers to facilitate interdisciplinary learning opportunities for allied health and nursing students who undertake clinical placement in a Community Rehabilitation setting.

It is envisioned that this resource will encourage and enable Community Rehabilitation competencies to be an ongoing component of allied health and nursing student placements.

For further information on the initiatives undertaken by the CRWP please visit [www.health.qld.gov.au/qhcrwp](http://www.health.qld.gov.au/qhcrwp)
THE COMMUNITY REHABILITATION STUDENT WORKBOOK

This resource has been developed as a guideline for clinical educators to facilitate learning when students are undertaking placements in Community Rehabilitation. The resource was originally designed for nursing, physiotherapy, occupational therapy and speech pathology students. However, other students may also benefit from the activities. This resource outlines a range of activities, referred to as “learning tasks”, on which the student can work independently, to assist their understanding of the Community Rehabilitation philosophies.

The workbook has been designed to stimulate discussion and investigation of the processes of case management and multi-disciplinary team work and to enhance the learning of students within the Community Rehabilitation setting. The International Classification of Functioning, Disability and Health (ICF) framework, and the MAGPIE, an interdisciplinary process for case management, are used to underpin the learning that takes place with the learning tasks.

The clinical supervisor should familiarise themselves with the resource before the student commences placement, and they should identify which of the learning tasks would be most relevant or beneficial for the student to complete whilst on placement. This will depend on a range of factors and is intended to be flexible. The students should not necessarily be expected to complete all the learning tasks.

The DVD included with the workbook contains copies of appropriate journal articles which can be printed and used by students to facilitate the learning tasks. The DVD also contains some examples of case studies completed by students during the CRWP, which may be useful reference tools for both students and supervisors.

During orientation, the clinical supervisor should make the student aware of this resource folder and talk through the learning tasks, which the student may be asked to complete. These can be written into a learning contract and time to work on these may be put aside on the timetable. Time-frames for completion should also be discussed.
THE INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH (ICF) FRAMEWORK

‘Health is the ability to live life to its full potential. For many people with disabilities, the realisation of that ability is dependent on factors in society. When a person in a wheelchair finds it difficult to enter into her office building because it does not provide ramps or elevators, the ICF identifies the focus of an intervention: it is the building that should be modified and not the person who should be forced to find a different place of work.’

Gro Harlem Brutland, Director-General, WHO; from speech at WHO conference on Health and Disability, Trieste April 2002.

WHY USE THE ICF FRAMEWORK?

Increasingly healthcare sectors are endeavouring to utilise a common framework, both for language and to contextualise assessment and management of health and welfare needs. The ICF framework, based on international consensus and collaboration, offers a series of models and has been recognised as valuable by Queensland Health (QH).

“The ICF 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. 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”.

(http://www.who.int/classifications/icf/en)

ICF DOMAIN DEFINITIONS

The ICF provides a taxonomy of domains within which measurement and health clinical interventions can be situated or contextualised. They are defined as follows:

- **Body Functions** are physiological functions of body systems (including psychological functions)
- **Body Structures** are anatomical parts of the body such as organs, limbs and their components
- **Impairments** are problems in body function or structure such as a significant deviation or loss
- **Activity** is the execution of a task or action by an individual
- **Participation** is involvement in a life situation
- **Activity Limitations** are difficulties an individual may have in executing activities
- **Participation Restrictions** are problems an individual may experience in involvement in life situations
- **Environmental Factors** make up the physical, social and attitudinal environment in which people live and conduct their lives

For additional information about the ICF, refer to the ICF brochure that has been included on the CRWP Resource DVD that is attached to this Workbook, or visit www.who.int/classification/icfBeginners Guide
CLINICAL PRACTICE IMPLICATIONS OF THE ICF FOR COMMUNITY REHABILITATION PRACTITIONERS

In hospitals and other institutional settings, intervention is often directed predominantly at:

- The health condition
- Body functions and structure
- Activity limitation

People are often discharged from inpatient and outpatient rehabilitation programs when their recovery has ‘plateau-ed’, and yet they are still a long way from being satisfied with their health outcome. Interventions may also need to be directed at the other factors impacting health outcomes in their broader sense.

In community settings, while there may still be some degree of intervention aimed at regaining function, we also need to focus on interventions which work to reduce participation restrictions. This will enable an individual to resume their premorbid roles, or if this is not possible, to assist them in identifying new, realistic and achievable goals within the scope of the individual’s chronic condition or acquired disability.

To do this effectively, we need to consider the contextual factors which interact with the individual who has a health condition, and determine the level and extent of the individual’s functioning. (These factors should be analysed for your case study, Part 3):

- Personal factors
  - Gender
  - Cultural background
  - Age
  - Other health conditions
  - Fitness
  - Lifestyle habits
  - Upbringing
  - Coping styles
Some of these contextual factors are able to be changed, and some are not. By analysis of the barriers and facilitators to participation, we are able to target our intervention appropriately. The example of wheelchair access (mentioned in the quote by Gro Harlem Brutland on page 6) is easy to understand. Sometimes the issue is more complex.

**Case example:**

A person with an Acquired Brain Injury (ABI) has been refused access to a day respite service due to sexually disinhibited behaviour.

The client had his injury 5 years ago, and has had extensive inpatient rehabilitation, plus an extended stay in a neurobehavioral unit. Cognitive Behavioural Therapy (CBT) was trialled, but the client’s residual cognitive impairments mean that he cannot remember or apply strategies to control or regulate his own behaviour.

5 years post injury, no further significant recovery of cognition is anticipated. Staff members refuse to accept the client back until some-one has ‘fixed’ the behaviour.
Issue:

Staff members expect the client's behaviour to change

Intervention:

The target of intervention should be the environmental level, as defined by the ICF, and in particular to 'attitudes' and 'services'. Exclusion of the person from the respite service on the grounds of his behavioural disability is discriminatory.

At what should the community rehabilitation practitioner's intervention be directed?

According to the framework provided by the ICF, the recommended intervention would be education of respite centre staff on the concept of 'behavioural disability' and how to manage challenging behaviour WHEN it occurs. With the appropriate education and support (e.g., behaviour management plan devised by a neuro-psychologist), and a consistent use of a range of strategies by all staff, the client's disinhibited behaviour MAY reduce in frequency or severity over time, although this is not a 'given'.

In this situation, staff members were made aware of what is realistically achievable for this client. Strategies included:

- regular repetition of information
- education on where it is “OK” to touch people
- immediate feedback when behaviour or conversation was inappropriate
- consistency of behaviour from staff i.e. some staff would hug the client, leading to confusion about what was appropriate
- client was given a package to hold on to when out in the community in order to keep his hands occupied

Case example:

Terry is a young person in an aged care facility. He has an ABI due to diabetes after suffering hypoxic injury secondary to a hypoglycaemic event. The Acquired Brain Injury Outreach Service (ABIOS) was contacted by staff due to the impact of Terry's behaviour on other residents. He was frightening the elderly residents by shouting at them in the dining room.
at mealtimes. Terry is 7 years post injury, has significant cognitive impairments and is non-compliant with medication and dietary management of his diabetes, which has resulted in numerous inpatient hospital admissions.

If Terry’s behaviour does not cease, or is unable to be controlled, staff would have no alternative but to make Terry eat his meal in his room. Terry has unstable diabetes and needs to be encouraged to eat. This would mean one staff member would have to go off-line to supervise Terry’s mealtimes.

**Issue:**

Terry was seated for meals at a table on his own (his preference) facing into the dining room. Terry was shouting at the other residents for staring at him when he was eating. Residents kept watching him because they were afraid he would come over and assault them as he threatened.

**Intervention:**

At what should the community rehabilitation practitioner’s intervention be directed? OR What should the intervention target?

According to the framework provided by the ICF, the recommended intervention should be directed at the environment and in particular the physical environment.

In this situation, Terry’s chair was placed on the other side of his table facing out of the dining room. Staff members were happy not to have to take meals down to Terry in his room. Residents no longer frightened by Terry at mealtimes. Terry is still able to benefit from social interaction at mealtimes, even if it is only with staff, and his dietary intake is monitored and encouraged. This highlights the importance of visiting the client in the environment in which he is living. (The issue of a 40 year old man living in an aged care facility in the first place is another matter!)
COMMUNITY REHABILITATION CORE COMPETENCIES

In 2006 the CRWP commissioned Griffith University to conduct an audit on the training and education needs of staff working in Community Rehabilitation (CR) in Queensland. This audit identified ten key core competency domains as being necessary for health professionals in the provision of effective community rehabilitation services. The model and activities described in this student workbook are examples of these core competencies and have been listed below with brief descriptors:

1. Frameworks of Understanding
   - Understanding, implementing and evaluating practice against recognised theoretical frameworks that underpin CR e.g. The ICF
   - Understanding, implementing and evaluating practice using recognised models of delivery

2. Consumer Engagement
   - Recognising the consumer as central to every process
   - Promoting consumer understanding, choice, control and engagement in their own health and wellbeing
   - Incorporating consumer need and consumer preference

3. Holistic Focus
   - Recognising that needs of individuals extend beyond immediate physical health issues and incorporate social and emotional health issues
   - Recognising situational, environmental, family, carer and community influences on consumers
   - Incorporating consumers’ bio-psychosocial needs in the specific context, environment or situation

4. Service Continuity
   - Coordination of support for consumers through transition points e.g. discharge from hospital, metropolitan back to rural community
• Ability to **identify** and mitigate **risks** in transition
• Ability to incorporate **following-up** and monitoring with recognition of long term outcomes

5. Networks

• Ability to engage and **work in a teams**
• Ability to build **partnerships/establish networks** - share information, and collaborate
• Ability to **practice in inter-disciplinary ways** that capitalise on the strengths of other disciplines and recognise the limitations of one’s own capacity
• **Coordination of** whole packages of service delivery and addressing gaps in service systems

6. Cultural Awareness

• Demonstrating an **awareness of cultural differences**
• Practicing in ways that **accommodate culture** and local knowledge
• Adapting and **accommodating to different** knowledge-bases or **perspectives**
• Accepting and **valuing different styles** of living

7. Community Engagement

• **Engaging with local communities** in a respectful and trusting way
• Understanding and **investing in the local community** to become a trusted partner
• Recognising how **individuals live and function** within a community
• Appreciating a **collective way of operating** and investing in the community

8. Boundaries and Safety

• Maintaining **professional boundaries** and keeping a “separateness of self” within one’s practice of CR (despite consumer and community engagement)
• Ability to work safely and prevent injury or illness arising from work by applying **good workplace health and safety** principles

• **Managing** competing **demands** on one’s time, recognising constraints and limitations, monitoring and prioritising workload while maintaining the principles of **CR**

9. Reflective Practice

• Thinking **creatively** to **solve problems**, prioritise, and plan through difficult and diverse tasks by using local solutions, a creative use of resources and a flexible approach to problems

• Ability to manage complicated tasks such as **supervising and training** family members, carers or support personnel

• **Acquiring knowledge** to support good practice, and disseminating knowledge meaningfully in the community

10. Systems Advocacy

• **Advocating** for changes which improve services for **consumer**

• Recognising that **CR** requires **advocates** who can lobby systems for recognition, resources and respect

For further information on these core competency domains, or on the Competencies Audit conducted by Griffith University, please visit: [www.health.qld.gov.au/qhcrwp/docs/comp_audit_summary.pdf](http://www.health.qld.gov.au/qhcrwp/docs/comp_audit_summary.pdf)
LEARNING TASKS FOR COMMUNITY REHABILITATION

The Learning Tasks outlined in this Workbook have been designed around the completion of a Case Study. Each Learning Task is designed to support and compliment the case study process and enable students to work independently on activities relevant to CR during their placements. This process reinforces learning based on the ten key core competencies for CR outlined previously.

During their clinical placements, students will be expected to produce a case study of a client which will involve:

- A full bio-psychosocial assessment following the ICF model
- Identification of client’s goals and of barriers/facilitators to achieving those goals
- A multidisciplinary treatment, progression and discharge plan

In the process, they will be identifying and discussing many of the aspects and components of holistic and client focussed CR.

Supervisors will discuss with each student the selection of a suitable case study client, obtaining consent, using the MAGPIE process and the structure of the bio-psychosocial assessment within the ICF framework. **It is important that students identify their case study client at the earliest possible time.**

Supervisors are encouraged to give direction to evolve students' case studies by discussing appropriate topics such as: multidisciplinary team (MDT) work, cultural awareness, resources, risk management, outcome measures and other aspects of working in CR.

As part of the Case Study, students will need to:

1) Visit the client in his/her own environment at least once during the assessment/goal setting/treatment process.
2) Identify and review the preferred Outcome Measure Tool used by their host service, and review the information regarding the three core Outcome Measure Tools provided in the Compendium of Clinical Measures for Community Rehabilitation (WHOQoL-BREF, Frenchay and Home and Community Environment instrument (HACE); Appendix B, page 30). From these reviews, select the most appropriate Outcome Measure to use in their case study. This can be either one used by the host service, or one from the Compendium.

3) Organise a visit to an agency with which their case study client is involved (other than the host service) to obtain information about community resources (see Week 3). For example:

- Home modification services
- Headway
- Respite agencies
- Non Government Organisations

If the placement is within Q Health, it is preferable to review an agency outside Q Health. If the placement is outside Q Health, students may elect to visit a service within Q Health, for example:

- Chronic Disease Clinics
- Community Health
- Transition Care

If there is no opportunity to visit an agency with which the case study client is involved, the clinical supervisor may assist the student to select a service that would “hypothetically” be involved in managing the clients’ situation.

The Case Study may contribute towards the student’s final assessment.

The format of the case study should be discussed by supervisor and student prior to commencing the Learning Tasks. If it is to be assessed, it should preferably be presented in a format that is suitable for presentation at a case conference.
The Learning Tasks selected can be modified to align with the needs of the host team. For example, the host team may want information on a particular cultural group or outcome measure, which the student could then investigate. The student may have the opportunity to present their work at a team in-service or team meeting. The case study information may be presented at a case conference. This should be discussed with the student at the beginning of the placement.

The number of tasks may be amended, depending on the placement length, clinical load or relevance to the host service. Tasks can be presented in a written format for use in discussion between student and supervisor, or via power point for presentation to, and discussion with, a student or health professional group. Tasks can be completed individually or in pairs, if the team is hosting more than one student.

Suggested times-frames (in brackets) have been provided for each task, to indicate the desired length of the verbal presentation, should the student be required to complete this task.

Completed examples of each of the Learning Task are available on the enclosed CRWP Resource DVD attached with this workbook or from your supervisor:
- Week 1 – ICF & Host Service Presentation
- Week 2 – Bio-psychosocial Assessment
- Week 3 – Agency Visit and Outcome Measures
- Week 4 – Final Presentation
LEARNING TASK OUTLINES

Week 1 - ICF & HOST SERVICE PRESENTATION

Discussion /presentation:

- Overview and discussion of journal articles with emphasis on increasing understanding of the ICF model and its implications for practice (See Appendix C, pg 32, for references to articles on The ICF Model, these articles are available on the enclosed CRWP Resource DVD attached with this workbook or from your supervisor).
- Review of use of MAGPIE process (see Appendix A, pg 27)
- Discussion of bio-psychosocial assessment process within the ICF framework
- Written/power point presentation about your host service, relating it to your case study client. This should include the following information and can be obtained from printed matter, leaflets, and interviews with staff.
  - Description of service model
  - Reason for and suitability of your clients' referral to the service
  - Type of assessment information gathered/assessment tool used
  - Roles of the health professionals within the team, with reference to your client
  - Risk management strategies used by your host service eg personal safety, occupational health and safety.

(20 minutes)

Week 2 - BIO-PSYCHOSOCIAL ASSESSMENT

Discussion /presentation:

- Written/power point presentation giving full information gathered in the bio-psychosocial assessment of your client (Part 1, Case Study, refer to pages 21 -24) (15 minutes)
• Discussion of the process of holistic assessments, assessment tools and information gathering, cultural and ethnic considerations, environment (within the ICF framework), personal factors, social issues and risk management.

• Discussion about written resource/education material written and produced for clients eg what makes it effective/ineffective (See Appendix C, pg 33, for references to articles on Educational Material for Clients. These articles are available on the CRWP Resource DVD attached with this workbook or from your supervisor).

### Week 3 – AGENCY VISIT AND OUTCOME MEASURES

Discussion /presentation:

• Power point presentation (10 - 20 slides, 15 - 20 minutes) or written format, detailing information from your agency visit including:
  - Type of agency
  - Services provided
  - Staff mix
  - Area covered
  - Referral sources
  - Eligibility
  - Funding
  - Client demographics
  - Cost to clients
  - Suitability and effectiveness of the resource/brochure used by agency to give clients information about the service (bring an example to show and discuss)
  - Why this agency this is suitable for your case study client
  - Any other information you feel is appropriate

• Discussion about the 3 recommended Outcome Measure Tools [World Health Organisation Quality of Life- brief version (WHOQoL - BREF), Frenchay Activities Index and Home and Community Environment Instrument (HACE) - refer to Appendix B,
pg 31], their applications and relevance to MDT work, holistic client focus and Community Rehabilitation. Discuss one of the Outcome Measure tools you are going to use for your case study client's goals/treatment. Include:

- The client or carer goals
- Why you chose this Outcome Measure
- How the tool is administered
- What domain/s of the ICF this tool measures
- How you would use this information
- Relevance to the MDT

**Week 4 - Final Presentation**

Discussion and presentation to team/group:

- Power point presentation (15 - 20 slides, 20 - 30 minutes) detailing your Case Study:
  - Your client's goals,
  - The barriers/facilitators to these goals (NB: To display this clearly, use a table with headings which cover all domains of the ICF including Body Structure and Function and the 5 Environmental Factors and Personal Factors)
  - The Outcome Measure Tools used in your client's treatment
  - The multi disciplinary treatment plan developed for your client including the role of each health professional, role of other service providers, the client, carers and family/friends if applicable, progression of treatment and discharge planning

- Discussion about client focussed service, client goals/goal setting, MDT work, discharge planning, networking and knowledge of resources available in the Community.
**CASE STUDY FORMAT**

**Introduction:**

Where, when and how the information was obtained, who was present, what records were accessed, how client consent was obtained etc.

**Part 1 (Required at the end of Week 2)**
Perform a [holistic biopsychosocial assessment](#) (use the outline provided on pages 24 - 27, or alternatively the host service may prefer you to use a different holistic assessment form eg the Ongoing Needs Identification Tool - ONI). You are required to collect information on the client's current status that could be used by the rest of the multidisciplinary team. Review all related documentation including medical chart, if available.

- This is to be based largely on information obtained by interviewing your subject. Family/carer perspectives are to be included if relevant, and if your subject gives consent for you to speak to them.

- Summaries of most recent relevant assessments by health professionals should be included if available, particularly assessments by professionals from the same discipline as yours.

**Part 2 (Required at end of Week 4)**
**Client centred goals**

- Ask your subject to nominate 3 goals of most importance to them, at least one of which is a long term goal. One of the goals may be a family/carer goal, if this is relevant. In this case, the goal should be identified by that person, not your subject.

- Analyse the factors impacting on the achievement of each goal (as facilitators or barriers) with reference to the ICF: illness or injury factors/ body structures and functions/ activity limitation/ participation restriction/personal factors/environmental factors.
Part 3 (Required at the end of Week 4)
Devise a comprehensive MDT community rehabilitation plan for your client:

- Identify interventions which would enable the facilitators and overcome the barriers you identified in Part 2, specifying who in the team is responsible for what, including the CR team, other service providers, the client, carers, family and friends where applicable.

- Outcome measurement: Which tool (of the 3 core tools outlined in Appendix B, page 30) could be used to measure the outcome for your client in the achievement of the goals identified in Part 2, and why? Also explain the use of the tool which your host service uses and recommends (if it is not an Outcome Measure from the Compendium).

- Discuss progression of treatment and discharge planning, with reference to appropriate Community engagement.
A BIO-PSYCHOSOCIAL ASSESSMENT WITHIN THE ICF FRAMEWORK

Introduction:

- Where and when the information was obtained
- Who was present
- What records were accessed
- How consent was obtained

1. Personal details (de-identified)

- Name
- Date of birth
- Medical diagnosis and previous medical conditions
- Medications
- Local medical officer contact details

2. Outline Body Structure and Function

- Orientation
- Sleep/fatigue
- Attention/memory/cognition
- Language/communication
- Vision
- Hearing
- Pain
- Mobility
- Nutrition
- Other pertinent information eg swallowing impairments, skin integrity

3. Outline Activity Limitations (difficulties in executing activities), and Participation Restrictions (difficulties in involvement in life situations)

- Learning and applying knowledge (eg. learning to read & write, learning arithmetic, solving problems)
• General Tasks & Demands (eg. doing a task such as planning a phone call, getting to an appointment on time)
• Communication
• Mobility (eg. lifting and carrying objects, hand use, walking, transport)
• Self Care (eg. washing oneself, grooming, toileting, dressing, eating, drinking)
• Domestic Life (eg. shopping, meal preparation, housework)
• Interpersonal interactions and relationships (eg. relating with strangers, forming & maintaining relationships)
• Major life areas (eg. education, employment/income source, budgeting)
• Community, social & civic life (eg. community life, recreation & leisure, religion & spirituality, community supports & key workers)

4. Outline Environmental Factors (including whether they are facilitators or barriers to participation)

• Products and technology eg. equipment for use in daily living, communication, indoor and outdoor mobility, design/construction of buildings. (** Include a table to list prescribed adaptive/’disability’ equipment: information on make/model, supplier and who pays for it is useful, if available).
• Natural environment & human made changes to the environment (eg. climate, light, sound, terrain around the house and in the local community. Include information such as paved footpaths, wheelchair crossovers etc).
• Support and relationships - details of “natural” or un-paid supports: who is involved, how often they see the client and what support they are providing (eg. immediate family, friends, peers, colleagues, neighbours, community members, personal carers). It is useful to include information as to whether the supports are secure, whether the family is coping, how much education they have had about the client’s condition.
• Attitudes (eg. attitudes of society, attitude of friends, family, personal carers, health professionals).
• **Services, systems and policies** (include a table to show the services currently involved, frequency, cost and who pays):

  o Housing eg. eligibility for rental assistance or public housing, home modification policy
  o Lifestyle support eg who provides it, who pays for it, how often they attend and what do they do?
  o Domiciliary services eg Bluecare/Meals on Wheels. How often do they come, what do they provide and who pays?
  o Community Health services eg Home Care
  o Communication eg. policy for assisting those with communication problems such as access to interpreters
  o Transportation
  o Legal
  o Social security
  o General social support
  o Health
  o Education and training
  o Labour and employment eg anti-discrimination laws
  o Other

5. **Outline Personal Factors**

• Motivation
• Personality pre & post injury/condition
• Gambling
• Substance use
• Mental health
• Depression/suicidal ideation/hopelessness *(do not directly ask this of your client, unless your supervisor has discussed this with your and has agreed for you to do so.)*
• Anger/aggression
• Anxiety/impulsivity
• Race/ethnicity
• Coping style
• Attitude to health workers
• Lifestyle
• Habits
• Education
- Social background
- Life events
- Other

The above list is a guide only. Depending on the client's condition, some sections of the assessment may need to be expanded or contracted to suit, for example:

- The 'physical' observations for a person with SCI will need to be quite long and detailed, but there may be no change in cognition.
- Sections on cognition or behaviour might need to be more detailed for a person with ABI, and there may be no residual physical disability.

Some questions/topics may not be covered routinely by your host service with their clients eg. questions about depression/suicidal ideation or relationships. For the purposes of this holistic assessment, please include the heading anyway, and include any information that seems relevant, even if you do not ask the question directly of the client, for example:

**Depression/suicidal ideation/hopelessness**

- Client did not describe suicidal ideation, although this was not expressly asked
- Mood appeared positive over the course of the interview. Client making plans for the future

It is then clear to the reader that you haven't simply overlooked the section.
APPENDIX A

MAGPIE: an interdisciplinary CR Process

Development of the MAGPIE

The learning tasks in this workbook are based upon the tasks undertaken by students who participated in the Interdisciplinary Student Placement in Community Rehabilitation (ISP) offered and supported by CRWP project officers from June 2005 until June 2008.

The key learning task in the ISP was the presentation of a comprehensive Case Study based on a CR client from the host service, and all other learning tasks were related to this. In developing their case studies, students of all disciplines were required to follow the same interdisciplinary process, based around the ICF, regardless of their host service model.

Arising from this, CRWP project officers have developed the MAGPIE\(^1\): an interdisciplinary CR or case management process, which describes the CR process students were required to use in developing their case studies. MAGPIE draws on existing descriptions of processes articulated in the rehabilitation and nursing literature (Wade 2005; Kozier, 2004).

The MAGPIE process has been incorporated into undergraduate curriculum in several universities whose students participated in the ISP, and has also been adopted as the CR process in the Graduate Certificate in Community Rehabilitation offered through Griffith University from 2008.


\(^1\)MAGPIE CR Process is currently under development by Nance J & Amsters D on behalf of Queensland Health.
MAGPIE- The ICF Applied in Community Rehabilitation

Meet

Assess

Goal set

Plan

Implement

Evaluate

1. MEET

Establish rapport

- Introduce self and service / nature of referral
- Trans-cultural issues- identify and address
- Explain services you are able to provide/ arrange
- Rights and responsibilities incl. complaints procedures
- Consent

Location - where possible, in the client’s own environment- much information can be gained from observation of the home environment.

2. ASSESS

An Holistic assessment of current situation covering all ICF domains.

Information obtained directly from the client and family/carer:

- Illness/injury factors
  - Impairment to body structures and functions
  - Activity limitations

'Improving the health of an individual, or the population as a whole, is not merely a matter of reducing premature death due to disease or injury. Health is also about human functioning, the capacity of individuals to live a full life as an individual and as a member of society.'

Gro Harlem Brutland, Director-General, WHO, speech at WHO conference on Health and Disability, Trieste April 2002.
3. GOAL SET
Collaborative goal setting/needs identification

- Short term goals/needs
- Long term goals/needs
- Family/carer goals/needs

4. PLAN
Collaborative process involving client and/or family/carers

**Step 1**
Analysis of facilitators and barriers to achieving goals/meeting needs
All domains of the ICF

**Step 2**
Identification of possible strategies to enable facilitators and overcome barriers identified in previous step

**Step 3**
Collaborative program planning with the client including prioritisation and gaining client endorsement of actions/interventions planned

5. IMPLEMENT
Program involves implementation of whatever strategies were identified and subsequently endorsed in Step 3 of Plan phase. Could include:

- Discipline specific assessment and intervention from a range of professionals
- Case management intervention
- Advocacy (individual or systems)
- Chronic disease self management
- Referral to other services
- Discharge planning
6. EVALUATE

- Program evaluation - outcome measures
- Quantitative measures
- Qualitative measures
- Linked to client goals/needs
- Global measures of change in domains of QoL, activity participation and environment

Diagrammatic representation of the MAGPIE process

APPENDIX B

OUTCOME MEASURES:
A Compendium of Clinical Measures for Community Rehabilitation

Outcome measures are "assessments which gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient’s perception of restoration of functional status, as well as measures of mortality, morbidity, cost, quality of life, patient satisfaction and others". www.futurehealth.ucsf.edu/cnetwork/resources/glossary/gloNO.html

Outcome measures are necessary to measure the outputs of community rehabilitation services; however problems with efficiency and effectiveness of outcome measures occur when:

- Outcome measures are chosen ad hoc, not according to best available evidence
- Teams may use many different measures to measure the same outcome and
- Training in application of measures is not standardised

The Compendium of Clinical Measures for Community Rehabilitation contains a suite of outcome measures for use in community rehabilitation settings, as identified from a systematic review of the literature. This is a synthesis of 28 measures and clinical tests which have been critically appraised and then approved by an expert working group of rehabilitation clinicians. The outcome measures were reviewed within the framework of the World Health Organisations International Classification of Functioning, Disability and Health.

Three core measures were identified for use, the WHOQoL -BREF, the Frenchay and the HACE. These measures can be administered by any member of the multidisciplinary team who is suitably skilled. In addition, a number of non-core measures were identified as recommended for use when specifically required to meet outcome measurement needs for specific clients and specific disciplines within the multidisciplinary team.

For more information please refer to the CRWP Resource DVD attached to this workbook or visit: www.health.qld.gov.au/qhcrwp/docs/clinicalmeasures.pdf
APPENDIX C

REFERENCE ARTICLES

Complete copies of all reference articles listed here in this appendix are located on the CRWP Resource DVD attached to this Workbook.

The ICF Model:


• Schneidert, M., Hurst, R., Miller, J., Ustun, B., The role of Environment in the International Classification of Functioning, Disability and Health (ICF), *Disability and Rehabilitation*, 2003; vol.25, No 11-12, 588 - 595.

**Educational Material for Clients:**
