

**Allied Health Professions' Office of Queensland**

**COMMUNITY REHABILITATION Learner Guide**

**Support client daily living requirements in a  
community rehabilitation context**

**April 2017**

## **Community Rehabilitation Learner Guide – Support daily living requirements in a community rehabilitation context**

Published by the State of Queensland (Queensland Health), April 2017



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## Acknowledgement

The Allied Health Professions' Office of Queensland (AHPOQ) wishes to acknowledge the Queensland Health allied health clinicians who have contributed to the development of these learning support materials. In alphabetical order:

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## INTRODUCTION

Welcome to Learner Guide: Support client daily living requirements in a community rehabilitation context.

Throughout the guide, you will be given the opportunity to work through a number of activities, which will reinforce your learning and help you improve your communication and organisation skills, manual handling skills and ability to apply therapeutic exercise practices. Take time to reflect during the module on how you may be able to apply your new knowledge and skills in your role as an allied health assistant.

### Learning requirements

It is important that you have an allied health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay “on track”, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials. This will be particularly important if you are having any specific learning difficulties.

Activities and assessment tasks may require access to the internet. If you do not have internet access please talk with your supervisor about your options.

### Self-Completion Checklist

The Self Completion Checklist outlines the underpinning knowledge and skills contained in each of the topics for the unit of competency you will be assessed against. You will be asked to review the list and place a tick in the box if you feel you have covered this information in each section and if you feel ready to undertake further assessment. If you have any questions about this checklist, ask your supervisor.

### Recognition for Prior Learning

If you subsequently enrol in the Certificate IV in Allied Health Assistance you may be able to undertake recognition assessment for the study that you have done. To enable you to gain recognition for the learning you have undertaken in this Learner Guide, it will be necessary for you to complete the Assessment Guide associated with this unit of competency. The assessment activities in this Assessment Guide must be signed off by your supervisor. Copies (Word version) of the Assessment Guide can be obtained by contacting the AHPOQ team via e-mail [AH\\_CETU@health.qld.gov.au](mailto:AH_CETU@health.qld.gov.au).



**Please Note** Due to the varied environments in which allied health assistance is carried out, the terms ‘patient’ and ‘client’ are used interchangeably throughout this resource. Please use your organisation’s preferred term when performing your duties.

## Symbols

The following symbols are used throughout this Learner Guide.



**Important Points** – this will include information that is most relevant to you; statistics, specific information or examples applicable to the workplace.



**Activities** – these will require you to reflect on information and workplace requirements, talk with other learners, and participate in a role play or other simulated workplace task. You may use the space provided in the Learner Guide to write down a draft response. Record your final answer in the Assessment Guide.



**Further Information** – this will include information that may help you refer to other topics, complete activities, locate websites and resources or direct you to additional information located in the appendices.



**Case Studies** – these will include situations or problems for you to work through either on your own or as a group. They may be used as a framework for exploration of a particular topic.



**Research** – this refers to information that will assist you complete activities or assessment tasks, or additional research you may choose to undertake in your own time.

## LEARNING OUTCOMES

As an AHA supporting client daily living requirements in a community rehabilitation context, you will be required to perform the following tasks.

- Clarify the relevance of supporting daily living to rehabilitation by:
  - Clarifying rehabilitation plan details with the supervising health professional
  - Working with the supervising health professional to identify daily living activities that need to be addressed as part of the rehabilitation plan
  - Working with the supervising health professional to identify daily living activities that could enhance progress against rehabilitation goals
  - Working with the supervising health professional and client to provide adequate and appropriate resources to promote independence
  - Clarifying with the supervising health professional concerns about client safety in relation to daily living activities
- Work collaboratively to establish a routine that fosters maximum client independence by:
  - Working with the health team to identify carer support provided to the client
  - Working with the health team to identify other community workers/services providing support to the client
  - Working with the client and health team to determine support routines that best suit the client's lifestyle and life routines while encouraging progression towards identified rehabilitation goals
  - Promoting benefits of daily living activities in terms of the client's rehabilitation goals
  - Identifying opportunities for daily living activities in the client's home and community that will support rehabilitation goals, and discuss with the supervising health professional
  - Discussing opportunities that are outside the rehabilitation plan with the supervising health professional
  - Working with the client and other community workers/services to provide coordinated and consistent supports to the client
- Support client to participate in activities of daily living that support rehabilitation goals by:
  - Recognising client concerns about participating in daily living activities
  - Under the supervision of the health professional, work with the client to develop strategies to overcome client concerns
  - Under the supervision of the health professional, identifying and reporting any aides, appliances and modifications that might be required for participation in daily living activities and discuss with the supervising health professional

- Under the direction of the supervising health professional, providing information and support to the client to use any aides, appliances and modifications in a safe and effective way
  
- Monitor impact of client involvement in daily living activities on rehabilitation goals by:
  - Monitoring outcomes that indicate involvement in daily living activity is supporting the rehabilitation goals
  - Identifying any negative impact of daily living activities and report to supervising health professional
  - Recognising medical issues and risk factors related to activities of daily living
  - Recognising wellness and medical issues prior to providing support
  - Applying strategies to involve the client in the monitoring and evaluation process
  - Providing client with regular feedback of progress
  - Working with the client to self-monitor progress
  
- Document client information by:
  - Using accepted protocols to document information relating to the rehabilitation program in line with organisational requirements
  - Providing regular feedback to the client's care team
  - Using appropriate terminology and format to document the client's progress, including any barriers or challenges to the rehabilitation plan

## LEARNING TOPICS

The table below outlines the relationship between the topics presented in this Learner Guide and the Essential Knowledge required for completion of the unit of competency.

Topics	Essential Knowledge
1. Working in community rehabilitation	<ul style="list-style-type: none"> <li>• Philosophy and values of community rehabilitation</li> <li>• Range of community services that could be providing support to clients</li> <li>• Relevant national and/or state-based community services and programs such as HASS, CACPS, veteran's home care</li> </ul>
2. Client services	<ul style="list-style-type: none"> <li>• Community care service providers including managers, supervisors, coordinators, assessment officers and case managers</li> <li>• Range of aids, appliances and modifications that could promote client participation in daily living activities</li> </ul>
3. Holistic Support	<ul style="list-style-type: none"> <li>• Awareness of cross cultural issues in a community rehabilitation context</li> <li>• Occupational health and safety (OHS) issues and requirements, risk assessment and risk management associated with working in client homes and the community</li> <li>• Psychological impact of illness and/or injury, especially in relation to client participation in daily living activities and routines</li> <li>• The importance and meaning of home and belonging to clients and the nature and significance of working in the client's home and community settings</li> <li>• Understanding of principles and practices of self management</li> </ul>

# CONTENT

## 1. Working in community rehabilitation

This topic covers information about:

- Philosophy and values of community rehabilitation
- Community rehabilitation programs

Activities in this topic address the following essential skills:

- Communicate effectively with relevant people in community rehabilitation context, including:
  - Verbal and non-verbal communication with clients and colleagues, including members of multidisciplinary teams
  - Cross cultural communication
  - Communication that addresses specific needs of people with disabilities
- Work within a multidisciplinary team

### 1.1 Philosophy and values of community rehabilitation

Before we start talking about community rehabilitation, we have to define what is meant by the term 'rehabilitation' in the health industry. Here is one definition from Queensland Health:

**Rehabilitation** is the process that brings about the highest level of recovery or improvement in function following the loss of function and ability from any cause.

Compare this to the following definition from the World Health Organisation (WHO):

'Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination.'

(World Health Organisation, 2010)

As you can see, the WHO definition explicitly mentions a person's functioning on a range of different levels, ensuring that the concept of rehabilitation extends beyond the physical consequences of illness or injury.

The rehabilitation process can be characterised further, as:

'Co-ordinated, multidisciplinary team-work, by a team with expertise and an interest in disability, who actively involve the client and family in the process, which is set within an explicitly recognized framework encompassing all aspects of illness.'

(Wade 2001: 230)

Further complexity in describing the rehabilitation process arises when we consider where along a client's continuum of care the rehabilitation is occurring.



What do we mean by 'Continuum of Care'?

'The provision of comprehensive care from the hospital to the home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system' (World Health Organisation 2006).

For instance, the continuum of care for rehabilitation commences with an acute presentation (which may be related to an acute illness, trauma or elective admission) and continues through discharge and referral to alternative care, including home. It is important to consider plans for discharge from the time of admission, as this would ensure a smooth and co-ordinated client journey. Along the continuum, given the client's changing needs over time, rehabilitation may take place in a number of settings including an acute unit, dedicated rehabilitation unit, as an ambulatory client into a hospital or community-based setting, or in the person's home. This is ensuring that the client is receiving the right care in the right place at the right time.

### **What is community rehabilitation?**

Now we have defined rehabilitation, how is community rehabilitation (CR) different?



From *Establishing a Baseline for CRWP Activities*, the following definition was developed by Queensland Health's Community Rehabilitation Workforce Project (CRWP):

'Community rehabilitation is a process that seeks to equip, empower and provide education and training for rehabilitation clients, carers, family, community members and the community sector to take on appropriate roles in the delivery of health and rehabilitation services to achieve enhanced and sustainable client outcomes.

'It is, therefore, a broad and diverse area which generally encompasses:

the physical, social and attitudinal environment in which services are delivered

the use of networks to create a complete response to consumer needs

the engagement of consumers in their own rehabilitation'

(Queensland Health 2008)

Put very simply, CR is a process to help people 'get on with life' after illness or injury even if they have not made a complete recovery.

CR services could be classified a number of ways:

- By speciality. Speciality teams, such as spinal cord injury or stroke teams, exist to provide services to a particular diagnostic group. Modelling services according to diagnosis results in a high level of expertise and specialist skills in the area; however, they are only appropriate where a large number of people with that diagnosis exist in an area. It would not be feasible, for example, for health services to provide speciality teams for Huntington's Disease or Motor Neurone Disease. Often these teams need to provide more of a consultancy role; for example, in Queensland, the spinal outreach team provides statewide assessment and case management and often relies on local services to provide actual treatment to clients and their families.
- By location or by the management providing the service. In Queensland, state government funded community rehabilitation teams are provided in geographical areas linked to health service districts. These services treat a wide range of often non-specific conditions. It could be argued that these teams are specialised in:
  - Assessing and managing common, usually not disease-specific problems, that affect a large number of people in the community, such as pain secondary to poor posture, skin problems associated with immobility, impairments and

disabilities associated with arthritis, minor problems in personal or domestic activities etc.

- Monitoring a client's disability, specifically to avoid or treat complications, such as joint contractures, pressure sores, weight gain etc.
- Encouraging a client back into a range of social roles locally including activities, such as going out shopping, going to clubs and day centres, and doing voluntary work
- Knowing all the resources available locally
- Knowing when to refer clients back to other specialised services appropriately
- Providing on-going support, for example through answering clients' and families' questions, and providing practical and emotional support

(Wade 2003: 879)

You can see that there are no consistent definitions of rehabilitation in general or CR in particular. There is also variation in the terminology used to describe the end 'user' of rehabilitation services: the terms *client*, *client* and *consumer* are used interchangeably for the purposes of this guide.

The lack of consistent definition of CR means that CR services are not all the same in the range and delivery of services offered. While some teams offer only specialist services such as stroke rehabilitation; other teams deliver services to people with a wide range of issues, such as those associated with ageing including frailty, falls, osteoporotic fractures and other neurological conditions (Hillier 2010).





## **Philosophy and values underlying community rehabilitation**

Health services have long been involved in the business of treating health conditions. Regardless of the quality of services provided, the fact remains that not everyone makes a full recovery. Some people will be left with temporary or permanent disabilities, and many of these will be referred to CR services.

As part of a range of services provided by Queensland Health, CR is influenced by the philosophies and values of the WHO. Consider the following vision statement from the WHO's *Disability and Rehabilitation: WHO Action Plan 2006–2011*:

‘All persons with disabilities live in dignity, with equal rights and opportunities’

(World Health Organisation: 1)

## **Human rights**

Some of the human rights Australians are entitled to include the right to:

- live with our families
- a basic education
- be treated equally by the law
- think what we like and practise any religion
- say what we like (without inciting hatred or violence)
- an adequate standard of living, including adequate food, clothing and housing
- access to appropriate health care
- maintain our culture and language
- freedom of movement
- privacy
- freedom from discrimination

(Human Rights and Equal Opportunity Commission 2009: 2)

## **Social justice**

Hand-in-hand with human rights is the concept of social justice; that is to say, ensuring that human rights are upheld for everyone, especially for the most vulnerable members of our society who may be unable to speak up for themselves.

‘Social justice can be defined as the responsibility to care for the dignity of the human person and the search for the common good. Social justice seeks to reduce gaps in opportunities (for example, access and entitlements, allocation of resources) between individuals and groups, and so begins to address some underlying social issues such as homelessness, hunger and unemployment.

‘Social justice is about relationships between people, and relationships between people and their environments; it is the responsibility of everyone. It is about taking action to redress inequalities, it is about respect and it is about human rights.’

(Department of Education and Training 2003)

Human rights also encompass freedom of choice, including the freedom to accept or reject treatment or intervention. In CR, the rehabilitation worker steps back from the role of ‘expert’, and takes on the role of ‘resource’. This involves handing over power to the client, respecting and accepting of their values and culture, and helping them to find and access support in order to meet their needs and achieve their goals. The client is central in the process, and should be involved in all aspects of service delivery including:

- goal setting
- program planning
- decision-making about interventions
- evaluation of program outcomes



## Activity 2: Reflection

Imagine you have had stroke (interruption of blood supply to the brain). Your stroke has left you with high support needs: you are unable to walk; and you need help with bathing, eating and drinking, personal hygiene and communication. You are very aware of your surroundings and recognise all the members of your family and your friends. The time is coming for you to be discharged from hospital. You have not made any significant improvement and your doctor has suggested there are two options open to you:

- You can return home and be cared for, full-time, by your spouse. Your spouse would have to give up work but would be eligible to receive a carer's pension.
- You can move into a nursing home.

You are 32 years old, with two young children, and your spouse is now the sole breadwinner for your family.

- a) Review the human rights for Australians listed on page 13 of this guide.
- b) What are the human rights implications for the two options you have been given: for you; your spouse and your children?

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You may wish to discuss your answers with your supervising AHP.

## 1.2 Community rehabilitation programs

### Rehabilitation services

Service providers comprise a mix of government (commonwealth and state) and private sector providers. Current funding arrangements have led to a mix of publicly- and privately-provided services for clients. Not all geographical areas are covered by all services. Some areas are well covered with a choice of providers for clients, whereas other areas will have only one provider who may not provide services to all types of clients or have a full range of services to provide.

### Queensland Health funded services

- Aged Care Assessment Teams (ACAT)
  - provide assessment only to older people
  - assess for eligibility for EACH or Home Care packages (see below)
  - generally teams include Nurses, Physiotherapists, Occupational Therapists, and Social Workers
- Transition Care Teams
  - provide ‘slow stream’ rehabilitation and case management for clients over 65 who are eligible for an ACAT package and who have had a hospital admission
  - aim to reduce unnecessary placement in residential aged care, or to reduce the level of care required (for example, from high care or nursing home level, to medium or low care or hostel level)
  - teams may consist of Registered Nurses, Enrolled Nurses, Occupational Therapists, Physiotherapists, Speech Pathologists, Dieticians, Social Workers, Case Managers, Community Health Aides (CHAs), and Team Leaders
- Community Adult Rehabilitation Services (CARS)
  - generally targeted at the older population and those with stroke and other neurological conditions
  - generally, teams include Physiotherapists, Occupational Therapists, Speech Pathologists, and AHAs, and may also include Psychologists, Social Workers, Dieticians, Nutritionists, and Nurses
  - operate throughout Queensland
  - provide rehabilitation for a wide variety of clients with neurological conditions
  - interventions provided within the community or home setting or centre-based, as required

## State-wide specialist services

- QLD Spinal Cord Injury Services (QSCIS)
  - Transitional Rehabilitation Program (TRP) assists people affected by spinal cord injury to transition from hospital rehabilitation to community living. It offers a flexible rehabilitation service focussed on individual goals and enables earlier discharge from hospital. TRP assists people to consolidate and build on skills developed in the Spinal Injuries Unit with the support of an experienced team of health professionals.
  - Spinal Outreach Team (SPOT) is an 'all of life' service that supports people affected by spinal cord injury throughout Queensland by providing quality, timely and client-focussed consultancy, early intervention and education services in the areas of Social Work, Physiotherapy, Occupational Therapy and Nursing.
- Acquired Brain Injury Outreach Service (ABIOS)
  - A specialist whole of life community-based rehabilitation service providing case management, training and consultancy for adults who have had an acquired brain injury (ABI) living in the community, their families and the services that support them.
- STEPS Program (Skills To Enable People and Communities)
  - An information and skills group program for adults aged 18-65 with stroke and ABI, their families and friends. It aims to establish sustainable networks of support in people's local communities throughout Queensland. It is a service arm of the ABIOS best suited for people who had their brain injury or stroke at least one year ago.
- Paediatric Rehabilitation Services
- Queensland Health Lady Cilento Children's Hospital includes a Department of Paediatric Rehabilitation which comprises a range of services and clinics, for example
  - Queensland Cerebral Palsy Health Program
  - Queensland Clinical Motion Analysis Service

## Other Support Services

- There are a variety of programs and funding packages to assist people to live independently in the community. These programs, funded by the Australian or Queensland governments aim to assist Australians to live in their own homes.

## Home Care Packages Program

Individually planned and coordinated packages of community aged care services designed to meet older people's daily care needs in the community. It is a care option for older people with complex care needs who prefer to remain living in the community rather than enter residential care.

The packages are flexible and designed to help with individual care needs. The types of services that may be provided as part of a package include:

- personal care
- support services
- home help
- nursing, allied health and other clinical services
- care coordination and case management

### **Extended Aged Care at Home (EACH)**

EACH packages provide high levels of support to assist frail older Australians to remain living in their own homes. These packages offer a higher level of support than a CACP. They also require a person to have been assessed by an ACAT as requiring high level care.

These packages may be used to fund services like those provided under a CACP, and in addition a person receiving an EACH package may also receive these services:

- registered nursing care
- care by an AHP such as a Physiotherapist, Podiatrist or other type of AHP
- assistance with home oxygen and enteral feeding supplies

### **Extended Aged Care at Home Dementia (EACHD)**

EACHD packages provide high-level care to people who experience difficulties in their daily life because of behavioural and psychological symptoms associated with dementia.

CACP or EACH approved providers deliver the care funded by these packages. Providers could include government organisations, like HACC (see below) or non-government organisations such as Bluecare or Spiritus.

### **Home and Community Care (HACC)**

The HACC program is jointly funded by the Australian, State and Territory Governments, with the Australian Government providing around 60 percent of the funding.

The HACC program provides services to support older Australians, younger people with a disability and their carers to function at home and in the community and to reduce unnecessary admission to residential care, for example, nursing homes.

Some of the services funded through the HACC program include:

- nursing care

- allied health care
- meals and other food services
- domestic assistance
- personal care
- home modification and maintenance
- transport
- respite care
- counselling, support, information and advocacy
- assessment

### **Veteran's Home Care**

This program is managed by the Department of Veterans' Affairs to help veterans and war widows or widowers enjoy a healthier lifestyle and remain living at home longer. The services through Veterans' Home Care are similar to HACC services and include help in the home, personal care, home maintenance, and respite care.

### **Disability and Community Care Services Queensland (DCCSQ) formerly Disability Services Queensland (DSQ)**

DCCSQ provides various services for people with a disability and service providers. These include programs, funding and grants, and access to a complaints process.

One example of DCCSQ funding is the Adult Lifestyle Support program, which assists adults with a disability to live and participate in their local community. This program contributes funding and support to help meet the disability support needs of individuals to complement informal (unpaid) networks and to promote access to other general community services. The funds provided through the Adult Lifestyle Support program can be used by adults with a disability in a variety of ways.

Including purchasing support to:

- live at home and manage their household
- take part in recreation and leisure activities
- strengthen personal and family relationships and networks
- purchase necessary aids and equipment that cannot be provided by other agencies or government departments

An adult support package is available to those who live in Queensland and have a disability that:

- is attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment or a combination of impairments

- results in a substantial reduction of capacity in one or more of the following areas; communication, social interaction, learning, mobility or self care/management
- results in needing support **and**
- is permanent or is likely to be permanent (and may or may not be of chronic episodic nature) **and**
- manifests itself before the age of 65

(Department of Communities 2011)



#### Further Reading

There are also family and early childhood programs, respite services and family support programs provided by Disability and Community Care Services. For further information refer to the website.

<http://www.communities.qld.gov.au/disability/support-and-services/our-services>



Depending on your workplace you may want to research these programs further.

Aged and Community Care Information Line on 1800 500 853

Commonwealth Respite and Carelink Centres on 1800 052 222 or via [carers/programmes-services/for-carers/commonwealth-respite-and-carelink-centres](http://www.dva.gov.au/Pages/home.aspx)

More information about services available for veterans, war widows and widowers, is available from the Department of Veterans Affairs:

<http://www.dva.gov.au/Pages/home.aspx> or 1800 555 254

## Community organisations and peak bodies

There are also community organisations dedicated to specific conditions, such as Multiple Sclerosis Queensland, Parkinson's Queensland Inc, and Arthritis Queensland. Many of these Queensland-based peak bodies have a national organisation as well.

Some peak bodies provide therapy services; however, others provide information and education only. Most of these organisations provide advocacy support for their client base.

Private not-for-profit providers, such as Bluecare, Spiritus and Anglicare, also provide domiciliary nursing, personal care and therapy services in the home for eligible clients. These are usually funded through commonwealth government programs such as HACC or EACH and therefore have eligibility criteria the client must meet in order to receive services.

There are also private rehabilitation providers operating in specific areas, for example Montrose Access provides support for people with degenerative neuromuscular disorders throughout Queensland.

As an AHA you may be involved in compiling and maintaining a database of information about services available and of relevance to the client group of your community rehabilitation service. This involves gathering information about each service including:

- referral and eligibility criteria and processes
- types of services provided
- any costs to clients
- transport options
- contact details

AHAs may also be involved in arranging, on behalf of a delegating AHP, referrals of community rehabilitation clients to other services. The decision for which services to refer to is the AHP's responsibility.



### Activity 3: Researching other services in the community

- Select an organisation outside of Queensland Health which is relevant to the client group of your community rehabilitation service
- Locate their website or contact details and research the following

Type of Organisation (for example, accommodation or equipment provider)	
Services Provided	
Staff mix	
Geographical area covered	
Referral sources	
Eligibility	
Funding (how is the service funded: federal or state government or non-government)	

Client-demographics (what types and ages of clients are able to access the service)	
Cost to clients	

## Key Points

This section of the Learner Guide has covered information related to the topic of working in CR. You should now:

- understand that rehabilitation takes place along a continuum from acute episode to the community setting
- understand that CR is about the client — the client is central to the process and is empowered to participate in roles and activities which they value
- understand that the philosophy of CR is centred in human rights and social justice

## Client services

This topic covers information about:

- Service providers
- Aides and appliances

Activities in this topic cover the following essential skills:

- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisation and client group:
  - This may include, for example, oral communication skills for working with clients and the health team, literacy skills for clarifying the rehabilitation plan for documenting client information

- Language used may be English or a community language
- Assist with facilitation of client involvement and participation in daily living activities within the context of rehabilitation plans and under supervision of an identified health professional
- Assist with identification of opportunities for client participation in daily living activities that support rehabilitation goals
- Communicate effectively with relevant people in a CR context, including:
  - Verbal and non-verbal communication with clients and colleagues, including members of multidisciplinary teams
  - Cross-cultural communication
  - Communication that addresses specific needs of people with disabilities
- Work within a multidisciplinary team

## 2. Service providers

Different people you will meet working in CR have different titles, although their roles may be similar or overlap.

**Managers or team leaders** are responsible for the overall direction and running of a team. They are also usually responsible for a budget and employing staff. Depending on the type of team, your manager could be from an allied health background or they could be a nurse or a doctor.

**Supervisors** are the people directly responsible for your work. As an AHA working in CR, your supervisor could be a:

Physiotherapist	Psychologist
Occupational Therapist	Cardiac Rehabilitation Nurse
Speech Pathologist	Diabetes Educator
Dietitian or Nutritionist	General Practitioner
Podiatrist	Registered Nurse
Social Worker	Medical Specialist

**Clinical Supervisors** delegate clinical service provision tasks to AHAs. These supervisors can be from a range of different disciplines, for example, Physiotherapy tasks may only be delegated by a Physiotherapist, Occupation Therapy (OT) tasks by an Occupational Therapist, and so forth. A nurse or doctor for example cannot delegate Physiotherapy or OT activities or programs.

**Assessment officers** usually work in specialised teams like the Aged Care Assessment Team. They assess a client's suitability and eligibility for other services or funded packages of care.

**Co-ordinators and case managers** are responsible for co-ordinating different strategies to help the client achieve their goals and make sure the appropriate services are involved. It is good for the client as they only have to liaise with one person from the team to ensure all their concerns are taken care of.



Most teams in the community are multidisciplinary so they are comprised of people from a variety of professions. Some teams employ health professionals to work in broad or general roles, for example a Physiotherapist may be employed to work as a rehabilitation case manager.

### **Allied health assistants**

As an AHA you are employed to work in a specific role. This is sometimes called a 'scope of practice'. The requirements of your role should be clearly listed in your role description (RD). Some tasks you will be expected to undertake **independently**, for example:

- ordering stock
- equipment inventory
- equipment maintenance
- preparation of treatment areas

Your role will also include working directly with clients on clinical tasks **delegated** to you by AHPs. The AHP is legally responsible for delegated clinical tasks, so it is essential that you are aware of your own scope of practice and do not undertake any tasks which are outside this scope.



If you are delegated a task that you believe is out of scope for your role or for which you believe you do not have adequate training, it is your responsibility to raise this with the delegating AHP or with your line manager.

If you are assisting across a range of professions, which is common in community rehabilitation, you will have a range of AHPs delegating tasks to you. Each one of these AHPs will be responsible for delegating clinical tasks specific to their discipline; a Physiotherapist can only delegate physiotherapy tasks, a Speech Pathologist is the only professional who can delegate speech pathology tasks, and so on. You can see why it is important to know the roles of all the professionals on the team as well as your own.

Duties which are **not** part of your role as an AHA (roles that are 'out of scope') include:

- diagnosis
- independent administration and interpretation of assessments\*
- independent referral to a provider or service outside the team
- interpretation of information provided to staff, clients, their families, and carers
- independent development or modification of a rehabilitation plan
- decisions about discharging clients from the service

\*In some disciplines and with appropriate training, AHAs may administer certain standardised screening tools or assessments and provide the results to supervising AHPs for interpretation. If this is part of your role, training will be provided locally to ensure that you have the appropriate skills.



#### **Activity 4: Who's who in your community rehabilitation team**

- Make a list of five professions represented on your CR team and list their roles and responsibilities. You may wish to make time to speak with team members and check that your list is complete.

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- What tasks might each of these AHPs delegate to you? Again, you may wish to arrange an informal interview with each AHP in your team.

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If you do not have a clear understanding of the role of any the people you work with, inside and outside of your organisation, make some time to talk with them to learn more.

## 2.1 Aids and appliances

Aids and appliances are used in rehabilitation to assist a client to achieve a task they may not otherwise be able to do or a task they can only achieve with difficulty. Aids and appliances are now included under the umbrella term of assistive technology (AT).

‘Assistive technology is a device or system that provides people with practical solutions to everyday life activities.’

(Life Tec Queensland)

AT can help people communicate, learn, care for themselves, work, and play. The use of AT is not an end in itself but is part of an ongoing therapeutic process to improve functional capabilities. AT devices can improve physical functioning, strengthen areas of weakness or prevent deterioration, and can be categorised as follows:

**Aids for Daily Living** are devices that help with daily living and independence.

Examples include:

- modified eating utensils
- adapted books
- pencil holders
- page turners
- dressing aids
- adapted personal hygiene aids

**Mobility Aids** are devices that help people move within their environments, for example:

- electric or manual wheelchairs
- modifications of vehicles for travel
- scooters
- crutches, canes and walkers

**Seating and Positioning** provide postural support and stability particularly for clients in wheelchairs. They enable clients to undertake activities safely and effectively while reducing pain and protecting skin. Examples include:

- off-the-shelf or custom made backrests and adapted seating
- cushions and wedges
- positioning belts and braces

**Augmentative Communication** devices help people with speech or hearing disabilities communicate. Examples include:

- communication boards
- speech synthesizers
- modified typewriters
- head pointers
- text to voice software

**Computer Access Aids** are devices that assist people with disabilities to use computers. Examples include:

- headsticks and light pointers
- modified or alternate keyboards
- switches activated by pressure, sound or voice
- touch screens
- special software
- voice to text software

**Environmental Controls** are electronic systems that help people control various appliances. Examples include:

- switches which are activated by pressure, eyebrows or breath to control telephone, TV, air-conditioners or other appliances

**Home and Workplace Modifications** are structural adaptations that remove or reduce physical barriers. Examples include:

- ramps and lifts
- bathroom changes
- automatic door openers
- expanded doorways

**Prosthetics and Orthotics** are replacement or augmentation of body parts. Examples include:

- artificial limbs
- orthotic aids such as splints or braces

**Sensory Aids** for Vision or Hearing Impairments include aids such as:

- magnifiers
- Braille and speech output devices

- large print screens
- hearing aids
- visual alerting systems
- telecommunication devices

**Recreation devices** enable participation in sports, social, cultural events. Examples include:

- audio description for movies
- adaptive controls for video games
- adaptive fishing rods
- cuffs for grasping paddles or racquets
- seating systems for boats

(Life Tec Queensland)



Life Tec Queensland is an organisation devoted to helping people living with disabilities. Life Tec displays and trials a wide range of equipment for clients. Their website contains a lot of details about different types of assistive devices. It is found at:

<http://www.lifetec.org.au/home/default.asp>

Some of the activities involving aids and appliances that an AHA might be required to perform include:

- taking equipment prescribed by an AHP to a client's home
- adjusting equipment, if necessary, to fit the client (for example height of toilet seat)
- instructing client in the safe use of their equipment
- checking that the client is using their equipment safely in their home or community environment

The types of AT you will need to know about will vary depending on the CR service where you work and the client population it serves. Before an AHP delegates to you any of the tasks described above, you will require specific training for each piece of AT involved.



### Activity 5: Assistive technology

Go to the Life Tec Queensland website, <http://www.lifetec.org.au/home/default.asp>, and list three different types of aids used to assist with the following:

- A person with poor hand function to eat independently

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- A person with mobility impairment to use public transport

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- A child with Cerebral Palsy to use a computer at school

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- An elderly person with limited strength to use a shower

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## Key points

This section of the Learner Guide has covered the topic of client services. On completion of this section you should:

- understand that there are a range of service providers in community rehabilitation
- know the different professions that make up multidisciplinary community rehabilitation teams
- know some of the range of aids, appliances and services that support community access and participation
- understand that the only way to become familiar with aids, appliances and services is to pick a specific area of interest and research it (for example, ask work colleagues, use resources within the workplace, search the websites in this learner guide, attend workplace in-service activities)
- understand that you do not need to know everything about all of these devices immediately; specific training will be provided when you need it

## Holistic support

This topic covers information about:

- Daily living
- Chronic disease self management
- Occupational health and safety

Activities in this topic cover the following essential skills:

- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisation and client group:
  - This may include, for example, oral communication skills for working with clients and the health team, literacy skills for clarifying the rehabilitation plan for documenting client information
  - Language used may be English or a community language
- Apply OHS knowledge in home and community settings
- Assist with facilitation of client involvement and participation in daily living activities within the context of rehabilitation plans and under supervision of an identified health professional
- Assist with identification of opportunities for client participation in daily living activities that support rehabilitation goals
- Assist with analysis of opportunities and concerns about client participation
- Communicate effectively with relevant people in a CR context, including:
  - Verbal and non-verbal communication with clients and colleagues, including members of multidisciplinary teams
  - Cross-cultural communication
  - Communication that addresses specific needs of people with disabilities
- Motivate client and build self esteem
- Work within a multidisciplinary team

### 3. Daily living

Imagine how you would feel if you were unable to do everyday activities that most people take for granted. Imagine if it was a huge effort just to get out of bed and dress yourself each morning. Now think about someone coming in and doing everything for you; washing you, dressing you, feeding you. Would that make you feel good? Do you think you would feel better if you could perform these activities by yourself or with a little assistance if you needed it?

Rehabilitation is not necessarily about doing things for clients but focuses on building on the abilities they have and enabling them to participate fully in home and community life.

#### **Coping with changed abilities**

Having an impairment may or may not have an impact on what clients do on a daily basis. Take, for example, a person who has lost their little finger in an accident. If the person were a school teacher, the loss of that finger would probably have no impact on his ability to do his job. But, if that person were a concert pianist, he might no longer be able to play at concert level, so he might have to change the course of his career.

An important quality of CR workers is the ability to empathise with the client. To have empathy means putting yourself in another person's shoes and seeing how the impairment affects them from their point of view. What this means is that the level of impairment is only one part of the story; knowing what our clients need or want to do in their lives helps us to gain an understanding of how that injury might affect them. There are lots of personal factors that change how a person might cope with a disability, for example: support from family and friends; the client's own personality, how well they cope with stress and change; and other health conditions they may be experiencing.

The case study on the following page illustrates how an injury can impact the lives of two different people.



### **Case Study: Dave and Joe**

Dave and Joe are both in their thirties. They have both had a spinal cord injury and are in wheelchairs, having lost the use of their legs. They are the main breadwinners for their young families.

Dave is a truck driver. The job involves loading and unloading the truck, securing the load and long trips interstate. He is unable to return to work.

Joe is a university lecturer. The spinal cord injury has had no effect on his ability to plan and deliver lectures, set and mark exams. He is able to return to work; in fact, while still an inpatient in the spinal injuries unit, he sets and marks exams for his students.

### **Activities of daily living**

We all have skills we use to function on a day-to-day basis. These skills grouped together are called 'Activities of Daily Living' or ADLs, and can be broken up into *basic* and *instrumental*.

One benefit of working in the client's home is that problems with ADLs are more easily observed and identified in the person's own environment. For example, a person may be independent in kitchen tasks in a simulated environment, like the kitchen in the OT department in a hospital, but may have real difficulties in their own kitchen, due to factors like bench heights, height of overhead cupboards or even space to turn in a wheelchair.

### **Basic activities of daily living**

Basic ADLs are skills needed for typical daily personal care. Usually an OT or a nurse will evaluate a client's ability to perform activities such as:

- bathing
- grooming
- dressing
- feeding
- toileting

A CR team can then, in consultation with the client, devise a program to make the necessary changes to allow the client to function as independently as possible.

Depending on what the client wishes to achieve, this might require input from a range of professionals:

- an OT to prescribe and arrange funding for bathroom modifications and equipment
- a Physiotherapist to prescribe a balance and muscle strengthening exercise program
- a case manager to apply for funding for a personal care attendant to be employed for daily assistance



Follow this link to a sample checklist which might be used to assess a client's abilities to perform personal or basic ADLs.

[http://gheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp\\_050\\_personal.pdf](http://gheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp_050_personal.pdf)

Even if a client is unable to complete an ADL, the CR program should only include this as a goal *only if that is what the client wants*. Consider the case study below:



### **Case Study: Jean**

Jean has had a stroke resulting in paralysis down one side of her body (hemiplegia) and she is now home after inpatient rehabilitation. The hospital discharge summary identified that, among other issues, Jean still has difficulties with dressing independently.

Now that she is home (and further recovery is likely to be minimal), Jean reports that trying to dress herself takes such a long time and effort that it leaves her exhausted, with no energy for doing other things she considers more important: like doing her own hair and make-up.

She decides that she does not wish to pursue the goal of independent dressing and would prefer to have someone assist her. The CR program changes; an application is made for a funding package which will pay for personal care attendants to assist with dressing, and the OT changes Jean's ADL program to focus on grooming.



### Activity 6: Motivating clients and building self esteem

- Consider the case study of Jean on the previous page. The CR worker insists on pursuing the goal of independent dressing. What do you think might be the impact of this on:

a) Jean's motivation to participate in her rehabilitation program

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b) Jean's self-esteem

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- Now put yourself in Jean's shoes and discuss how changing the focus of activities of daily living to grooming might impact on:

a) Jean's motivation to participate in her rehabilitation program

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b) Jean's self-esteem

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## Instrumental activities of daily living

Instrumental ADLs are skills that help individuals to function in their homes, workplaces, and social environments. Instrumental ADLs may include typical domestic tasks such as driving, cleaning, cooking, and shopping, as well as other less physically demanding tasks, such as operating electronic appliances and budgeting.

In the work environment, an ADL evaluation assesses the qualities necessary to perform a job, such as strength, endurance, manual dexterity, and pain management.



The links below will take you to sample checklists for assessing client ability to perform instrumental ADLs:

[http://qheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp\\_052\\_domestic.pdf](http://qheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp_052_domestic.pdf)

[http://qheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp\\_051\\_community.pdf](http://qheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp_051_community.pdf)

An AHP, usually an OT, will work with clients to identify which ADL are of most importance. The AHP will then devise a rehabilitation program and may delegate the practice of some tasks, or components of tasks, to the AHA to work on with the client. Here are some examples of ADLs and the types of activities which may be involved:

- housekeeping:
  - sweeping and vacuuming
  - mopping
  - washing and hanging out clothes
- transport:
  - help client to prepare for using public transport
    - time management
    - having money ready
    - purchasing ticket
    - finding correct train platform or bus stop
    - assist client to actually make a trip on public transport
- finances:
  - banking (within organisation guidelines for privacy, confidentiality and financial abuse)
  - budgeting
- shopping:
  - access local shopping centre, for example assist client in researching what local shopping centres are available
  - develop a shopping list, ensure they have money
  - assist client in deciding how they will get to the shops

- accompany client on a visit to the local shopping centre and ensuring they can navigate the area safely
- leisure:
  - access and participate in leisure activities
  - assist client in identifying local clubs or groups available in their area
  - assist client to contact group and arrange for visit
  - assist client in determining how they will get to club or group
  - assist and train client in how to prepare for club or group, for example money, appropriate dress, equipment
  - assist client to attend group or club

Every client will have different abilities and different preferences, so they will have a unique CR program, tailored to their needs.

As mentioned earlier, rehabilitation is often most effective in the client's own environment, as it provides an opportunity to practice skills in a 'real-life' situation, not merely a simulated one.

Working in the community environment brings with it certain risks; there are no emergency buttons or security personnel to contact if things go wrong. When you are working with a client in the home environment, you may therefore need to do a risk assessment. This involves thinking about what issues might arise and how you would plan or be prepared to deal with these.



## **Holistic care**

What do we mean by the term 'holistic'? This is one definition:

'...relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts—holistic medicine attempts to treat both the mind and the body.'

(Miriam-Webster 2011)

From the WHO:

'The holistic nature of health is by now an accepted fact; the World Health Organization's definition of health as being "complete state of physical and mental well-being and not merely the absence of disease or infirmity" has been a telling reminder, for the past 60 years, of the comprehensiveness of this concept of health.'

(World Health Organisation 2008)

By these definitions, therefore, rehabilitation should aim, as far as possible, to restore physical and mental well-being which may have been reduced through illness or injury and holistic support should consider the 'whole person' which includes their ability to function as an individual and at a family and social level.

## **Working in a person's home**

When you work in the community setting, you often work in a person's home. This is a very personal space. People organise their homes with objects that are special and important to them. Everyone has a different perspective on what is important and what is not. Sometimes people collect things like old newspapers or magazines that you might consider junk. However, these objects can be special or important in some way to that person. It is important to be aware that we are unique and this is something to be respected and celebrated.

CR professionals may provide advice or recommendations on changes that would benefit the client's safety and function, for example:

- taking up loose mats that could pose trip and falls risks
- installing grab rails in showers or toilets to aid with transfers
- removing unnecessary furniture and objects to minimise housework
- installing whiteboards to assist people with memory impairments

Advantages of working in the home have been identified as:

- seeing the person in their own environment and understanding what they wish to achieve
- creating a relationship with family friends and carers allowing greater communication
- increasing collaboration with the family and the community and voluntary sectors
- clearer identification and assessment of goals
- increased ownership of goals
- increased motivation for achievement of goals
- increased achievement of goals
- increased ability to see the impact of subtle changes of the environment
- knowledge that each person and their issues are unique
- increasing self awareness and reflection of own practice

As an AHA you may be required to follow up on whether professional recommendations have been acted on.

Remember that CR clients may not live alone; everyone who lives in the home may wish to be involved in decisions about suggested or recommended changes. It is important that you show empathy in your approach and respect client and family choices. These are, after all, reflected in some of the core values of Queensland Public Service.



The five core values of the Queensland Public Service are:

- Customers first
- Ideas into action
- Unleash potential
- Be courageous
- Empower people

(Queensland Government, *Our Values*)



### **Case Study: Mrs Thomas**

Mrs Thomas is an elderly client of your service who uses a four-wheeled walker to mobilise. Last time you visited her, with the OT, they recommended that many of her belongings should be moved in order to make the house safe to navigate.

On your next visit, you notice that there is still a lot of 'clutter' in the entry and hallway. For Mrs Thomas, the 'clutter' is her collection of family photos, objects she has bought on family trips, and gifts her children have sent from overseas. These objects are precious to her.



### Activity 8: Demonstrating respect for clients

Refer to the Case Study on the previous page and compare the following two approaches to Mrs Thomas.

Response 1: 'The OT said you need to get rid of all that clutter.'

How do you think this might make her feel?

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Response 2: 'You have some lovely things! Have you thought about what the OT recommended? Perhaps moving some of them would make it safer for you, maybe even decrease the chance you might knock something over and break it! Have a think about it; would you be happy for me to help you move them to a safer spot.'

How do you think you would respond to an approach like this if you were Mrs Thomas?

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## Impaired decision-making capacity

In some CR services you may be working with clients who have impaired capacity to make decisions which may place them or others at risk of harm, hardship or exploitation.



### Case Study: Peter

Peter has had a brain injury. You are on a home visit and someone knocks on the door and asks Peter for a donation to a charity. Peter says he will donate \$50. You know that Peter is on a pension, is behind with his bills and only has \$50 or \$60 dollars to last him until pension day next week. You think that Peter is making a bad decision and you are concerned that due to his brain injury he may not actually be capable of making decisions. This is also referred to as impaired decision-making capacity.

Impaired decision-making capacity is the inability to go through the process of reaching a decision and putting it into effect. There are three elements to making a decision:

- understanding the nature and effect of the decision
- freely and voluntarily making a decision
- communicating the decision in some way

If an adult is unable to carry out any part of this process for decision-making, the adult is said to have 'impaired decision-making capacity'. This is not ignorance, eccentricity, different ethical views, cultural diversity, poor communication, poor judgement or poor decision making (Department of Justice and the Attorney-General 2011).

In the case study above, you may suspect that Peter does not understand the nature and effect of the decision and you wish to intervene and stop him from making the donation. You know he is in danger of having his electricity cut off and you are worried that he may not have remembered this when deciding to make the donation.



It is not your role as an AHA to decide if a person has impaired capacity to make decisions. It is not even the role of the health professionals in your team. It is the role of the Queensland Civil and Administrative Tribunal (QCAT). If you are in a situation where you are concerned about the person's capacity to make decisions for themselves, you need to report this immediately to your supervisor who may then choose to refer the matter to QCAT.

Until QCAT has made its ruling, the person is presumed to have capacity for decision making, so even seemingly bad decisions should be respected provided they do not involve unlawful or dangerous activities.

You can read more about QCAT by following this link:

<http://www.qcat.qld.gov.au/matter-types/decision-making-for-adults>

In Peter's case, therefore, an appropriate course of action might be to ask Peter if you can have a word with him in another room (you do not wish to embarrass him in front of the door-knocker), remind him about his unpaid bills and check that he is sure about the donation. If he still wishes to go ahead, you should respect his decision but you should also report your concerns to your supervisor when you return from the home visit.

### **Impact of Culture**

People who live in Queensland come from diverse social, political, cultural and economic backgrounds; have a wide range of experiences, behaviours, beliefs, and attitudes in relation to health and illness. Depending on their backgrounds they may have different perceptions of health, illness, symptoms, or disease as well as varying notions and expectations of treatment.

When these different perceptions come together in a health care encounter, care should be taken to ensure that services are respectful of potential differences in knowledge and perceptions.

The following factors may impact on the health and illness experiences of all people, but may also differ depending on cultural backgrounds, as shown by the examples provided:

- language and communication styles
  - eye contact with person of authority is sometimes not culturally appropriate

- asking direct questions may be considered rude in some cultures
- explanatory models of health and illness
  - clients from some cultures may have the belief that illness/disability is a punishment or a curse and is therefore something to be ashamed of
- knowledge and familiarity with health system and procedures within health services
  - in some countries relatives stay in hospital with their family member and may find the idea of ‘visiting hours’ hard to understand
- use and belief in medicines including traditional medicines
  - in some cultures medication may not be taken as it is thought to be ‘wrong’ to poison the body
  - clients may not think to report on traditional medicines they are using, not being aware that even so-called ‘natural’ medicines may interfere with the effectiveness of prescribed medications
- spirituality and religion
  - some religions do not agree with practices such as blood transfusions or organ transplant
  - not all people from the same religious background will have the same beliefs and practices; this will vary sometimes on what branch of the religion the person adheres to, and whether they are practising or non-practising
- family and community
  - some cultures might see it as shameful to accept outside help when caring for a family member, seeing it as a family responsibility
- gender and modesty
  - dress codes may mean people cannot show certain parts of their bodies to workers of a different gender
- diet and food preferences
  - some people elect to follow vegetarian diets, because of religious or personal convictions about eating meat
  - medicines may be unacceptable to the client if they are developed from products of animals considered ‘unclean’ within that client’s culture or religion
- pain and disability
  - admitting to pain may be perceived as a sign of weakness
  - disability may be a source of shame or stigma and something to be hidden away
- impact of trauma
  - people such as political refugees who have experienced torture by guards in refugee camps may fear and mistrust anyone wearing a uniform

(Queensland Health, *Multicultural Clinical Support Resource*)



Cross-cultural capabilities resources and training are available within Queensland Health. You may wish to investigate this further by following the link below: <http://qheps.health.qld.gov.au/multicultural/>



## Activity 9: Cultural considerations

Follow the link below to find information on religious practices and health care:

[http://gheps.health.qld.gov.au/multicultural/support\\_tools/8MCRS\\_hlth\\_relgn.pdf](http://gheps.health.qld.gov.au/multicultural/support_tools/8MCRS_hlth_relgn.pdf)

Read through the 'dietary needs' column for the section on Islam and also the section entitled 'religious restrictions and medication.'

How do you think coming from a Jewish background might affect the following?

a) A client's acceptance of 'Meals on Wheels'?

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b) How might you adapt rehabilitation programs for retraining cooking skills to suit the client?

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c) A client's compliance with prescribed medications?

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Discuss your answers with your allied health supervisor.

## Cross cultural communication

You may hear the term 'Culturally and Linguistically Diverse', or CALD, used to describe the backgrounds of some of your community rehabilitation clients. Before visiting a client from a CALD background some research can help minimise the chances of causing offence or miscommunication.



You may wish to investigate Queensland Health guidelines to provide care to people from Culturally and Linguistically Diverse backgrounds by following the link below:

[http://www.health.qld.gov.au/multicultural/health\\_workers/guide\\_pract.asp](http://www.health.qld.gov.au/multicultural/health_workers/guide_pract.asp)

As an AHA working in the community setting, it is likely that at least some of the clients you see will come from CALD backgrounds. Some of these clients will speak English as a second language and may not speak it well enough to understand the more complex and specialised terminology and concepts associated with health and rehabilitation.

In order to ensure that everyone can obtain the information they need in a form that they can understand, Queensland Health has policies relating to the use of translators and interpreters.

### **Translators and interpreters**

There is often some confusion around these terms; they are used interchangeably and incorrectly. The difference is quite simple:

- translators deal with written text interpretation
- interpreters deal with the spoken word

(Queensland Health, *Interpreting and Translating*)

The *Queensland Health Language Services Policy Statement* states that health services should make written information on health service matters available in other languages, as appropriate (2000: 2).



Follow this link to a wide range of health information topics translated into other languages on the Queensland Health website:

<http://www.health.qld.gov.au/multicultural/public/language.asp>

Queensland Health's policy on the use of interpreters stipulates that:

- every client of Queensland Health has the right to the use of an interpreter if required
- interpreters can be provided either in person or by phone at no cost to the client
- it is Queensland Health policy to use friends or relatives as interpreters only in an emergency situation; if the friend or relative is under 18 years of age, they should not be used as an interpreter under any circumstances

(Queensland Health, *Rights to an Interpreter*)



## Activity 10: Cross cultural communication

Follow this link to Frequently Asked Questions about the use of interpreters:

[http://www.health.qld.gov.au/multicultural/interpreters/QHIS\\_FAQ.asp](http://www.health.qld.gov.au/multicultural/interpreters/QHIS_FAQ.asp)

- Queensland Health policy is to use accredited interpreters where possible. In your own words, describe three reasons for this policy.

a) \_\_\_\_\_  
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b) \_\_\_\_\_  
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\_\_\_\_\_

c) \_\_\_\_\_  
\_\_\_\_\_  
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- When is it ok to use family or friends as interpreters?

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\_\_\_\_\_  
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- When is it appropriate to use children as interpreters? Please give reasons for your answer.

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\_\_\_\_\_  
\_\_\_\_\_  
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Discuss your answers with your supervising AHP.

## Communication with clients

There is a lot more to communication than merely the spoken or written word; non-verbal communication is also extremely important. Various estimates place 60% or more of our communication as non-verbal, another 30% or more of communication is in our 'tone' (it's not what you said, it's the way you said it), leaving 10% or less of our communication to what is actually said.

Non-verbal communication can include:

- posture – whether we seem tense or relaxed, interested or distracted, whether our arms or legs are crossed (this is called closed posture and can be a barrier to communication)
- gesture – putting our finger to our lips to indicate 'sshhh', or holding up three fingers to represent the number three
- facial expressions – many of these are common across cultures, for example happiness, sadness, fear, anger, surprise
- spatial relations – the distance between us, whether we sit beside someone or on the other side of a desk
- touch – may be used to gain attention or to indicate a body part
- display – presentation, for example whether we wear a uniform or regular clothes

(Beer 2003)

## Communication impairments

Some health conditions, for example stroke, Parkinson's disease or dementia, may result in specific communication impairments; the ability to understand the spoken or written word, to find the right words to respond, or even to move the muscles of the face and tongue to form clear speech.

These and other health conditions can also affect a person's conversational skills, including:

- taking turns in speaking
- being able to read the other person's body language, for example understanding when a person wants the conversation to end
- concentrating on what is being said
- 'blocking out' unnecessary environmental sounds and attending to what is being said



There are many different conditions which may lead to different communication impairments in clients. Follow this link for tips on how to communicate effectively with a person with dementia:

[https://www.alz.org/national/documents/brochure\\_communication.pdf](https://www.alz.org/national/documents/brochure_communication.pdf)

This Learner Guide will not cover all the skills required to work with all clients with communication impairments. If your CR service has clients with specific impairments you will need additional training from a speech and language pathologist.



#### Further Information

You will find a fact sheet with more information about specific communication disorders that may occur with certain health conditions, , “Communication Impairment in Australia” on the Speech Pathology Australia website at:

[https://www.speechpathologyaustralia.org.au/spaweb/Document\\_Management/Public/Fact\\_Sheets.aspx#anchor\\_impair](https://www.speechpathologyaustralia.org.au/spaweb/Document_Management/Public/Fact_Sheets.aspx#anchor_impair)



## Activity 11: Communicating with clients

In the following situations, do you think effective communication is happening? How might the client feel in these situations? What is one strategy that might assist?

- You are talking to a person in a wheelchair. You are standing and there are no chairs around.

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- A client with dementia doesn't respond when you say hello.

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- Your client has had a stroke and his speech is slurred and difficult to understand. You ask his wife how he is getting on with his home therapies.

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## 3.1 Chronic disease self management

The rising incidence of acquired and chronic health conditions in our population presents many challenges to our health services.

The National Chronic Disease Strategy has defined chronic disease as:

- having complex and multiple causes
- usually has a gradual onset
- can occur across the lifecycle (more prevalent with old age)
- can compromise quality of life through physical limitations and disability
- long term and persistent leading to a deterioration of health
- most leading cause of premature mortality

(Commonwealth Department of Health and Ageing 2006: 1)

Some of the more common chronic diseases are:

- asthma
- cancer
- cardio vascular diseases
- chronic obstructive pulmonary disease
- diabetes
- haemoglobin disorders
- HIV/AIDS
- mental illness, including depression
- musculoskeletal disorders
- obesity
- osteoarthritis, rheumatoid arthritis
- physical disability
- stroke



Self management is the active participation by people in their own health care. Self management incorporates:

- health promotion and risk reduction
- informed decision making
- care planning
- medication management
- working with health care providers to attain the best possible care and to effectively negotiate the health system

(Community Services and Health Industry Skills Council 2009: 9)

### Principles of chronic disease self management

There are six key principles of chronic disease self management that underpin good practice for AHAs. They are:

- client-centred practice
- holistic practice
- accurate, comprehensible, timely, and appropriate information
- partnership and participation
- strengths-based practice
- coordination of support

- **Client-centred practice**

Client-centred practice requires working with clients with respect to build on their strengths and build resilience and behaviours that support the self-management of chronic disease. In order to achieve successful chronic disease self management, support and care must be centred on the unique needs, characteristics, and circumstances of the client. This includes:

- working within the client's context (including motivation, individual and community beliefs, values, and language)
- working within the client's access constraints (including financial, travel, language, and cultural)
- working according to informed client choices and preferences
- working according to client's pace and timing requirements
- working with regard for the client's pain, suffering, and impact of the condition on life circumstances

- **Holistic practice**

Chronic disease self management requires support and care across a range of issues other than clinical treatment. The application of this principle requires information and

support across all aspects of the client's life that could have an impact on the management of a chronic disease, including:

- providing direct support for positive lifestyle and wellbeing (including information, kits, education, nutrition support, exercise support, and other support services)
- providing indirect support for positive lifestyle and wellbeing (including preparation of food, policy, and staff development)
- supporting the client to implement, monitor, and evaluate treatments, including medication use
- supporting appropriate client coping skills and behaviour
- supporting family and other networks' capacity to support the client

- **Accurate, comprehensible, timely, and appropriate information**

Successful self-management of chronic disease relies on the client being an active partner in the management of chronic disease. Accurate, comprehensive, timely, and appropriate information is essential for active participation. Some applications of this principle include:

- supporting client understanding of the nature of the condition
- supporting client psychosocial wellbeing
- supporting client understanding of treatment, care, and behavioural responses to the condition

- **Partnership and participation**

Client partnership and participation underpins the self-management of chronic disease. This occurs through care-planning and monitoring, and decision making and problem solving. The application of the partnership and participation principle requires collaboration with the client as an equal partner with AHAs in the management of chronic disease. Practices that support partnership and participation include:

- supporting the client to actively participate in planning and monitoring
- supporting client decision making and problem solving
- supporting client self-management practices and priorities

- **Strengths-based practice**

Traditional health and community service provision has focussed on 'doing for' rather than 'doing with'. Working within a strengths-based perspective requires the identification of and building on coping skills, competencies, and positive aspects of the client in order to facilitate the knowledge and skills required to self-manage chronic disease.

Practices that support this principle include:

- supporting the client to identify and mobilise strengths
- supporting the client in solution-focussed self-management strategies
- providing feedback to the client to validate decisions and actions
- providing information and support to clients to access and use compensatory equipment, aids, and procedures

- **Coordination of support**

People with chronic disease may be required to negotiate a complex service system. Wherever possible and within the client's context, assistance and support with coordination or integration of services on a local level, and in a culturally sensitive manner, is a priority to the facilitation of the capacity to self-manage chronic disease. Supporting practices include:

- supporting contact and use of appropriate services and resources
- providing information to appropriate personnel about variations to client wellbeing
- utilising information technology to effectively communicate with the client and other services as appropriate

(Community Services and Health Industry Skills Council 2009)

### **Practices of Chronic Disease Self Management**

There are many different approaches to the management of chronic conditions: the Stanford Chronic Disease Self Management program, Flinders Chronic Care Management Program, and Wagner Chronic Care Model are some of the more commonly encountered. While approaches may vary, for example group versus individual programs, factors impacting on client ability to self-manage are fairly consistently identified as:

- goal setting
- motivation
- knowledge of the condition
- pain and symptom management
- other conditions that can occur
- cultural, religious, and family beliefs
- ability to manage independently
- family dynamics
- access to services and support of health professionals



If, as part of your role as an AHA, you are involved directly in the running of chronic disease self-management group programs (for example, as a co-facilitator) specific training will be required.



For more information about the prevention and management of chronic conditions in Australia refer to the Queensland Government's Chronic Conditions Manual <https://publications.qld.gov.au/dataset/ef6d9f9e-e8aa-445e-a345-02a016e7251b/resource/bbe5439c-be87-45b6-b704-3b557fbee1e0/download/chronicconditionsmanual1stedition.pdf>



## 3.2 Occupational health and safety

When you work in the community, your work space is at times someone else's home. Private homes are not always safe or well maintained. There can be environmental hazards such as poorly maintained paths and steps. In addition, there can be other hazards such as dogs, a history of violence or substance abuse, and clients or other family members who have psychological, emotional, or mental health issues.



Your organisation will have a policy and procedure on home visiting. Before you undertake a home or community visit, a risk assessment is conducted. This is to screen for OHS issues and to ensure a safe and healthy work environment.



The link below takes you to a sample risk assessment tool, Darling Downs Hospital and Health Service Home Visit Risk Screen  
<http://qheps.health.qld.gov.au/darlingdowns/pdf/forms/mr31.pdf>

To undertake a home visit successfully it is also important to have a plan. This can include the following items:

- health rehabilitation or support services to be provided
- resources to be allocated
- equipment required to undertake the home or community visit



It is your responsibility to make sure you know the safety procedures and concerns of your industry and work in a safe manner in your organisation and in people's homes.



The link below will take you to an example Procedure for Home Visiting and Personal Safety from the Darling Downs Hospital and Health Service.

<http://qheps.health.qld.gov.au/darlingdowns/pdf/procedure/4-04-001.pdf>

Ask your supervisor to help you locate your local policy or procedure for Home Visiting.

It is an OHS requirement that you take reasonable action to make sure that:

- accidents are prevented
- clients and staff are protected from injury
- hazards are removed, reported, or controlled
- injuries and 'near misses' are reported

Queensland Health runs orientation programmes and mandatory annual training programs that cover relevant OHS training such as:

- manual handling
- working with hazardous substances
- electrical safety
- cultural awareness
- infection control
- personal safety
- aggressive behaviour management
- driver safety (transport to the home or community environment)
- fire safety



### Remember

- Before you go out to someone's home for the first time be sure a risk assessment has been conducted.
- Make sure someone knows when you are going, where you are going (exact address), and the time you are expected back.
- Call if your return to the office is delayed for any reason.
- Take a charged mobile phone into the house with you – it is no good in the car.
- Make sure you have an exit strategy in case something goes wrong (for example, it is a good idea to sit where no one can block your exit)
- Make sure you look after yourself – if, *for any reason*, you feel unsafe entering or remaining in a client's home or other community setting, you should leave the situation immediately and report to your team leader, clinical supervisor, or line manager.
- Expect the unexpected and know what to do about it.
- If in doubt, ask a supervisor.



## Activity 14: Occupational health and safety

You are going on a home visit. A risk assessment was undertaken and no safety concerns were identified. As you enter the yard, you notice that the rail of the front steps has fallen down and some of the steps are missing. There is a back door.

- What would be the appropriate action for you to take in this situation?

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- How could this situation have been avoided?

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*Activity continues on the next page.*



### Activity 14: Occupational health and safety (continued)

- What strategies are in place in your workplace to maximise your safety during home or community visits?

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- What strategies are in place locally to enable staff to inform others of their whereabouts?

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Discuss your responses with a clinical supervisor.

## Key Points

This section of the Learner Guide has covered information related to the topic of holistic support. On completion of this section you should:

- know the difference between basic and instrumental Activities of Daily Living (ADL) and understand the importance of client choice in the design of an ADL rehabilitation program:
  - daily living tasks are the tasks we normally do in daily living, including any activity we perform for self-care (such as feeding ourselves, bathing, dressing, grooming), work, homemaking, and leisure; many impairments limit the extent to which clients can perform these tasks and it is common for health professionals to work on strategies with clients to improve their ability to do so
- have a basic understanding of the principles and practice of self management:
  - self-management encourages clients to become actively engaged in their own healthcare; health practitioners work in partnership with the client to achieve positive outcomes
- understand the additional OHS risks for workers in the community setting and be aware of basic strategies to minimise these risks:
  - staff and client safety when going out on home visits is paramount; AHAs must be familiar with local policy regarding home visiting and be able to undertake a risk assessment prior to performing a home visit

## SELF-COMPLETION CHECKLIST

Congratulations, you have completed the topics for HLTCR402B Support client daily living requirements in a community rehabilitation context.

Please review the following list of knowledge and skills for the unit of competency you have just completed. Indicate by ticking the box if you believe that you have covered this information and that you are ready to undertake assessment.

### HLTCR402B Support client daily living requirements in a community rehabilitation context

Essential Knowledge	Covered in topic
Awareness of cross cultural issues in a community rehabilitation context	<input type="checkbox"/> Yes
Community care service providers including managers, supervisors, coordinators, assessment officers and case managers	<input type="checkbox"/> Yes
Occupational health and safety (OHS) issues and requirements, risk assessment and risk management associated with working in client homes and the community	<input type="checkbox"/> Yes
Philosophy and values of community rehabilitation	<input type="checkbox"/> Yes
Psychological impact of illness and/or injury, especially in relation to client participation in daily living activities and routines	<input type="checkbox"/> Yes
Range of aids, appliances and modifications that could promote client participation in daily living activities	<input type="checkbox"/> Yes
Range of community services that could be providing support to clients	<input type="checkbox"/> Yes
Relevant national and/or state-based community services and programs such as HASS, CACPS, veteran's home care	<input type="checkbox"/> Yes
The importance and meaning of home and belonging to clients and the nature and significance of working in the client's home and community settings	<input type="checkbox"/> Yes
Understanding of principles and practices of self management	<input type="checkbox"/> Yes



## Activity 15: Questions

For this task you are required to answer the questions that relate to your work as an Allied Health Assistant working in a community rehabilitation context.

- Describe some strategies you would use to motivate a client to participate in their rehabilitation program at home.

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- How can you effectively monitor a client's progress with their rehabilitation plan?

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*Activity continues on the next page.*



### Activity 15: Questions (continued)

- How would you effectively communicate with a client who has communication and cognitive impairments?

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## Activity 16: Scenario

For this task you are required to read and respond to the scenario provided.

### Scenario

You have been referred a client who has previously been prescribed a bath board for safe transfers. You have been informed by a family member that this client refuses to use the equipment.

- How do you manage the situation?

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- Who would you consult with about this situation?

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### **Activity 17: Workplace Observation Checklist**

You will be observed supporting clients daily living requirements in a community rehabilitation context. The learner is required to work with the client in their home and the community, to assist the client to achieve their goals in activities of daily living.

Examples include:

- Increasing client independence in shopping tasks
- Increased involvement in leisure activities
- Increasing independence in meal preparation task

You will need to assist with the rehabilitation of clients on at least two occasions to demonstrate competence.

# WORKPLACE OBSERVATION CHECKLIST

Assessor to date and sign (draft only, please record in the Assessment Guide)

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 <sup>st</sup> observation date & initial	2 <sup>nd</sup> observation date & initial	Comments	*FER
<b>Clarify the relevance of supporting daily living to rehabilitation goals</b>				
<ul style="list-style-type: none"> <li>Discusses client's rehabilitation plan with professional (including goals, client's current function, social situation, mood)</li> </ul>				
<ul style="list-style-type: none"> <li>Demonstrates understanding of the importance of community rehabilitation in order for the client to increase independence</li> </ul>				
<ul style="list-style-type: none"> <li>Assists the professional to identify activities of daily living that are a priority area and which involvement will have positive outcomes for the client (e.g. self care tasks, community integration)</li> </ul>				
<ul style="list-style-type: none"> <li>Discusses potential concerns/risks with professional</li> </ul>				
<b>Work collaboratively to establish a routine that fosters maximum client independence</b>				
<ul style="list-style-type: none"> <li>Obtains client consent</li> </ul>				
<ul style="list-style-type: none"> <li>Liaises with team to determine and organise appropriate services (e.g. domestic assistance, community transport)</li> </ul>				
<ul style="list-style-type: none"> <li>Provides ongoing education to client/others about benefits of involvement in rehabilitation plan in order to achieve independence in activities of daily living (e.g. encourage client to prepare their own breakfast rather than have family members get their breakfast)</li> </ul>				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 <sup>st</sup> observation date & initial	2 <sup>nd</sup> observation date & initial	Comments	*FER
<b>Support the client to participate in activities of daily living that support rehabilitation goals</b>				
<ul style="list-style-type: none"> <li>Abilities to recognise client's concerns/any issues (e.g. client's fear of falling whilst at the shops or whilst having a shower). Discusses with professional</li> </ul>				
<ul style="list-style-type: none"> <li>Implements strategies to assist clients to overcome concerns (e.g. provision of aids for mobility/shower chair)</li> </ul>				
<ul style="list-style-type: none"> <li>Assists professional to prescribe aids/appliances/modifications to increase client independence in activities of daily living. Educates on the benefits, provide information on how to safely use/clean (e.g. mobility aids, one handed chopping boards, bath board / shower chair)</li> </ul>				
<ul style="list-style-type: none"> <li>Abilities to recognise client's concerns/any issues (e.g. client's fear of falling whilst at the shops or whilst having a shower). Discusses with professional</li> </ul>				
<b>Monitor the impact of client involvement in daily living activities on rehabilitation goals</b>				
<ul style="list-style-type: none"> <li>Monitors client's progress and involvement with rehabilitation plan, including any negative impacts/safety concerns. Liaise with professional</li> </ul>				
<ul style="list-style-type: none"> <li>Reviews client's goals and progress with professional and adjust rehabilitation plan as required</li> </ul>				
<ul style="list-style-type: none"> <li>Provides ongoing feedback to client about performance</li> </ul>				
<b>Document client information</b>				
<ul style="list-style-type: none"> <li>Documents all interactions with the client/others/in medical records/case notes</li> </ul>				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1 <sup>st</sup> observation date & initial	2 <sup>nd</sup> observation date & initial	Comments	*FER
<ul style="list-style-type: none"> <li>• Liaises with team regularly to discuss program (goals, progress, concerns)</li> </ul>				

\*FER – Further Evidence Required

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