Allied Health Professions' Office of Queensland

COMMUNITY REHABILITATION Learner Guide

Support community access and participation

April 2017

Community Rehabilitation Learner Guide – Support community access and participation

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Acknowledgement

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Contents

INTRODUCTION

Welcome to **Learner Guide: Support community access and participation.**

This Learner Guide has been developed specifically for Allied Health Assistants (AHAs) to provide the necessary knowledge and foster the skills required to work with clients to support rehabilitation within the community.

The Learner Guide includes information on:

- working in community rehabilitation
- organisation practices
- holistic support

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.

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 working with clients to optimise community access and participation in the context of a rehabilitation plan, you will be required to perform the following tasks.

1. Clarify client access issues identified in the rehabilitation plan by:
   • Clarifying rehabilitation plan details with the supervising health professional
   • Working with the supervising health professional to identify client access support requirements
   • Working with the supervising health professional to identify community rehabilitation's function in supporting client access
   • Participating in rehabilitation planning that involves the client and relevant professionals, where appropriate
   • Clarifying with the supervising health professional concerns about client safety in relation to community access and participation

2. Work collaboratively to maximise opportunities for community access and participation by:
   • Working with the health team and supervising health professional to identify other community workers/services providing community access to the client
   • Under the supervision of the health professional, providing information to the client about how accessing and participating in the community will contribute to rehabilitation goals
   • Under the supervision of the health professional, working with the client and health team to identify concerns about community access and participation
   • Working with the client and health team to identify strategies to enable community access and participation
   • Discussing access and participation strategies outside the rehabilitation plan with supervising health professional

3. Support the client to access and participate in the community under the supervision of a health professional and according to the rehabilitation plan by:
   • Identifying access and participation opportunities and barriers in the community
   • Under the supervision of the health professional, working with the client to develop a plan for access and participation
   • Under the supervision of the health professional, identify aides, appliances, supports and other services that would facilitate community access and participation
   • Identifying client access and participation needs and desires outside the rehabilitation plan and discuss with the relevant supervising health professional

- Working with the client to develop safeguards to maximise safe access and participation in the community
- Providing support to the client to facilitate interest and desire for community access and participation

4. Monitor impact of community access and participation on rehabilitation goals by:
    - Monitoring outcomes that indicate community access and participation in supporting the rehabilitation goals
    - Identifying any negative impact of community access and participation and report to supervising health professional
    - Under the supervision of a health professional, 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

5. Document client information
    - Using accepted protocols to document information relating to the rehabilitation program in line with organisation requirements
    - Providing regular feedback to the client's care team, including positive impact on the client
    - 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	• Importance of community access and participation to client well being • Motivational strategies to promote client interest in accessing and participating in the community • Philosophy and values of community rehabilitation • Relevant national and/or state-based community services and programs such as HACC, CACPS veteran's home care.
2. Client services	• Community care service providers including managers, supervisors, coordinators, assessment officers and case managers • Range of aides, appliances and services that facilitate community access and participation
3. Holistic support	• Occupational health and safety (OHS) issues and requirements, risk assessment and risk management associated with working in client homes and community. • The importance and meaning of home and belongings to clients and the nature and significance of working in the client's home and community settings • Understanding of principles and practices of self-management.

1.   Working in community rehabilitation

This topic covers information about:

• Philosophy and Values of Community Rehabilitation
• Community Rehabilitation Programs
• Access and Participation

Activities in this topic address the following essential skills:

• Analyse opportunities and concerns about community access and participation
• Communicate effectively with relevant people in a 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
- Facilitate client access and participation in community within the context of rehabilitation plans and under supervision of an identified health professional
- Facilitate client involvement and participation in the rehabilitation process
- Identify and confirm opportunities for, and barriers to, access and participation in community
- Motivate client and build self esteem

1.1 Philosophies 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.'

Further complexity in describing the rehabilitation process arises when we consider where along a client'scontinuum 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:

1. 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 state-wide assessment and case management and often relies on local services to provide actual treatment to clients and their families.

2. 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).

Not all CR services offer 'treatment' in the way it is generally understood. We will look at the different types of interventions that sit under the umbrella of community rehabilitation in the section about Models of Care.

Regardless of where they are placed along the continuum of care or what model of service they use, all CR services are underpinned by common philosophies and values.

Activity 1: What is disability?

1. Reflect on people with disability you know or have worked with as well as the use of the word 'disability' in the descriptions of rehabilitation on pages 7 to 10 of the Learner Guide. What does 'disability' mean to you?

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2. Compare your reflections with what the WHO says about disability: '…every human being can experience a decrement in health and thereby experience some degree of disability. Disability is not something that only happens to a minority of humanity.' (World Health Organisation 2011)

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Activity continues on the next page.

Activity 1: What is disability? (continued)

3. List three common disabilities that occur as people grow older, even without any specific illness or injury, and how each disability can affect the client and their family/carer. You may wish to discuss your answer with your supervising AHP.

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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 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:

1. 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.
2. 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 allied health professional.

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 andABI, 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 package 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 Physiotrist, 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 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

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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

https://www.dss.gov.au/disability-and-carers/programmes-services/for-carers/commonwealth-respite-and-carelink-centres

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, providing 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 CR clients to other services. The decision about 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	

1.3 Access and participation

Before we discuss this topic, we need to define these terms and explore the differences between access and participation.

Access: permission, liberty, or ability to enter, approach, or pass to and from a place (Miriam-Webster 2011).

Participation: is involvement in a life situation (World Health Organisation 2002).

Importance of community access and participation

Access and participation are related, but they are not the same and do not always occur together. It is very possible, for example, to have access without participation.

Read the following case study for an example of what this might mean in a real life situation.

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Case Study: Angela

Angela is a woman who has had a stroke, leaving her with word-finding difficulties that affect her communication. She is able to understand most of what is said to her. She has paralysis on one side of her body and uses a power wheelchair for mobility. She has a paid carer, Penny, who assists her with personal care and household management tasks.

Each week, Penny takes her on an outing to the local supermarket to do some grocery shopping. Penny drops Angela off at a coffee shop in the shopping centre, orders her a cappuccino and then goes and does the grocery shopping. Penny finds that doing the shopping this way takes less time.

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You can see in this case study that, although Angela has been able to access her local shopping centre, she has not participated in any meaningful way in the experience of grocery shopping.

It is also possible to have participation without physical access. Let's look again at Angela and her carer.

Case Study: Angela continued

Angela has developed a pressure area on her bottom and has been advised to stay in bed until the pressure area has fully healed.

On shopping day, Penny brings copies of a flyer from the local supermarket, with all the weekly specials. Together they look through the flyer and Angela points to items she wishes to purchase. The usual weekly shopping list is adjusted accordingly. Penny goes to the shops and buys everything Angela has chosen.

It is clear from this example that, even though Angela was unable to access her local shops, she did participate in the shopping experience by deciding what was to go on the shopping list that week.

Let's now take a look at the word 'community'. It is a word which is used a lot, but can have many different but related meanings.

Community: people with common interests living in a particular area; an interacting population of various kinds of individuals in a common location; a group of people with a common characteristic or interest living together within a larger society; joint ownership or participation; social activity; a social state or condition. (Merriam-Webster 2011)

Community, therefore, could refer to a group of people living in a similar location or it could refer to the social relationships between people who may not even share the same location. In the computer age, for example, there are online 'communities' of people from around the world who have shared interests but may never actually meet face to face.

In health and rehabilitation, the term 'community' tends to refer to a physical location which is not a hospital or other institution. Home Care Packages, for example, are funding packages provided by the federal government to assist frail older Australians to remain living in their own homes (Australian Government Department of Health 2016).

What do we mean by community access and participation?

Community access refers to the ability to get to, into and to move around in places, spaces, buildings or other venues in the community setting. In health and rehabilitation the 'community setting' is a term that can include the immediate home environment, places within the local community such as shops, schools, services, cinemas, community centres, day therapy or respite centres, plus the various transport options

required to get to them. Wheelchair accessible taxis and buses, and adaptations like ramps, paved footpaths, lifts, wide checkout isles, Braille buttons in lifts and so forth will also impact on access for people with various disabilities. Access may also include the means to pay for transport or for admission into various venues or events.

Community participation tends to refer to the involvement of a person in family and social roles in the community setting. This could include anything from assisting a child with homework, to voting in the local elections, to joining a chess club. As every individual is unique, the extent to which they participate in their community can vary greatly and is dictated by individual choices and preferences.

Let's visit Angela again and take a closer look at her visits to the shopping centre. We will also meet Anna, another of Penny's clients. Anna has also had a stroke, with similar mobility and communication outcomes to Angela.

Case Study: Angela and Anna

Angela has always hated grocery shopping, but one of the highlights of her week is when she goes to the shopping centre with Penny. She loves sitting in the coffee shop, drinking her cappuccino, and watching people as they go by. A few regular customers stop to say hello to her and Angela is able to practice her social communication skills. The staff always bring her the latest copy of her favourite magazine to look through. Some mornings, the coffee shop owner brings her baby to work with her and Angela loves to play peek-a-boo with the baby and look through picture books together. The coffee shop owner finds it really helpful to have Angela entertain her baby, as it gives her an opportunity to go over the stock orders at table close by.

Anna, on the other hand, loves to shop. She doesn't tend to like making shopping lists. In the supermarket, Anna and Penny always get the basics first, like milk, bread, meat, fruit and vegetables, cleaning products etc., and then Anna likes to browse. She really enjoys looking at the new products and sampling those that are being demonstrated in the supermarket. Penny helps get things down from shelves that Anna can't reach and keeps a running total of how much has been spent as they go round, so Anna can stick to her budget.

From this case study, we can see that, although access and participation may be related, they are different concepts. We can also see that the things that a person may wish to participate in can vary greatly from person to person; we cannot assume that everybody has the same goals and priorities.

As CR workers, the 'gold standard' of rehabilitation would be to assist our clients to gain access to and participation in everything that they need or want to be involved in. This will not be possible for everyone and can be impacted on by a range of factors: health conditions, impairments, and ability to undertake activities, plus environment and personal factors. If physical access is not possible for any reason, rehabilitation can and should still aim for participation.

Being able to get around in the community is valued by most people at any age. When people are not able to access their local community they are at risk of social isolation, depression and reduction in or loss of family and social roles important to them. When people are able to get to the places that they need to and also to the places they enjoy visiting, they can experience the following benefits:

- improved quality of life
- ability to engage in meaningful activities and roles
- engagement in social and emotional interactions
- increased independence
- maintenance of self-respect

Activity 4: Access and participation; barriers and outcomes

Imagine you have fallen down some stairs and broken your left arm and left leg. You are not allowed to take any weight through your leg and you can't use crutches with your broken arm. This means you will be in a wheelchair for at least eight weeks and you can't even push the wheelchair because of your broken arm.

1. What impact would this have on your ability to access:

    a) Different areas in your own home and yard?

    _____

    _____

    _____

    _____

    b) Your local community?

    _____

    _____

    _____

2. What impact would this have on your participation in your roles and responsibilities:

    a) Within your family?

    _____

    _____

    _____

    _____

    b) Your life outside the family?

    _____

    _____

    _____

Activity continues on the next page.

Activity 4: Access and participation, barriers and outcomes continued

3.   List some of the main barriers to your access and participation.

4.   List some strategies which might provide you with opportunities for (overcoming barriers to) access and participation.

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

Transport

Sometimes access to the community is restricted due to a lack of suitable transport options. For example, a person may have had to give up their driving licence due to their medical condition and there may not be any local public transport. Driving has a special meaning for many people as it allows for personal independence, particularly in pursuing leisure activities or employment. It is often seen as a 'rite of passage' into adulthood and the loss of independence can be a very difficult adjustment. To understand the impact, think of how the loss of a driver's licence would impact on your own access and participation.

Some medical conditions may lead to a restricted licence or cancellation of the licence due to safety concerns. Some of these common medical conditions include:

• stroke, particularly when it affects vision, cognition and movement

• dementia

• epilepsy

Further information about fitness to drive can be obtained from the Austroads website:

http://www.austroads.com.au/drivers-vehicles/assessing-fitness-to-drive

For people whose ability to drive is affected, alternative transport options will need to be investigated, including:

• public transport options like buses and trains

• taxis, including application for Taxi Subsidy Scheme

• community transport options

AHPs are among the health professionals authorised to complete sections of the application form for the Taxi Subsidy Scheme:

https://www.qld.gov.au/disability/out-and-about/taxi-subsidy/

The decision about which form of transport is most suitable will involve consultation between the client and an AHP. This may be affected by a range of factors, such as client mobility, cognition, cost and convenience, but also by client choice and

preferences, for example, a person who is capable of using public transport may choose to use taxis instead as they don't like using buses or trains.

As an AHA, you may be involved in providing support in various ways:

- implementing a public transport training program prescribed by an AHP (usually an Occupational Therapist) by helping clients to plan journeys, consult timetables, work out the fare and change, get on and off transport safely etc.
- researching local community transport and access options
- making referral to local transport services, if delegated by a health professional
- assisting clients to complete paperwork (you may need some training in specific forms and will not be able to complete sections requiring health professional input)

Promoting client interest in accessing and participating in the community

Motivation is important in order to 'initiate, sustain and direct psychological or physical activities to satisfy needs' (Shaw 2004). There are two main types of motivation:

- **intrinsic motivation** which occurs when people are internally driven to do something because it brings them pleasure; they think it is important; or they feel that what they are learning is significant (like cooking a favourite meal or learning to drive)
- **extrinsic motivation** which comes into play when a person is compelled to do something or act a certain way because of external factors (like praise or good marks)

(Shaw 2004)

Apparent lack of motivation to participate in rehabilitation may be due to any number of factors. For example:

- the client can't see any improvement and, therefore, can't see a reason to continue
- the client may experience depression as a result of a life-changing medical condition
- the rehabilitation goals may have been set by a treating rehabilitation professional or a family member and do not reflect the client's priorities
- something else is going on in the client's life which is more important to attend to (for example, marriage breakdown, a sick child or relatives visiting from overseas)
- the client finds the rehabilitation professional bossy and negative, and doesn't enjoy therapy sessions
- everyone else in a rehabilitation group program seems to be doing better

Motivation may be easier to maintain for a client who requires only a short period of rehabilitation for an injury where a full recovery is expected compared to someone whose recovery has been slow with many setbacks.

Motivation will also depend on personal factors, such as individual coping style. For example, a person who has always been pessimistic in their outlook may think they have no control over the situation and feel helpless ("It will affect everything I do'; 'I'll never get better'). Compare this attitude with someone who is naturally optimistic ('I'm not going to let this affect the good things in my life'; 'It could have been worse').

Cultural, gender, prognosis, and age issues will also impact on client motivation. AHPs will need to review client progress regularly to ensure that goals and therapeutic activities are meaningful to the client.

> Health care professionals, and in particular rehabilitation staff, have the responsibility for encouraging participation in rehabilitation by reducing negative experiences, increasing rapport, and establishing and maintaining a safe and trusting environment filled with humour and positive support. All of these factors, in conjunction with appropriate goals, will serve to increase motivation and thereby increase the likelihood of success and an appropriate discharge plan. The increase in motivation will serve to improve overall functional performance and quality of life for these clients (Shaw 2004).

Helping clients to become and stay motivated can be a complicated process; it is not always straightforward and the steps may need to be revised along the way. It also requires client input at all stages. When it is apparent that the client is not making progress or is perhaps not ready to make changes, AHPs will need to work with the client to identify strategies to overcome these barriers. The main steps include:

- identification of the client's goals, strengths, abilities, and interests
- identification of barriers to access and/or participation
- selection of strategies that will assist with goal achievement (small steps may be necessary)
- creating opportunities for the client to be successful. This is especially important early on and will help the client to self-motivate
- the environment can also be modified to ensure success with rehabilitation activities and aid self-motivation
- as the client progresses and is able to motivate him or herself, less input should be required from the CR worker, for example sessions may become less frequent, or each session may take less time

It may help to bear in mind the following points when working with clients in order to help them become and stay motivated:

- the client is central to the process—there is little point in working on an activity that has no meaning for the client or for which they feel has been forced on them; as an AHA you may be in a position to observe changes in client motivation and provide

feedback to the CR professional, who may then problem solve with the client or even review and adjust the stated goals

- your clients will come from diverse backgrounds and you must not force your beliefs on them—for example, if you said to a client 'You'll have to give up drinking alcohol because it's affecting your recovery', do you think that will make them do it? Perhaps the client has tried to give up before and has very low motivation to try again or perhaps their social network is based around a sporting club or pub where alcohol is consumed and, if they don't go, they don't see their friends
- some people will need to move through rehabilitation by very small steps and others may be more confident to tackle bigger goals in one go
- timing is important—as people's 'readiness to change' can be a facilitator or barrier to motivation, CR professionals need to work at the client's pace and with the stage of change in which they are in at any given time

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Further Reading

Follow this link to a description of the stages of change identified as necessary to change behaviour around falls prevention and the factors impacting on motivation at each stage:

http://www.health.qld.gov.au/stayonyourfeet/documents/33331.pdf

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Activity 5: Facilitating access and participation

Read this case study and answer the questions that follow.

Case Study: Mrs Russell

Mrs Russell is a 75 year old who has had a stroke. She made some recovery following a period of inpatient rehabilitation and has returned home to live alone. Mrs Russell can attend to most personal and instrumental Activities of Daily Living (ADL) within the home environment, as she is very familiar with this environment.

However, the stroke has left Mrs Russell with a right hemianopia that means she has lost vision in the right side of each eye. An effect of this condition is that Mrs Russell finds it difficult to see everything in her field of vision, which poses a safety risk when moving about in the community. She bumps into things and feels nervous. She is no longer allowed to drive.

As a result, she stopped going out to get her groceries and to church, an activity that previously gave her joy. Mrs Russell does not want to rely on others to take her.

Her goals were:

- to do her own shopping
- to get to church every week using a transport system where she was not reliant on friends or family

Initially, the Occupational Therapist worked with Mrs Russell within her home environment to practise scanning techniques so that she could compensate for her visual impairment. As this improved the Occupational Therapist worked with her in outdoor settings, starting with her garden, then the local streets, and finally in the local shopping centre. Mrs Russell then started going to the shops with an AHA present for supervision but was able to tackle the shopping centre on her own after several months.

Activity continues on the next page.

Activity 5: Facilitating access and participation (continued)

1. Imagine that Mrs Russell lives in your suburb. Use the Commonwealth Respite and Carelink Centres website to identify transport options which might enable Mrs Russell to access her local community:

https://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability

_____

_____

_____

_____

_____

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_____

_____

2. Mrs Russell had identified the goal of participating in shopping. What were the main barriers and what strategies were used to overcome them?

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_____

_____

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_____

Key Points

This section of the Learner Guide has covered information related to the topic of working in community rehabilitation. On completing this section you should:

- understand that rehabilitation takes place along a continuum from acute episode to return to community participation

- understand that the philosophy of CR is centred in human rights and social justice

- understand that there is a difference between access and participation—the client is central to the process and is supported to participate fully in family and social roles that are necessary and important to them

- understand there are many community service providers that enable clients to remain in their own homes and clients may need assistance to choose the most appropriate service for them

- appreciate that being able to undertake meaningful activities within the community is very important for client wellbeing and independence

- know that CR workers are able to facilitate client participation within the community by working with the client to establish their individual needs and use a variety of strategies to encourage this

2.   Client services

This topic covers information about:

- Service providers
- Aids and appliances

Activities in this topic cover the following essential skills:

- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisations and client group:
  – This may include, for example, oral communication skills for working with clients and health team, literacy skills for clarifying the rehabilitation plan, developing a plan for access and participation and for documenting client information
  – Language used may be English or a community language
- 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
- Facilitate client involvement and participation in the rehabilitation process
- Identify and confirm opportunities for, and barriers to, access and participation in community

2.1 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
- Occupational Therapist
- Speech Pathologist
- Dietician or Nutritionist
- Podiatrist
- Social Worker

- Psychologist
- Cardiac Rehabilitation Nurse
- Diabetes Educator
- General Practitioner
- Registered Nurse
- Medical Specialist

Clinical Supervisors delegate clinical service provision tasks to AHAs. These supervisors can be from a range of different professions , for example, physiotherapy tasks may only be delegated by a Physiotherapist, occupational 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 multi-disciplinary 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 will 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 which 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 professional or with your line manager.

If you are assisting across a range of professions, which is common in CR, you will have a range of professionals delegating tasks to you. Each one of these professionals 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 professions 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 6: Who's who in your community rehabilitation team

1. 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.

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

2. 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.

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

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

2.2 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)

LifeTec Queensland is an organisation devoted to helping people living with disabilities. LifeTec 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 7: Assistive technology

Go to the LifeTec Queensland website, http://www.lifetec.org.au/home/default.asp, and suggest some different disabilities these aids could assist with:

a)   Feeding cup and base

_____

_____

_____

_____

b)   Bedstick

_____

_____

_____

_____

c)   Walking frame

_____

_____

_____

_____

d)   Shower chair

_____

_____

_____

_____

Key Points

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

- know 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

- understand that there are many community service providers that enable clients to remain in their own homes and clients may need assistance to choose the most appropriate service for them

Key Points

3.   Holistic support

This topic covers information about:

- Daily living
- Self-management
- Health and safety

Activities in this topic cover the following essential skills:

- Analyse opportunities and concerns about community access and participation
- Apply language, literacy and numeracy (LLN) competence appropriate to the requirements of the organisations and client group:
  - This may include, for example, oral communication skills for working with clients and health team, literacy skills for clarifying the rehabilitation plan, developing a plan for access and participation and for documenting client information
  - Language used may be English or a community language
- Apply OHS knowledge in home and community settings, particularly in relation to supporting community access and 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
- Facilitate client access and participation in community within the context of rehabilitation plans and under supervision of an identified health professional
- Facilitate client involvement and participation in the rehabilitation process
- Identify and confirm opportunities for, and barriers to, access and participation in community
- Motivate client and build self esteem
- Work within a multidisciplinary team

3.1 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 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 below 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://qheps.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 activities of daily living program to focus on grooming.

Activity 8: Motivating clients and building self esteem

1. 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

_____

_____

_____

b) Jean's self-esteem

_____

_____

_____

2. 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

_____

_____

_____

b) Jean's self-esteem

_____

_____

_____

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_051_community.pdf

An AHP, usually an OT, will work with clients to identify which activities of daily living 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 activities of daily living 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
    o time management
    o having money ready
    o purchasing ticket
    o 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 ensure 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.

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://qheps.health.qld.gov.au/multicultural/support_tools/8MCRS_hlth_relgn.pdf

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

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

1.   A client's acceptance of 'Meals on Wheels'?

_____

_____

_____

_____

2.   How might you adapt rehabilitation programs for retraining cooking skills to suit the client?

_____

_____

_____

_____

3.   A client's compliance with prescribed medications?

_____

_____

_____

_____

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 CALD backgrounds by following the link below:

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

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

a)   _____
    _____
    _____
    _____

b)   _____
    _____
    _____
    _____

c)   _____
    _____
    _____
    _____

2.   When is it ok to use family or friends as interpreters?

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

Discuss your answers with your supervising allied health professional.

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

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 sheets 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

Activity 11: Communicating with clients

In the following situations, what non-verbal communication might be happening in the following situations and describe one strategy that might assist.

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

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

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3.   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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3.2 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

Activity 12: The impact of chronic disease

Look at the list of common chronic diseases on the previous page. Choose three chronic diseases and describe the impact they might have on a person's quality of life. You may wish to choose conditions common among clients in the CR service where you work.

1. _____
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2. _____
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3. _____
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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

<div align="right">(Community Services and Health Industry Skills Council 2009: 9)</div>

Principles of chronic disease self- management

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

1. client-centred practice
2. holistic practice
3. accurate, comprehensible, timely, and appropriate information
4. partnership and participation
5. strengths-based practice
6. coordination of support

1. **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

2. **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

3. **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

4. **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

5. **Strengths-based practice**

Traditional health and community service provision has focused 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-focused 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

6. **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

Activity 13: Self-management

List five things that might help a client manage their own care:

1. _____
2. _____
3. _____
4. _____
5. _____

List five things that might prevent a client from managing their own care:

1. _____
2. _____
3. _____
4. _____
5. _____

List some support strategies that you could use to help a client through their illness

_____
_____
_____
_____
_____
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3.3 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.pd

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

Activity 14: Home visiting risk assessment

Obtain a copy of the home visiting risk assessment tool used by your CR service, or follow this link to a sample risk assessment tool:

http://qheps.health.qld.gov.au/scwbhsd/docs/frms/wbmr/tcp_28_environment.pdf

Complete a risk assessment based on a client you know and discuss the completed assessment with your supervising AHP. Please attach the de-identified risk assessment.

List any additional strategies in your workplace for ensuring your safety as a worker when undertaking home visits. You may consider strategies for OHS, manual handling, infection control, personal safety, and driver safety.

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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 15: Minimising risk in the community setting

You are running a group session in a local community centre, which has three steps and no ramp at the entrance. A risk assessment was undertaken and no safety concerns were identified. One of your clients rings to advise you that she has just broken her leg and is not confident enough with her using crutches to negotiate stairs.

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

_____

_____

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_____

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_____

2.   How could this situation have been avoided?

_____

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_____

Activity continues on the next page.

Activity 15: Minimising risk in the community setting (continued)

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

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4.   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

4. SELF-COMPLETION CHECKLIST

Congratulations, you have completed the topics for HLTCR403B Support community access and participation.

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.

HLTCR403B Support community access and participation

Essential Knowledge	Covered in topic
Community care service providers including mangers, supervisors, coordinators, assessment officers and case mangers	☐ Yes
Importance of community access and participation to client wellbeing	☐ Yes
Motivational strategies to promote client interest in accessing and participating in the community	☐ Yes
Occupational health and safety (OHS) issues and requirements, risk assessment and risk management associated with working in client homes and the community	☐ Yes
Philosophy and values of community rehabilitation	☐ Yes
Range of aides, appliances and services that facilitate community access and participation	☐ Yes
Relevant national and/or state-based community services and programs such as HACC, CACPS, veteran's home care	☐ Yes
The importance and meaning of home and belongings to clients and the nature and significance of working in the client's home and community settings	☐ Yes
Understanding of principles and practices of self management	☐ Yes

Activity 16: 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.

1. List three examples of services in the community which would facilitate increased community access and participation.

_____

_____

_____

_____

_____

_____

_____

2. List three examples of aids, appliances which would facilitate increased community access and participation.

_____

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Activity continues on the next page.

Activity 16: Questions (continued)

3.   List three benefits to clients of accessing and participating in the community.

_____

_____

_____

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_____

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_____

Activity 17: Scenario

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

Scenario

Mr Brown is a 70-year-old man who lives alone. He has reduced mobility and has limited social supports and family. Mr Brown rarely leaves the house and also has anxiety issues and fears of falling. He is currently depressed and unmotivated.

What do you do to support Mr Brown to access the community? Consider equipment and services as well as the benefits of access and participation.

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Activity 18: Workplace Observation Checklist

The learner will be observed providing support to clients in order to optimise access and participation.

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	1st observation date & initial	2nd observation date & initial	Comments	*FER
Clarify the relevance of supporting daily living to rehabilitation goals				
• Discusses client's rehabilitation plan with professional (including goals, client's current function, social situation, mood)				
• Demonstrates understanding of the importance of community rehabilitation in order for the client to increase independence				
• 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)				
• Discusses potential concerns/risks with professional				
Work collaboratively to establish a routine that fosters maximum client independence				
• Obtains client consent				
• Liaises with team to determine and organise appropriate services (e.g. domestic assistance, community transport)				
• 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)				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initial	2nd observation date & initial	Comments	*FER
• Provides opportunities for clients to practice activities of daily living in a supported and safe environment. (e.g. performing task with supervision of family member). Encourages clients to incorporate activities into weekly schedule (e.g. put in diary/calendars, reminders from family)				
Support the client to participate in activities of daily living that support rehabilitation goals				
• 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				
• Implements strategies to assist clients to overcome concerns (e.g. provision of aids for mobility/shower chair)				
• 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				
Monitor the impact of client involvement in daily living activities on rehabilitation goals				
• Monitors client's progress and involvement with rehabilitation plan, including any negative impacts/safety concerns. Liaise with professional				
• Reviews client's goals and progress with professional and adjust rehabilitation plan as required				
• Provides ongoing feedback to client about performance				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initial	2nd observation date & initial	Comments	*FER
Document client information				
• Documents all interactions with the client/others/in medical records/case notes				
• Liaises with team regularly to discuss program (goals, progress, concerns)				

*FER – Further Evidence Required

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