Occupational Therapy Services

CONTRACT REFERENCE GUIDE FOR REPORT FORM C589
(PERSONAL CARE ALLOWANCE ASSESSMENT)

Service Description

The Personal Care Allowance Assessment is used to determine a Worker's functional ability, personal care, and adaptive equipment needs relative to their Compensable Injury. This information, along with other relevant medical data, may be used to determine an allowance the WCB may pay to cover the cost of in-home care for an injured Worker. The allowance is called a Personal Care Allowance, and is designed to provide an alternative to institutional care for severely injured Workers by providing funding for care in the home.

The service provider shall not render an opinion directly to the Worker with respect to the extent of injury, compensation, personal care, treatment or equipment needs without prior Case Management authorization. The service provider shall direct the Worker back to the attending WCB Claim Owner to address these issues.

Reporting/Service Guidelines

1. The service provider will commence the assessment within five (5) working days from the date of referral.
2. The service provider will provide the completed Personal Care Allowance Assessment Report to the WCB within five (5) working days from the date of Assessment.
3. The report will address the criteria as outlined below, as well as specific issues and questions identified by the Claim Owner. The service provider should have a clear understanding of the Worker's medical history and compensable injury prior to initiating the assessment.
4. The report shall be **typewritten** with relevant **point form** information under each heading of the Assessment Report.
5. To assist the Workers' Compensation Board of Alberta in determining personal care needs, the following items should be addressed.
   - Please indicate if the Worker is able to complete the task independently, with the assistance of a device or a caregiver, is totally dependent, or not application (n/a).
   - Also, indicate the length of time it would take to complete the task, how often assistance is required (e.g., 1 x per day, 2 x per day, etc.), and who provides the assistance.
   - Accuracy and details are required.
   - Information reported by the Worker should be validated by observations when possible.

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Report Field:
General

Background:

1. Provide a brief description of the nature and extent of the work related disability and any other factors such as non compensable medical problems or age.

Physical Assessment:

1. Comment on physical limitations which would affect task performance:
   - Muscle strength (0-5)
   - Range of motion (in degrees)
   - Sensation
   - Vision
   - Hearing
   - Communication
   - Balance (sit, stand)
   - Tone
   - Respiration
   - Circulation
   - Others, as applicable

Report Field:
Mobility

1. Does the Worker require assistance getting in and out of a vehicle, moving around the home, community, etc.? If yes, please describe.
2. Does the Worker require assistance in transferring:
   - Bed to wheelchair
   - Into shower
   - Wheelchair to toilet
   - Into tub
   - Other, please specify.
3. How often is assistance required? (1 x per day, 2 x per day, etc.) How much time is required? (Time/day)
4. Is the Worker able to leave the home independently without assistance from a caregiver? If not, please explain why.
5. Is the Worker able to go from home to the garage independently? It not, please explain why.

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Report Field:
Personal Hygiene

1. Does the Worker require assistance with bowl and bladder, bathing, skin care/grooming, shaving, hair care, dental care, etc.? If yes, for each task, please describe how often assistance is required and how much time is required.
2. Bowel and Bladder
   - Bladder care, such as catheterization, drainage system, incontinence/retention
   - Bowel care, such as inserting suppository and digital stimulation, constipation/diarrhea, incontinence
   - Cleaning worker/equipment/extra laundry after incontinence
   - Menstrual care
3. What is the Worker's bowel/bladder routine? Is the routine performed in bed or using a commode?
4. How often is assistance required? How much time is required? (Time/day)
5. Bathing: How often is assistance required? How much time is required? (Time/day) Who provides the assistance?
   - Preparing bath, shower or bed bath
   - Bathing and drying Worker
6. Skin Care and Grooming: How often is assistance required? How much time is required? (Time/day) Who provides the assistance?
   - Checking for pressure sores or eruptions
   - Applying prescribed lotions or powder
   - Applying deodorant, makeup, and/or shaving
   - Cutting of finger/toe nails, foot care
   - Hair brushing/hair care
   - Oral hygiene
7. Comment on tissue and skin integrity concerns.

Report Field:
Dressing

For each item, please note how often assistance is required, how much time is required and who assists.

1. Does the Worker require partial or total assistance in dressing or undressing? Describe and note time required. (Time/day)
2. Does the Worker require assistance to select and put away clothes? Time? (Time/day)
3. Does the Worker require assistance with adjusting glasses, hat earrings, hearing aids? Time? (Time/day)
4. Is assistance required to put on outer clothing, shoes, and gather together materials that may be required for an outing? Time? (Time/day)

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Report Field:
Feeding

For each item, please note how often assistance is required, how much time is required and who assists.

1. Is the Worker able to feed independently or is assistance required? Please describe.
2. What assistive devices are used?
3. Is the Worker able to provide a drink independently, or is set up and special equipment required? (Time/day)
4. For nutritional consideration, indicate what the Worker has eaten in the last 24 hours.
5. Does the Worker require assistance to select and put away clothes? Time? (Time/day)
6. Does the Worker require assistance with adjusting glasses, hat earrings, hearing aids? Time? (Time/day)

Report Field:
Medical or Para-Medical Requirements

1. Does the Worker require assistance with the following tasks? Please specify how often care is provided, time required, and the skill and education level required by the caregiver.

   Assessor: Please observe and comment on any home treatment program (range of motion exercise, safety concerns re: exercise equipment).
2. Dressing changes? (Time/day)
3. Medication? (see attached form) (Time/day)
4. Range of motion exercises? (Time/day)
5. Orthotics? (Time/day)
6. Does the Worker require assistance ordering and maintaining supplies and equipment? Please specify who provides this assistance, how often, and ho much time is required. (Time/day)

Report Field:
Supervision

1. Does the Worker need to be monitored some or all of the time? Why? (Time/day)

Report Field:
Mental Status

1. Does there appear to be any behavioral management issues or concerns? Please specify.
2. Are there any additional mental status/psychosocial issues or concerns (e.g., memory, orientation, aggression, wandering, sexuality, spirituality, etc.)? Please specify.
3. Does the Worker smoke? If yes, how many packs per day. Safety concerns?
4. Comment on Worker's use of alcohol or drugs. Is misuse or abuse apparent? Has there been a chance in use over the past 12 months?

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Report Field:
Living Situation

1. Is the Worker living in a house or apartment? Is it rented or owned?
2. What adaptations have been made or appear to be needed?
3. Does the Worker live alone or with family? Describe Worker's support system.
4. To what extent does the Worker receive assistance from friends or family (e.g., banking, correspondence, driving, etc.)?
5. Does the Worker have children? Please advise age(s), school grade(s), and health issues.
6. Who provides daily child care? Are emergency or alternate child care plans in place?

Report Field:
Homemaking Services

1. Does the Worker require assistance with the following tasks? If yes, for each task, please specify the amount of time required, how often assistance is required and who provides the assistance.
2. Preparing the Worker's meals? Specify breakfast, lunch, dinner, snacks. (Time/day)
3. Kitchen clean up? (Time/day)
4. Washing and ironing Worker's clothes? (Time/day)
5. Changing and making the Worker's bed (Time/day)
6. Cleaning and caring for wheelchair assistive devices? (Time/day)
7. Cleaning and general household duties for the Worker? (Time/day)
8. Heavy duty cleaning, including inside windows, washing and wall washing? (Time/day)
9. General shopping (grocery, clothes, toiletries, etc.)? (Time/day)
10. Is there a change in these responsibilities as a result of the Worker's accident or condition? If yes, please specify.

Report Field:
Transportation

1. Describe the purpose (work, leisure, medical) and model of transportation required (private, public, taxi, other). (Time/day)

Report Field:
Vehicle

1. Please note the type of vehicle (make, model, yet).
2. Do modifications appear to be required?

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Report Field:
Banking

1. Does the Worker require assistance with the following tasks? If yes, please specify, for each task, the amount of time required, how often assistance is required, and who provides the assistance.
2. Is assistance required for money management? (Time/day)
3. Does the Worker require assistance for writing cheques or maintaining personal care payroll records? (Time/day)
4. Is assistance required for banking and other financial transactions? (Time/day)

Report Field:
Self Managed Care

1. Assessor: In your opinion, do you feel this Worker has the skills and abilities (physical/emotional) to participate in a self managed care program?
2. What additional training or community support services are required for the Worker to participate in a self managed care program?
3. Should the Worker be monitored while on a self managed care program? If yes, how often?

Report Field:
Vocational

1. Is the Worker employed or engaged in productive activity? If yes, please specify.
2. Is the Worker interested on expanding vocational options?
3. Does the Worker have a computer? If yes, is the Worker able to operate the computer independently or is assistance required? If assistance is required, please specify.
4. How many hours per day does the Worker use the computer?
5. Is the Worker attending classes? If yes, please specify.
6. Is the Worker able to attend classes independently or is assistance required?

Report Field:
Recreation

1. What are the Worker's leisure interests?
2. How does the Worker occupy his/her day?
3. Doe you feel the Worker would benefit from a leisure assessment?

Report Field:
Aid and Equipment

1. Has the Worker been provided with necessary assistive aids and devices (e.g., wheelchair, mechanical lift, feeding, communication [emergency call system]? If yes, please specify noting make, model and year provided. Please note the condition of the equipment.
2. Are follow-up assessments required for aids and equipment, wheelchair, vehicle, home modifications?

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Report Field:
Additional Information

1. Comment on the caregivers present ability to provide care in terms of availability, physical emotional capacity. Note limitations.
2. Comment on family dynamics, relationships and stress which may affect the Worker's care.
3. Other information relevant to personal care.
4. From your assessment, is the Worker functioning at a level consistent with the injury or disability? If no, please explain.

Report Field:
General Recommendations

1. Note the date discussed with referring Claim Owner.
2. Provide a proposed date of when the Worker's needs should be re-assessed and, if relevant, any suggested modifications or reduction of care hours you would anticipate.

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