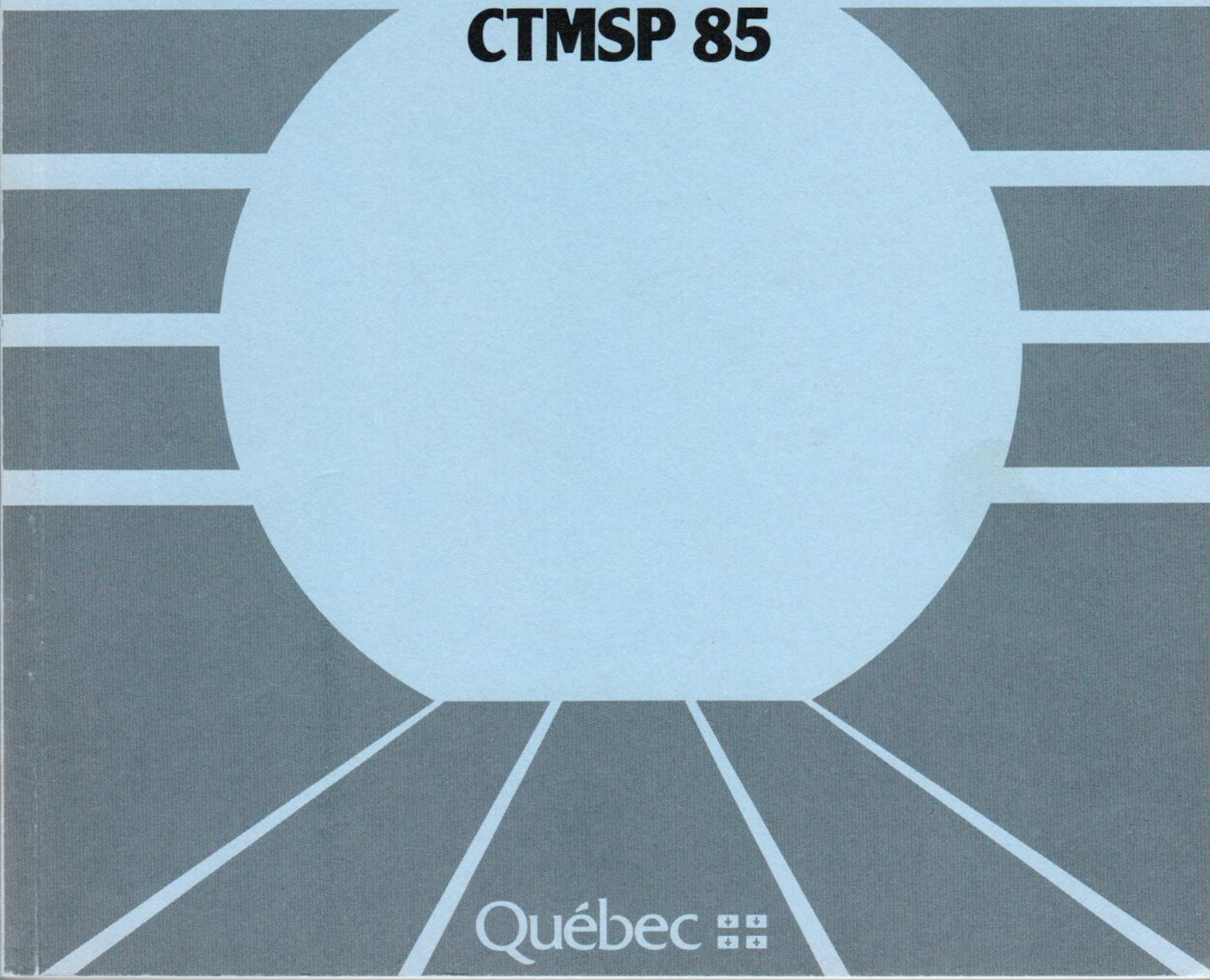
A SYSTEM FOR THE ASSESSMENT OF NEEDS DESIGNED FOR A NETWORK OF ORGANIZATIONS PROVIDING EXTENDED SERVICES

CTMSP 85



Québec

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A system for the assessment of needs
designed for a network of organizations
providing extended services

Autonomy Assessment
and
Medical Assessment
of the
Beneficiary

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CTMSP 85

Autonomy Assessment and Medical Assessment of the Beneficiary

Charles Tilquin
Johanne Fournier

with the cooperation of the
Comités de révision des Formulaires d'évaluation
de l'autonomie et d'évaluation médicale

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TABLE OF CONTENTS

Page

LIST OF FIGURES

Page

LIST OF APPENDICES

V. Autonomy assessment form, "intermediate or institutional resources" version (with mini-guide)

VI. Autonomy assessment form, "short-term care hospital centre - STCHC" version (with mini-guide)

VII. Complementary autonomy assessment form, to be completed with the significant person; "short-term care hospital centre - STCHC" version

VIII. Autonomy assessment form, "at home" version (with mini-guide)

IX. Complementary autonomy assessment form, to be completed with the significant person; "at home" version

X. Medical assessment form (with mini-guide)

LIST OF ACRONYMS

AAF: Autonomy assessment form

CAAF: Complementary autonomy assessment form

CHD: Community health department (Département de santé communautaire)

CTMSP: Classification by types of Program in extended care and service facilities (Classification par types en milieu de soins et services prolongés)

ECHC: Extended care hospital centre (Centre hospitalier de soins de longue durée)

EROS: Equipe de recherche opérationnelle en santé

HC: Hospital centre (Centre hospitalier)

HCC: Home-care centre (Centre d'accueil et d'hébergement)

LCSC: Local community service centre (Centre local de services communautaires)

MAF: Medical assessment form

MAS: Ministère des Affaires sociales (former name of the MSSS)

MSSS: Ministère de la Santé et des Services sociaux

RHSSC: Regional health and social service council (Conseil régional de la santé et des services sociaux)

HS: Home Support (Maintien à domicile)

STCHC: Short-term care hospital centre (Centre hospitalier de soins de courte durée)

WHO: World Health Organization (Organisation mondiale de la santé)

PREFACE TO THE FIRST EDITION

The EROS team undertook the CTMSP project in response to a two-fold concern on the part of the network of organizations providing extended services in Québec: directing beneficiaries into the institutional or home-care program best suited to attending to their extended service needs, and planning a network of extended services programs. We were encouraged to undertake the project by the Regional health and social service council (RHSSC) of region 6C (Montréal south) and the Ministère des Affaires sociales du Québec, in particular. We were thus able to count on cooperation from Pierre Provencher and Hung Nguyen of the RHSSC - 6C, and, initially, from Nicole Martin and Jacques Pigeon followed by Paul Lamarche and Pierre Boyle of the Ministère des Affaires sociales du Québec.

The CTMSP system is the result of research which began in 1976. The initial objective was to build a system to assess and measure the needs of beneficiaries to provide a basis for resoùrce allocation within the network. In developing CTMSP, we systematically sought expert opinions, consulted continuously with workers in the network and, over a period of five years, repeated the "pilot project - feedback - adjustment" cycle over and over.

Secondly, and to address the two concerns expressed above, starting from the needs assessment system, we had, on the one hand, to define a structured process for directing the beneficiary within the network of institutional and home-care extended service programs, as his needs dictated, and, on the other, to design and construct a network planning system using the data generated by the needs assessment module and those produced by the program direction process. Research addressing these two concerns, from which the CTMSP system was developed, is still underway. A report on the subject will be issued in due course.

Financing for the design and development of the CTMSP 77 system was provided by the Ministère des Affaires sociales du Québec and by the National Health Research and Development Program, of Health and Welfare Canada. The pilot project was financed by the Verdun Hospital Centre Community Health Department and by INSA (Institut National de Systématique Appliquée). INSA provided financing for both the revision of the CTMSP 77 system and the final adjustments to the CTMSP 81 system.

This is the first version of the autonomy assessment and medical assessment procedure for CTMSP 81. We fully recognize certain improvements may be required in the future. During five years of working with the CTMSP 77 system, we have been able to "break it in" well enough for the revised version to be distributed and implemented for use in assessing the needs of beneficiaries throughout the network. Over the coming months, any comments, criticisms and suggestions from users will be systematically collected and

used in revising the system's autonomy assessment and medical assessment process.

For the long-term credibility and validity of the CTMSP system, the revision process must be carried out in an orderly and unified manner. The Institut National de Systématique Appliquée (INSA) Inc., a non-profit corporation which already performs this function for other systems, will undertake this revision process. We are counting on cooperation from users of the CTMSP system to help us improve it.

Montréal, December 1, 1981.

Charles Tilquin, Ing., Ph.D.
Head of research, CTMSP project

PREFACE TO THE SECOND EDITION

The CTMSP assessment process has been applied to thousands of beneficiaries since 1977. During that time, it has been continuously reviewed and improved.

Following two years of use and testing on a large scale, a systematic revision of the assessment tools has just been completed. The revision was conducted jointly by the system's investigators and by the Ministère de la Santé et des Services sociaux. In December 1983, the Ministère adopted the CTMSP as its standard tool for the assessment of beneficiaries suffering a loss of autonomy.

The autonomy assessment and medical assessment forms have been substantially improved, and the conditions for their utilization have been more clearly defined. Although the changes reflect the recommendations made by users of the system, we realize they will not meet all expectations. It was necessary to be selective, since we received very many recommendations, which frequently conflicted with one another. To be sure, further improvements in the new tools are possible, but we are convinced they are operational as they now stand. They need to be used for a period of time before once again being examined in the light of comments, suggestions and recommendations from users. In the long run, a structured, regular revision of the CTMSP can only bolster its credibility and validity.

The CTMSP 81 system was revised in 1984-85, thanks to the steady work of the members of the Comités de révision des Formulaires d'évaluation de l'autonomie et d'évaluation médicale. The members were attentive to the expectations of workers in the network and drew on their own experience as professionals or administrators and users of the system. They overcame cleavages generated by different schools of thought, differences in philosophy and in approach and reached consensus on all the points needed to allow them to fully accomplish their mandate. We are particularly indebted to Mrs. Odile Bédard and Dr. Pierre St-Georges for their exceptional work in coordinating the efforts of the committees.

Thanks are also due to Johanne Fournier who carried on the day-to-day work for the EROS team during the revision. She supplied the committees with summaries of recommendations received from users and members of the EROS team involved in implementing the CTMSP. The committee benefited greatly from the lessons drawn from the literature and the analyses of the CTMSP data banks she undertook during the period 1978-1984. She prepared various versions of the forms, the mini-guides and this text. For over a year, she has devoted all her time and energy to the revision.

Once again, we wish to thank Micheline Mathieu, Evelyne Amar and Serge Chevalier who typed and edited the many versions of the various documents generated by the revision process.

Charles Tilquin, Ph.D.
August 1985.

1. INTRODUCTION

The autonomy assessment and medical assessment process presented in the following pages is the outcome of the revision of the CTMSP 81 system carried out in 1984-85. Significant improvements have been made to the system. Nevertheless, no matter how good the process is, it remains a tool and, as such, the information it contains will never be superior to the information gathered by the autonomy assessor and the physician as they use the system. As with any other process, it cannot be over-emphasized that the key element is not the system itself, but rather the user.

This text is designed to assist the assessor in carrying out his task. However, it is not a substitute for skill and experience, nor for empathy for the person being assessed. It can only act as a technical adjunct. The assessment approach described is somewhat different from current practice. The assessor and the physician must be aware of this in order to know as accurately as possible the type and quality of information expected from them.

In the first part of the text, the conceptual framework underlying the CTMSP assessment and program direction system is presented in summary fashion. We then turn to how autonomy assessment and medical assessment fit within the overall CTMSP approach to the assessment of the beneficiary's needs. This section is followed by a description of the (basic and complementary) revised autonomy and medical assessment forms and the conditions for their use. Finally, the last section outlines a number of principles and remarks concerning the autonomy assessment interview. The (basic and complementary) revised autonomy and medical assessment forms are included in the appendices. The agreements reached by the Ministère de la Santé et des Services sociaux and the system's designers as well as the process followed during 1984-85 in revising and testing the CTMSP are also outlined in the appendices.

Note: Throughout this text, the masculine form is used to designate both men and women.

2. SUMMARY OUTLINE OF THE CTMSP SYSTEM

This theoretical section summarizes the conceptual framework on which the CTMSP (Classification by types of program in extended care and service facilities) system for assessment and program direction is based.

Over the past decade, the aging of the population has been a major source of difficulties for the health and social services network. Yet, if we compare our demographic situation with that of other industrialized countries, Québec clearly is in a relatively favourable position. How is it, then, that the network seems unable to adjust to the needs of the population? How do we explain that the occupation rate for elderly persons of beds in hospitals or home-care facilities is roughly twice as high as it is in European countries?

In 1976, when the CTMSP system was first designed, project researchers formulated the hypothesis that the network was experiencing problems not so much because of the aging of the population, but rather because of the inability to deal with this phenomenon from a management point of view. In general terms, the researchers hypothesized that:

- the extended care and service system was neither planned, nor programmed, nor budgeted on the basis of the needs of its beneficiaries;

- both control and coordination were absent from the utilization of the system's resources.

As a result of a large number of contacts with professionals and administrators in the system, the authors saw that the problem was not primarily one of insufficient resources, and that the majority of the system's dysfunctions would disappear if the right beneficiary was admitted to the right program at the right time.

A logical approach was then advanced to achieve this objective, as follows:

1. develop reliable and valid tools/procedures for assessing needs in order to obtain a good grasp of the beneficiary's condition;

2. develop reliable admission criteria allowing a determination of which program will best meet the beneficiary's needs;

3. coordinate admissions and registrations in order to control them and speed them up, while interpreting the

beneficiary's needs in regard to the admission criteria in a standard and neutral manner;

4. budget the programs in relation to the needs of the beneficiaries they are intended to serve;

5. ensure that the network in each region offers all the programs required to meet the needs of its beneficiaries as far as quantity of human resources and timing of the services are concerned (planning and programming in relation to needs).

In 1976-77, the designers developed a process and tools for assessing needs. These tools were subsequently used for controlling resource utilization and for planning, programming and budgeting. After seven years of testing, the Ministère de la Santé et des Services sociaux (MSSS) du Québec (*) selected the CTMSP system as the exclusive system for assessing the needs of persons suffering a loss of autonomy and in need of extended services. (**)

2.1 Criteria used in developing the process for the assessment of needs

The process for the assessment of needs had to:

1. in order to satisfy planning/programming/budgeting requirements, when used as part of an investigation of the needs of a population:

(*) In June 1985, the Ministère des Affaires sociales (MAS) was renamed the Ministère de la Santé et des Services sociaux (MSSS).

(**) The concept of extended care and services is to be understood in a very broad sense. Care and services covered include nurses, social workers, physiotherapists, ergotherapists and physicians as well as home-care services (family assistance, preparation of meals, transportation, etc.). The common thread linking these services is that they are required for long periods of time. They are provided by intermediate, institutional (foster families, HCC, HC, etc.) organizations or those involved with home support (LCSC, day centres, etc.). However, it should be noted that immediate or short-term service needs can be identified using the new version of the process for assessing autonomy in the home, as a result of its staggered assessment structure.

- enable a variety of programs to be defined, and thus allow for the identification of all the various programs required to meet the population's needs;

- provide a means of determining the exact number of places needed at a given moment or by a given date in each program to meet the population's needs;

- provide a means of determining the quantities of human, medical, paramedical (nurses, ergotherapists, social workers, physiotherapists) and non professional resources needed by the average beneficiary of each program.

2. in order to satisfy resource utilization control requirements, when used to assess the needs of a specific beneficiary:

- provide a means of determining which program the beneficiary requires, with or without allowance for the assistance he might receive from his natural network;

- provide a means for choosing the organization best able to meet the beneficiary's needs, in other words, offering the program best suited to his needs;

- provide a means of measuring the gap between the program the organization offers the beneficiary and the program the beneficiary needs.

Given all these requirements, a process limited to a traditional assessment of needs, that is, an assessment of biological, psychological and social functions accompanied by a medical assessment, seemed insufficient. In addition, the process had to provide a means of identifying those basic services the beneficiary needed and of measuring the quantities of (human) resources needed to provide those services, leading to an identification of the program he required and of the organization that could offer the program to the beneficiary. The assessment was therefore to be carried out in four stages:

functional/medical ---→ services needed ---→ human resources needed ---→ programs needed

2.2 Autonomy assessment and medical assessment

This section of the assessment draws on the concepts of illness - impairment - disability and handicap put forward by the WHO (*). The medical assessment focuses on the beneficiary's illnesses/ impairments while the autonomy assessment concentrates on disabilities and handicaps. As far as possible, both assessments stress the beneficiary's potential. If the beneficiary has a natural (social & family) network, its ability to provide support is also assessed.

2.3 Determining the services needed

The purpose of this section of the assessment is to identify the service elements the beneficiary needs in the following sectors:

- support services, namely: meal preparation, housework and shopping, supervision (non professional), socialization (community activities, friendly visits, etc.);

- nursing care, professional and non professional assistance for diet, hydration, elimination, respiration, hygiene, comfort, communication, medication, other treatments (bandages, etc.) supervision and diagnosis;

- occupational therapy services (ergotherapy), of both a mental and physical nature;

- physiotherapy services;

- social services;

- medical services.

For each of these sectors, professionals in the various disciplines involved have compiled lists of service elements. All together, these lists amount to 220 service elements grouped into six forms corresponding to the six service categories listed above.

A multidisciplinary team, specifically formed for this purpose, is charged with determining which services the beneficiary needs. The team is made up of a physician, a social worker, a nurse, a physiotherapist and an ergotherapist. The team does not

(*) Wood, P. International Classification of Impairments, Disabilities and Handicaps, WHO/OMS, Geneva,, 1980, 200 pages.

meet with the beneficiary, but proceeds on the basis of the functional and medical assessment. Following an analysis of the beneficiary's needs and after reaching a consensus, each member of the team completes the form for services required that corresponds to his specialty. A pooling then takes place, eventual duplications are eliminated and supplementary service elements are identified to deal with needs to which none of the members may have paid attention.

Once again, it should be noted that the members of the multidisciplinary team must not only identify which services are needed, but must also specify how often (per week for nursing services, per month for social services, etc.) the service elements identified are needed.

Finally, for those beneficiaries who can rely on assistance from a natural support network, the team identifies both the total package of services the beneficiary needs (potential services) and the services his natural support network cannot provide (real services).

2.4 Measuring the resources needed

The purpose of this section of the CTMSP assessment is to measure the quantity of human resources required to provide the services the beneficiary needs.

The lists of services required mentioned above are weighted: a value is assigned to each service element to take into account the time required to provide the service element. The frequency at which a service element is required is known, so when this frequency is multiplied by the value of the service element, the result is the average time required to provide this element during the period over which the frequency is calculated (year, month, week or day). When all the times thus calculated in regard to the service elements specific to a resource (ergotherapy, for instance) are added, the quantity of this resource needed by the beneficiary per unit of time is obtained.

In this way, the following measures of resources needed by the beneficiary can be calculated:

- hours of nursing care/day
- hours of professional nursing care/day
- hours of non-professional nursing care/day
- hours of nursing care for diet and hydration/day
- hours of nursing care for elimination/day ... etc.
- hours of ergotherapy/week
- hours of physical ergotherapy work/week
- hours of mental ergotherapy work/week ...etc.

- hours of physiotherapy/week
- hours of physiotherapy requiring specialized equipment/week ...etc.

- hours of social service/month
- hours of social service - mental therapy/month
- hours of social service - family therapy/month
- hours of social service - information/month ...etc.

This list is only an example, and is not exhaustive.

Support resources and medical resources needed are the only resources not measured in terms of time. Support resources are measured by the number of contacts needed per year, while medical resources are expressed in terms of the type and frequency of visits needed per year.

Once the multidisciplinary team has determined which services are required, a measure of the resources needed to provide these services can be determined by simple arithmetic.

For beneficiaries who can rely on assistance from a natural support network, and thus for whom the team identifies both the potential services and the real services required, both the potential resources and the real resources needed to provide these services are measured.

2.5 Program definitions

The process we have just described (first three stages) was used to assess the needs of two samples of persons over age 65: the first numbering 1,500 beneficiaries living in home-care centres and extended care hospital centres; the second numbering 600 randomly selected elderly persons living at home. The samples were drawn by controlling sex and age (three age groups: 65-74; 75-84; 85+) to obtain equal representation in each cell (compared to the general public, men and persons of advanced age were therefore overrepresented in the sample). The decision was made to proceed in this way because, a priori, it was most likely to exhibit the whole spectrum of needs, and thus enable the whole range of programs required to be identified.

Using these methods, a bank of autonomy - services - resources profiles for 2,100 elderly persons was developed.

The 2,100 resource profiles were analysed using clustering (CLUSTAN program) (*) and principal component analysis techniques. The analyses identified four discriminant resource variables (from among the 39 variables making up the client's resource profile - a partial list of these variables was given earlier), that is, variables that can be used to distinguish groups whose members are homogeneous, but which are heterogeneous amongst themselves.

The four variables (and their levels) used to distinguish the groups are as follows:

1. Non professional supervision (SUPR)

Supervision provided by a person (a non-professional) for the client's security or that of others. (Systematic observation by the nurse or physician is not involved).

This variable may take on four (4) values:

Level	Interpretation
0	Supervision not required
1	Supervision required during some periods in the week (caretaking)
2	Continous or near-continous supervision required (excluding cases covered by level 3)
3	Continuous or near-continuous supervision required because of significant behaviour problems

2. Organization of materials (ORMAT)

This is the assistance needed to prepare meals, do shopping and routine housework.

This variable can take three (3) values:

(*) Wishart, D., CLUSTAN - User Manual, Third Edition, Program Library Unit, Edinburgh University, St. Andrews, Scotland,

Level	Interpretation
0	Organization of materials not required
1	Organization of materials required only for shopping, housework (and eventually for preparing meals, but only once or twice/week)
2	Preparation of meals required three or more times per week

3. Total nursing care: professional and non-professional (TNC)

This variable expresses the time required to provide the beneficiary with the professional and non-professional nursing care (direct and indirect) he needs for respiration, diet and hydration, elimination, communication, treatment and diagnosis.

The values are expressed as hours of care/24 hours.

Level	Interpretation
0	x = 0 hours of care/24 hours
7	4.375 x

4. Rehabilitation (REHAB)

This variable expresses the hours of physiotherapy and ergotherapy needed by the beneficiary.

Level	Interpretation
0	Neither physio. nor ergo. required
1	Ergo. required; physio. not required
2	Ergo. not required; physio. required
3	Both ergo. and physio. required

Theoretically, then, there are as many distinct groups of beneficiaries as combinations of levels of these variables:

4 (SUPR) X 3 (ORMAT) X 8 (TNC) X 4 (REHAB) = 384

However, a number of these combinations are impossible (for instance, ORMAT = 0, TNC = 7) and some are so infrequent (i.e. correspond to very few beneficiaries) that, for strictly operational reasons, they have to be grouped together. Experts were assigned to carry out these groupings.

In this way, from the 384 possible groups, 37 were identified. They are displayed using a decision tree in Figure 1. Each branch of the tree corresponds to a class or group whose number is found in the terminal node of the branch:

- class 1 includes beneficiaries who do not need organization of material services (ORMAT = 0) but may eventually require either nursing care, or rehabilitation or again two or all three of these services. The vast majority of beneficiaries in fact need only very few services.

- classes 2, 3 and 4 include beneficiaries
- who do not require supervision or require only episodic supervision from the network (real caretaking service)
- and require organization of material services but not meal preparation.

These classes distinguish between beneficiaries who need neither nursing nor rehabilitation services, those who need nursing services but not rehabilitation services and those who need both nursing and rehabilitation services.

- classes 5 to 11 include beneficiaries
- who do not need supervision or require only episodic supervision from the network (real caretaking service)
- and require organization of material services including meal preparation.

These classes group beneficiaries according to their need for nursing care and according to whether or not they need rehabilitation.

- class 12 includes beneficiaries
- who need organization of material services
- who need continuous or near-continuous supervision
- who do not need nursing care or need less than 0.625 hours/day.

- classes 13 to 32 include beneficiaries
- who need organization of material services (services at level 2 in 90% of cases)
- who need continuous or near continuous supervision.

These beneficiaries are grouped according to nursing care class (from 2 to 6) and rehabilitation class (from 0 to 3):

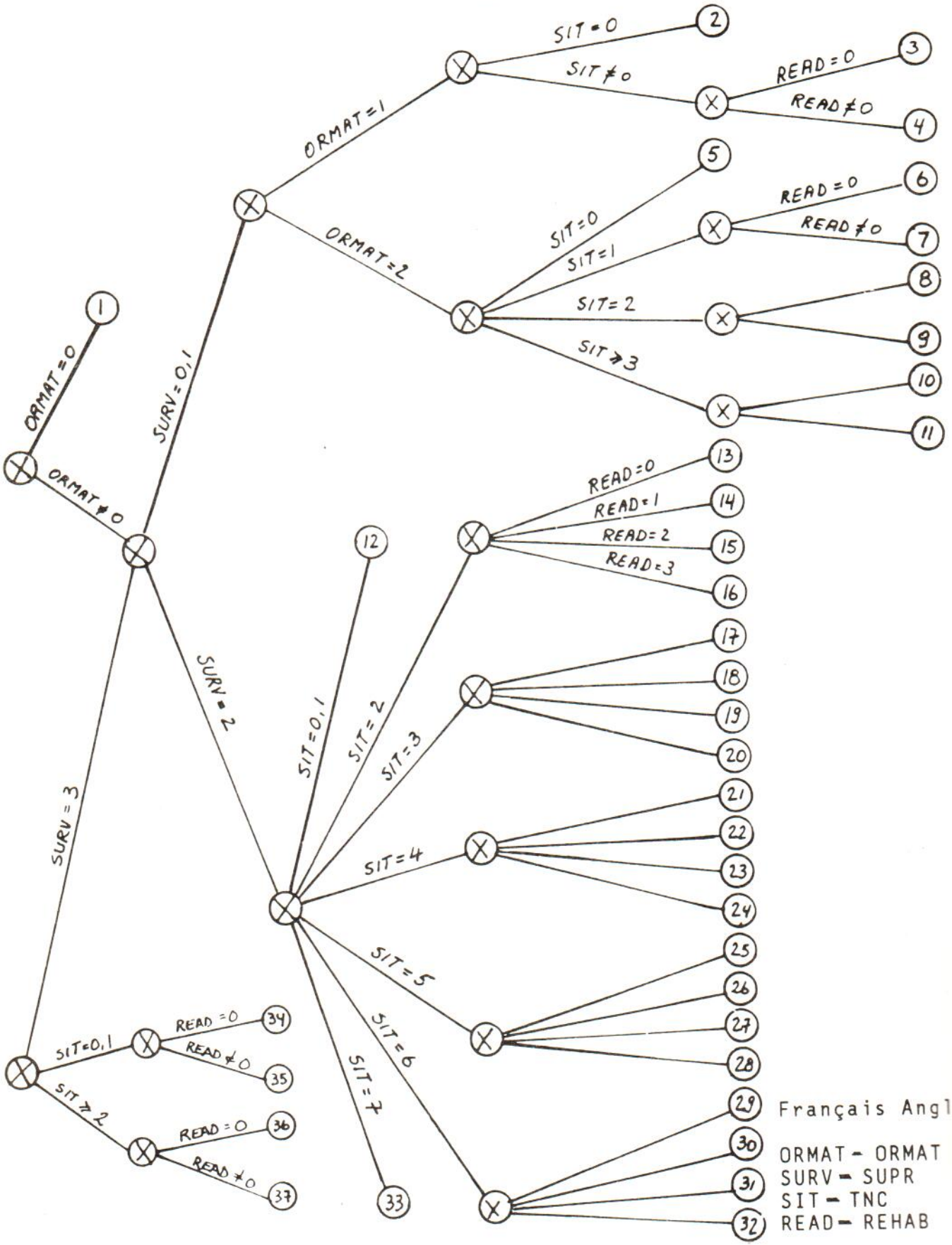

Figure 1: Diagram showing classification of programs.

- class 33 includes beneficiaries
- who need organization of material services
- who need continuous or near continuous supervision
- who belong to nursing care class 7

- classes 34 to 37 include beneficiaries
- who need organization of material services
- who need continuous or near continuous supervision

because of significant behaviour problems.
These beneficiaries are grouped according to their nursing care class (0, 1 or 2) and according to whether or not they need rehabilitation.

Corresponding to these 37 classes are 37 programs which should be available from the care and service system for persons suffering from loss of autonomy and which are likely to be needed by the system's beneficiaries. Each program covers beneficiaries who are quite similar as to their human resources requirements in terms of supervision, material organization, nursing care and rehabilitation. Checks were also carried out which confirmed that, within the same group, beneficiary autonomy profiles were close to one another, but were appreciably different from group to group.

The 37 programs were thus defined on an empirical basis using the human resources requirement profiles of a sample of persons suffering a loss of autonomy.

This chapter has summarized the conceptual framework underlying the CTMSP system. The balance of the document will focus essentially on the first section of the system, namely, the autonomy assessment and the medical assessment of the person suffering a loss of autonomy. Readers wishing a more detailed explanation of program definitions, of how required services are determined and how resources needed are measured, are referred to the documents describing the two other components of the system (*).

(*) Tilquin, C., Sicotte, C., et al: CTMSP: La détermination des services requis et la mesure des resources requises par le bénéficiare, EROS, Université de Montréal, Montréal, 1982, 220 pages.
Tilquin, C., Sicotte, C., et al: CTMSP: L'orientation du bénéficiare dans le réseau, EROS, Université de Montréal, Montréal, 1983, 110 pages.

3. THE CONTEXT OF AUTONOMY ASSESSMENT AND MEDICAL ASSESSMENT IN THE CTMSP SYSTEM

Within the CTMSP system, the autonomy assessment and medical assessment process we will now describe is the basis for the orientation of the beneficiary. Persons who will be using the process to assess beneficiares will certainly be interested to know why they are gathering information, how it will be used and by whom. This is what we shall attempt to do in this chapter.

Any assessment process proceeds from a goal which serves to justify and legitimize it. The assessment procedures and content we present here were primarily designed to obtain the best possible knowledge (allowing for obvious "feasibility" constraints) of an existing or potential beneficiary of an extended services network, with a view to directing him toward the (home support, intermediate or institutional) resources best able to meet his needs for assistance (*). They are necessarily influenced by the particular objective selected, and would have been quite different had thè objective been to gather information needed to establish a treatment plan for the beneficiary, or to develop the instruments needed to assess the effectiveness and efficiency of the extended services network programs.

As presented in the previous chapter, the module for assessing the needs of a person suffering a loss of autonomy, under the CTMSP system, is structured and operates as follows:

- The process begins with an assessment of the beneficiary's autonomy and of his medical condition (the subject of this text). The autonomy assessment is undertaken by a professional (ex.: nurse, social worker, ergotherapist, ...) who interviews the beneficiary and, if necessary, a significant person or the care-giver. If need be, the assessor may call upon the services of one or more participating professionals, but he remains responsible for the entire assessment process. The medical assessment should be undertaken more or less simultaneously by a physician who meets with the beneficiary.

- The autonomy assessment and medical assessment forms completed in the first stage are sent to a multidisciplinary team made up of a social worker, a nurse, a physician and, at least on referral, a physiotherapist and an

(*) The CTMSP is designed for adults and elderly persons suffering a loss of autonomy. For beneficiaries with complex problems (ex.: several handicaps, psychiatric problems, behavioural problems, etc.) and for cases in which the CTMSP assessment process is not sufficient, the assessor is requested to attach a more specific assessment supplement.

ergotherapist. Using the information provided, the team produces a summary of the beneficiary's biological, psychological and social autonomy and decides, by consensus, which services (support, nursing, medical, social, rehabilitation) the beneficiary needs.

- In the third stage, the human resources the beneficiary needs (both the quantity and type) are calculated (mathematically, using simple addition and multiplication), based on the assessment of services needed as completed by the multidisciplinary team.

- The data produced by this three-tiered assessment program are then fed into the beneficiary orientation module, together with data on network resources, to determine which organization (for residence in the home, intermediate or institutional) is best suited to satisfy the beneficiary's needs.

The essential element in all this is that the information gathered during the autonomy assessment interview(s) and the medical interview is transmitted to a multidisciplinary team which does not meet with the beneficiary (nor the significant person or care-giver) and must decide - at a rather detailed level (since the lists of services available contain approximately 220 distinct service elements) - which services the beneficiary requires (*). The data gathered during the first assessment stage, which is dealt with here, must therefore be **relevant, exhaustive, coherent** and **reliable** since the quality of the multidisciplinary team's assessment of required services depends primarily on these data.

For a better understanding of what is expected from the autonomy and medical assessments, it is worthwhile to analyze them from the standpoint of the assessment of services needed by the beneficiary. To do so, we will begin with the notions of need and need for assistance. Since these two concepts are discussed in many works, we shall limit ourselves to a few reminders.

A **need** is simply defined as something necessary for physical and/or social well-being. A **specific need** of an individual is a need which can be differentiated, bounded, isolated,

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(*) It is not, however, a matter of setting up an intervention plan for the beneficiary. The services required are identified only to obtain indicators which will be of assistance in making a decision as to the beneficiary's orientation. An intervention plan will be drawn up for the beneficiary, after the orientation question has been decided, by the professionals of the organization named to provide services to him.

defined in such a way that it cannot be confused with another need. A specific need can only be satisfied by a specific action. If an individual is able to carry out this action himself, it is called an **autonomous specific action**. (Figure 2).

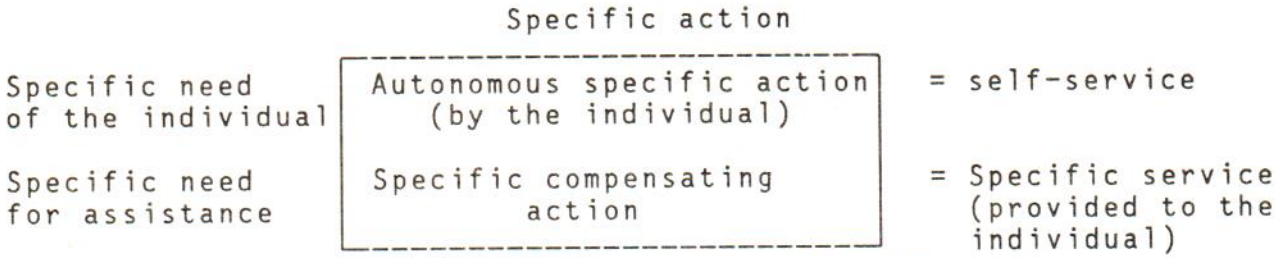

Figure 2: Concept of service

Generally, persons suffering a loss of autonomy require assistance to meet specific needs; they are said to have **specific needs for assistance**. This assistance is provided by what we shall call a **specific compensating action**. Depending on the beneficiary's degree of autonomy (*), a given specific need may be met by an autonomous action, a combination, in various "proportions", of an autonomous action and a compensating action, or finally, entirely by a compensating action. Compensating actions are what are referred to as services in popular language. We will thus refer to physiotherapy service when the compensating action is undertaken by a physiotherapist.

Compensating actions or services may be "performed" by extended services network personnel or by the person's circle: spouse, father, mother, children, relatives, neighbours, friends,... This distinction is very important because it helps to separate the concepts of **potential need** and **real need** for assistance (Figure 3). Potential needs for assistance cover all the beneficiary's needs for assistance, regardless of who satisfies them: extended services network or circle. Real needs for assistance correspond to the beneficiary's needs for assistance which

(*) We view the individual's degree of autonomy as the degree to which his capacities (functional, economic, etc.) are adapted to his needs, that is, to the requirements of the specific physical, mental and social actions he must perform to maintain his health and well-being. A person's autonomy can be upset by many factors. Essentially, they act to reduce the person's capacities: a decrease in the level of the organism's performance, morbidity, loss of physical integrity, retirement, a reduction in income, the loss or departure of loved ones, etc. These are all factors that erode a person's physical, mental or social capacities.

must be satisfied by the extended services network. Therefore, they are obtained by "subtracting" the needs for assistance that are met by the circle from the potential needs. Given the relation previously established between a specific need for assistance, a specific compensating action and service, we shall take a similar freedom and speak of **potential services** and **real services**: the former are all the services the beneficiary needs while the latter cover only those required from the extended services network (Figure 3).

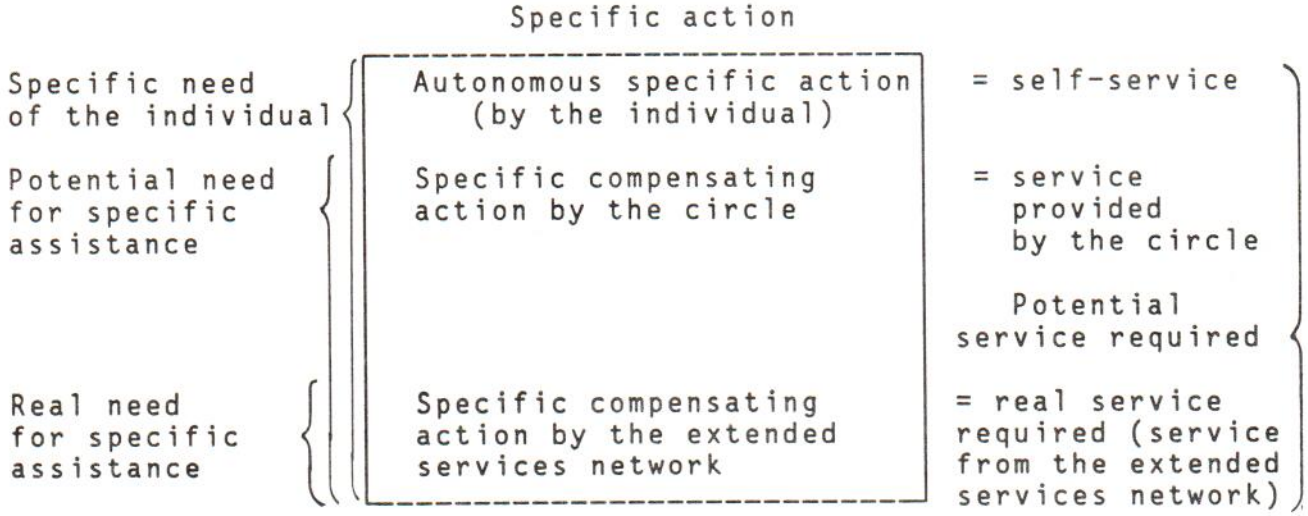

Figure 3: The concepts of potential and real service

The notion of services, whether potential or real, can be usefully associated with the notion of an overall service profile for a beneficiary and that of the profile of services associated with a given resource: for instance, the profile of nursing services. A service profile is nothing but a list of services required at a given moment. A beneficiary's nursing service profile is therefore the list of all the nursing services he needs, whether potential or real, depending on what is to be measured. The overall service profile is the list of all the services he needs in regard to all the services of the extended services network.

The foregoing suggests that a logical and structured way of identifying a beneficiary's overall service profile is to begin by isolating his needs for assistance, considering his capacities and his needs, and thus his autonomy and the factors eroding it. For the beneficiary living at home who can or eventually could count on some help from his circle, the preceding statement must be modified somewhat since the multidisciplinary team charged with determining the services required is asked to distinguish between the potential service profile and the real service profile.

It then becomes a question not only of isolating the beneficiary's needs for assistance, in view of his capacities and needs (used to identify the potential service profile) but also of assessing the capacity of his circle to provide assistance, so as to identify the beneficiary's real service profile.

The process is shown in Figure 4:

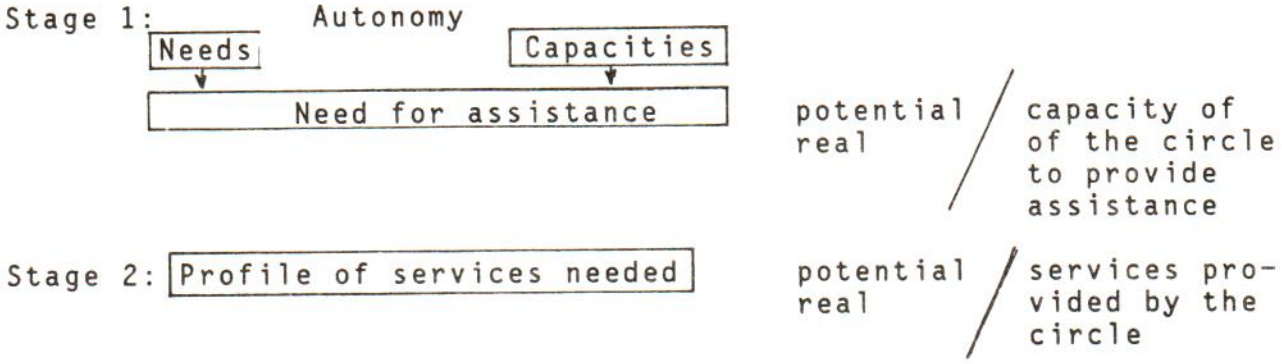

Figure 4: The first two stages in the assessment of needs process

To correctly assess the services the beneficiary needs, it is necessary to go even further in clarifying the concept of the circle's **capacity for assistance,** as we shall see. The circle's **actualized capacity for assistance** refers to the assistance actually provided by the circle at the time the beneficiary's needs are assessed. Three not necessarily mutually exclusive situations are possible:

1. The circle "is doing too much" in view of its capacities. The assistance it provides the beneficiary places an unacceptable burden on the circle which, at some point in the future, could have irreversible negative effects on its health and biological, psychological and social well-being. The circle is then said to display an "excessive" capacity for assistance, part of which must be deactivated: this is called the **capacity for assistance to be de-actualized.**

2. The circle provides assistance commensurate with its capacities.

3. The circle could do more but, for various reasons, it does not. In this case, the circle is said to display an insufficient capacity for assistance, which must be increased: this increase is called the **actualizable capacity for assistance.**

In general, any one of these situations may be observed. However, it is entirely possible for them to coexist in certain

cases: the circle doing what is necessary and what it can do in one area, too much in another and not enough in a third.

In practice, as far as autonomy assessment is concerned, the actualized capacity for assistance, the capacity for assistance to be de-actualized or the actualizable capacity for assistance of the beneficiary's circle is pointed out.

The multidisciplinary team will then identify the real services the beneficiary needs based on the potential services he needs, using the expression:

real services = potential services - services actualized by the circle
+service provided by the circle to be de-actualized

At the same time, the multidisciplinary team's recommendations to the orientation committee will comment on the results that can be expected (in terms of additional services available from the circle) from an attempt to actualize the circle's capacities. The multidisciplinary team can, if it feels the need, request a more thorough assessment of the circle's capacities. This will happen infrequently since the autonomy assessment will normally contain sufficient information to form an idea of what actualization could contribute both qualitatively and quantitatively.

There are then two possible courses of action. Once the orientation committee has received the information from the multidisciplinary team,

- it either decides that, given only the services actualized by the circle, the beneficiary can remain at home. Nonetheless, it may decide, at that time, to attempt to actualize additional assistance to eventually relieve, either in whole or in part, the burden on the home support program;

- or it concludes that, in view of the actualized services, the beneficiary can no longer remain at home; then, either

  . the committee concludes that even with a successful actualization initiative, the beneficiary cannot remain at home. In this case, the only solution is admission to an intermediate or institutional resource.

  . or the committee concludes that a successful actualization initiative may obviate "institutionalization". In this case, it decides that the beneficiary is to be maintained at home on a provisional basis (pending case) and attempt actualization. The orientation committee receives the results of this

attempt and takes them into consideration in its final orientation decision.

What should be retained from all this? As understood under the CTMSP system, assessment of needs must lead up to a determination of which services the beneficiary needs. This task belongs to a multidisciplinary team. In order to proceed, this team needs to be informed or have available the information needed to assess:

- the beneficiary's needs
- his capacities
- the factors affecting his capacities
- his autonomy
- his needs for assistance
- the capacities for assistance of his circle
- actualized
  . to be de-actualized
  . actualizable

This information must be produced by the beneficiary's autonomy assessment and medical assessment.

But that is not all. The individual's needs, capacities and needs for assistance will differ depending on whether it is the individual himself who perceives and expresses them, or various outside observers, suppliers of services, etc. (assessor, physician, volunteer, family, etc.). This also applies to the capacities of the beneficiary's circle. The assessment process must then proceed in such a way that it points out these varying views of needs, capacities and needs for assistance. The multidisciplinary team will summarize this multifaceted information, and determine the services the individual needs, paying particular attention to the wishes and preferences the individual expressed during the autonomy assessment interview(s) and which may influence the choice of services.

The assessment of needs leads up to the allocation of resources to compensate for the beneficiary's deficiencies (needs for assistance), but also to reduce (*), if possible, these deficiencies to the point where, eventually, the beneficiary recovers full autonomy (adaptation and rehabilitation), or to retard as much as possible the deterioration in autonomy (maintenance, prevention). The last two objectives indicate that the beneficiary's

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(*) There are two ways to treat deficiencies, that is the gap between needs and capacities: the first is to increase capacities (rehabilitation), the second to lead the individual to adjust his needs to his capacities (adaptation).

autonomy status is not seen as something fixed and final. This status can improve, remain stable or deteriorate, and thus the beneficiary's needs for assistance can eventually change. This means the assessment of needs process must be dynamic, that assessment must be repeated, in whole or in part, each time the beneficiary's autonomy changes significantly and for a time period which can also be assumed significant.

Seen from this perspective, there is an additional dimension to the assessment of needs. It is no longer simply a question of assessing the individual's needs for assistance and the services and resources required. The results of compensating actions that have been taken must also be assessed, and the results expected from actions suggested must be specified. As a result, the assessment of needs must not be limited to a listing of capacities, needs for assistance and services. It must state explicitly the links between needs/capacities/needs for assistance on the one hand, and services on the other (justification of interventions by the multidisciplinary team). The assessment of needs must thus explicitly state the reason for each service or group of services and the results expected (prognosis) from providing the services. It should finally specify the time(s) at which these results should be achieved. This (these) time(s), as well as those corresponding to major and unexpected changes in the beneficiary's autonomy or in the circle's capacity for assistance, are milestones in the dynamic process of assessing the beneficiary's needs. At these points, the professionals caring for the beneficiary must ask themselves whether there is reason to reassess his real or potential needs for assistance. Since the assessment of needs as envisaged in this document is performed with a view to the optimum program direction for the beneficiary, the answer to the preceding question will be positive if there is a presumption that the beneficiary's needs for assistance, potential or real, no longer correspond to the resources that can be allocated to him within the program under which he is currently receiving services.

The essential points to be retained from an analysis, from the perspective of the autonomy and medical assessments, of these considerations involving the overall process of assessing needs are that these two assessments must contain (a) the data needed for a judgment of the results of previous interventions (only for those beneficiaries having already received services), and (b) the data the multidisciplinary team needs to specify the results expected from an allocation of services. In other words, the multidisciplinary team cannot state a service is needed if it cannot provide a justification based on the data from the autonomy assessment or the medical assessment. The results achieved and the results expected are part of such a justification, so the autonomy assessment and medical assessment must enable the former to be measured and the latter to be estimated.

4. INTRODUCTION TO THE REVISED AUTONOMY AND MEDICAL ASSESSMENT FORMS AND THE CONDITIONS FOR THEIR USE

During 1984-85, two working committees (autonomy and medical) revised the autonomy and medical assessment forms. The members of the committees were guided to a considerable extent in their work by the comments, criticisms and recommendations received from users of the system (*). An introduction to these revised forms follows.

To maintain the credibility and validity of the CTMSP system, the system must be regularly revised in an orderly and unified way. From the time the CTMSP system was designed in 1976 until 1984, the system's researchers undertook this task alone. Their work drew on the results achieved from testing and implementing the system, comments, criticisms and recommendations from users and, finally, on the results of recent research in the field of assessment of needs of persons suffering a loss of autonomy.

The M.S.S.S., concerned with the need for a standard tool for the assessment and orientation of beneficiaries within the network, selected the CTMSP system in December 1983. The department and the designers of the system then initiated negotiations concerning the rights and privileges for the utilization of the system. One of the resulting agreements provided for a revision of the CTMSP to be undertaken jointly by the two parties.

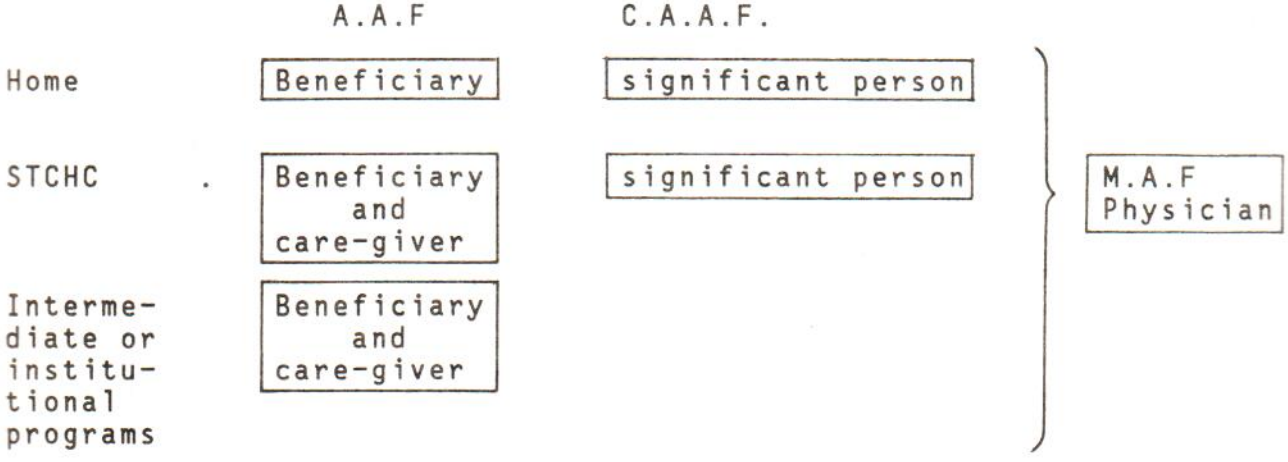

Figure 5: Autonomy assessment and medical assessment forms resulting from the revision

(*) Further information on the revision and testing process for autonomy and medical assessment forms carried out during 1984-85 is provided in Appendix I.

Forms and rules for their use imply formalization, and the type of autonomy assessment we have opted for is indeed formal. We believe a formal assessment is more likely to be exhaustive, that is, to gather all the factual and perceptual data the multidisciplinary team requires to assess the services the beneficiary needs. By proceeding in a formal manner, there is less chance of overlooking key items of information. We also believe a formal assessment provides better assurance as to the relevance (validity) of the information gathered. The assessor is less likely to get bogged down in details that are of little or no interest in view of the stated objective. The formalization of the assessment is considered to enhance its reliability, by imposing a uniform plan and a content for the interview (the same for all assessors and all beneficiaries), and by allowing for formulations and sequences of questions designed to minimize the chances of unreliability. In an informal interview, it is extremely difficult to avoid formulating questions and gathering information in a format that may be confusing. Finally, by formalizing the assessment, it can be systematically sown with related questions which can subsequently be used to check the coherence of the information gathered.

Indeed, thanks to the formalization of the assessment, which facilitates the exhaustiveness, reliability and relevance of the data gathered, the assessor can concentrate on establishing a good rapport with the beneficiary, and on the content of each question.

We have, moreover, avoided the snare of formalization at any cost by allowing space for open questions and comments. This has been done so that additional information shedding light on the beneficiary's situation, nuances, questions, reflections, impressions and observations may be recorded.

The assessment takes the form of a series of questions addressed directly to the beneficiary. The assessor is expected to record the answers as fully and faithfully as possible, and in the beneficiary's own words. The assessor is therefore not to converse with the beneficiary on various subjects and then himself answer the questions based on what the beneficiary said. Moreover, wherever possible, the questions have been directed to the factual, the behavioural. Essentially, they are designed to isolate everyday biological, psychological and social capacities/ incapacities. However, it is acknowledged that objects, facts and behaviour have a subjective element and, as a result, to obtain a complete picture of these, both the beneficiary and another person (care-giver or significant persons), whenever possible, are asked to indicate how they see things. The assessor is also asked to give his opinion through comments both during the interview and at its conclusion.

Finally, users will note that an effort has been made to "de-professionalize" the assessment by formulating the questions in such a way that technical and specialized terms, specific to a profession, are avoided. This has been done to facilitate

communication between the assessor and the beneficiary and, subsequently, between various professionals and non professionals involved, both within the multidisciplinary team and later within the orientation team.

4.1 The autonomy assessment form for various facilities: home, STCHC and intermediate or institutional programs

Two versions of the autonomy assessment form were included in the CTMSP 81: the first for beneficiaries living in an "establishment" of the extended services network; the second for persons living at home. These two versions have been retained in the revised CTMSP. Moreover, in view of the high percentage (*) of assessments performed in short-term care facilities and the specific features of this residential context (temporary and transitional), the revision committee developed a third version of the form to be used for beneficiaries hospitalized in an STCHC.

Distinct forms are needed according to the facility in which the beneficiary lives at the time of his assessment because it is not always possible to treat the various themes in the same way in different residence facilities, and because a more detailed exploration of one theme may be justified in one facility, but not in another. For example, at home, the emphasis will be placed on the circle's actualized and actualizable capacities, while in an STCHC, the capacities of the circle will be assessed from the perspective of the beneficiary's new condition (resulting from the crisis leading to his hospitalization and allowing for the capacities actualized prior to hospitalization). Three distinct versions can also be justified because certain themes do not apply or are not relevant in a given context. For example, use of medical and paramedical services, support from the natural network, and housing conditions are all themes that are not explored when the beneficiary is living in an intermediate or institutional program, but are explored in other situations (i.e. in an STCHC or at home).

(*) In some regions, the number of assessments performed in STCHCs exceeded 50%. Among other reasons, this situation could be due to existing problems with respect to the reception, assessment, direction and admission of beneficiaries in the network. Given the crowding in home support programs (resulting from lack of resources) and the waiting periods for admission to home-care and extended hospitalization programs, a person suffering a loss of autonomy who is faced with a crisis will turn to an STCHC, which is then seen as the final resource.

Apart from certain elements relating to the housing facility, there are few differences in the three versions of the autonomy assessment form, as can be seen in Figure 6, showing the list of themes making up the form.

In CTMSP 81, the questions addressed to the significant person and to the care-giver were incorporated within the form. In the revised form, the questions addressed exclusively to the care-giver are still part of the basic questionnaire (intermediate or institutional programs or STCHC), but those addressed to the significant person have been consolidated in a separate form (STCHC and home). This form is described in section 4.2.

THEMES	AUTONOMY ASSESSMENT FORMS FOR BENEFICIARIES: Under home care, interm. or insti. hospitalization programs	Hospitalized in an STCHC	Living at home
	(An X indicates the theme is not explored)		
Identification			
Sociodemographic information			
Residential context			
Reason for admission			X
Context of the request			
Eyesight, hearing, speech			
Physical mobility			
Functional autonomy			
Elimination			
Specific care required			
Medication	X	X	
Habits			
Utilization of medical and paramedical services	X		
Family and social relations			
Support from the natural network	X		
Beneficiary's responsibilities			
Personal and community activities			
Economic situation and budget management			
Housing conditions	X		
Beneficiary's opinion with respect to his situation and placement			
Intellectual capacities, emotional condition and behaviour			
Assessment context			
Summary of problems and recommendations			
Beneficiary's authorization			

N.B.: Slight differences may occur in the themes common to the three versions of the form, reflecting particular features of the three contexts.

Figure 6: Themes covered in the autonomy assessment form, versions: home, STCHC and intermediate or institutional programs.

Testing has confirmed the utility of incorporating general user instructions and an explanatory mini-guide into the form. From now on, they will be included in each version of the form.

The following precepts have been prepared as a guide to choosing which version of the form to use for a specific beneficiary, based on his living situation:

Situation: beneficiary receiving home-care or hospitalized under an intermediate or institutional program

This form will be used for a beneficiary already receiving care under an intermediate program (foster family, pavilion, etc.) or receiving care or hospitalized under an institutional program (HCC, ECHC, etc.). The information is obtained from the beneficiary and the care-giver (*).

Situation: beneficiary hospitalized in a short-term care hospital centre.

This form is used for a beneficiary occupying a short-term bed(**) and for whom active treatment has ceased. The information is obtained from the beneficiary and the care-giver. The complementary form must be completed with a significant person in every case with a presumption of a change in living situation (i.e. the beneficiary will not return home). It is optional (at the assessor's discretion) in all other cases.

During testing, we observed that the autonomy assessment of a beneficiary suffering a loss of autonomy and hospitalized in an STCHC was performed using the CTMSP form only when there was a presumption of institutionalization. The needs of other persons suffering a loss of autonomy are not assessed using this form when they can return home or enter an intermediate program.

We feel it is important that every person suffering a loss of autonomy who must leave a short-term care hospital centre be assessed using the CTMSP for STCHC or, according to circumstances, that he be referred to the LCSC in his region for a CTMSP assessment if there is a presumption or necessity for support at home. Systematic referral mechanisms must therefore be set up with

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(*) The care-giver is on the staff of the establishment where the beneficiary resides or is hospitalized. He knows the beneficiary well and may be a key source of information in assessing his autonomy.

(**) For beneficiaries in extended care units of an STCHC, the version for a beneficiary receiving care or hospitalized under an intermediate or institutional program is used.

the network's partners to provide services on a continuing basis. Such referrals could, for instance, help cut back on or avoid (re)hospitalization. It is up to each region to set up these mechanisms.

Situation: beneficiary residing at home.

This form is used for beneficiaries living at home who submit a service request to any home support program (*). The form has been divided into five parts to more closely reflect the existing situation and the operation of all home support programs, namely:

A. Reception and registration of the request
B. Preliminary autonomy assessment
C. Assessment of the beneficiary's autonomy
D. Complementary assessment of the beneficiary's autonomy, completed with the significant person
E. Reassessment

The purpose of Part A, reception and registration of the request, is to forward requests to the appropriate quarter.

Part B, the preliminary autonomy assessment, leads to four possible outcomes:
- the request is rejected;
- the person is directed towards another resource;
- services are provided on a short-term basis;
- the assessment is continued.

Part C, the assessment of the beneficiary's autonomy, begins with a list of the themes covered in the assessment. The assessor checks the themes he chooses to investigate. The assessment can be performed over a varying time frame, depending on the beneficiary's situation. Every theme must be covered when a change in living situation is contemplated, or when the beneficiary presents major risk factors.

Part D, the complementary assessment of the beneficiary's autonomy, must be completed whenever there is a presumption of a change of situation, and is optional otherwise.

Part E, reassessment, is used to indicate the themes that have been reassessed and the dates of reassessment.

(*) A home-care or assistance program, a day centre or day hospital.

4.2 The complementary autonomy assessment form completed with the significant person, for STCHC and home-care facilities

As mentioned above, the questions addressed to the significant person have been removed from the basic autonomy assessment form and grouped in a separate document. This new form goes over certain themes covered in the basic autonomy assessment form, but in a more general manner, using open questions.

The complementary autonomy assessment form is completed with the significant person for beneficiaries who are hospitalized in an STCHC or living at home. As with the basic form completed with the beneficiary, the justification for the two versions of the complementary form lies in the particular features of each living situation. However, the only differences between the two versions are to be found in the wording of the questions. There is no difference in the themes dealt with. These themes are listed below, in Figure 7.

- Context of the request
  The beneficiary's functional autonomy at home (*)
- Family and social relations
- Support from the natural network
- Intellectual capacities, emotional condition and behaviour
- Opinion of the significant person as to beneficiary's situation and program orientation
- Context of the assessment

Figure 7: Themes covered in the complementary autonomy assessment form completed with the significant person, versions: home and STCHC.

Regardless of the situation (home or STCHC), the complementary form is to be completed with a significant person whenever a presumption of a change in the beneficiary's living situation exists. The form is optional in all other situations, and can be used if the assessor considers it necessary.

Whenever possible, the significant person is one with whom the beneficiary lives (or lived), such as the spouse, a child,

(*) This theme is explored in greater detail in the "home-care" version of the form than in the "STCHC" version. This is due, in part, to the fact that in an STCHC, a third source of information, the care-giver, provides detailed information on several aspects of the beneficiary's functional autonomy.

... or a person he knows well and with whom he is on familiar terms.

Although, overall, the autonomy assessment form we have designed stresses information provided by the beneficiary, it seemed important, in regard to certain subjects, to obtain the views of the significant person. During the interview with this person, the assessor is to keep in mind that, whereas a person suffering a loss of autonomy tends to overestimate their capacities, loved ones tend to underestimate them. At the outset, then, the assessor will avoid giving preference to either source. However, should there be a significant difference, he must try, using all the information at his disposal, to give an opinion on what he feels is the most accurate reflection of the beneficiary's situation (*).

4.3 The medical assessment form

The beneficiary's biological, psychological and social autonomy is assessed by means of a medical assessment. For this purpose, the attending physician or, should the person not be under medical treatment, a designated physician completes the medical assessment form.

The revision committee assigned to the medical assessment form made significant changes in its content. For instance, the examination of both the beneficiary's habits and his functional autonomy have been significantly improved. The assessment themes are set out in Figure 8.

- Identification
- Current situation
- Illness or health problems
- Additional data (including habits)
- Summary assessment of functional autonomy
- Relevant reports from complementary examinations or consultations
- Proposed interventions
- Prognosis
- Physician's opinion as to the beneficiary's program direction
- Other information the physician deems important, or specific recommendation(s)
- Beneficiary's authorization

Figure 8: Themes covered by the medical assessment form

(*) This comment is equally applicable to the care-giver who, whether in an STCHC or an intermediate or institutional program, must provide additional information concerning the beneficiary's autonomy.

The medical assessment form must be completed in every case requiring a full autonomy assessment, or at the discretion of the organization to which the service request is addressed.

5. THE AUTONOMY ASSESSMENT PROCESS

5.1 The assessor and the participating professional(s)

The autonomy assessment form has been designed to provide a portrait of the biological, psychological and social situation of a person suffering a loss of autonomy. Although the CTMSP approach to autonomy assessment is global, the revision committee agreed with requests from social workers to group the form's sections under two categories, the first dealing with the physical aspect and the second, the psychosocial. This was not done in order to create two separate parts to be administered by two different assessors. Since the assessment should be undertaken under the best possible conditions for the beneficiary, it is preferred that a single assessor, whoever is in the best position to assume responsibility for the assessment, undertake the task. He may be a nurse, a social worker, an ergotherapist, a physiotherapist, ... The assessor responsible for the process may, however, call upon other professionals to lend their expertise to specific aspects of a case, so as to provide a better profile of the beneficiary's autonomy. Moreover, it is to be emphasized that the form was designed so that, regardless of the assessor's profession, he can perform the assessment of the beneficiary's autonomy.

5.2 The assessment interview(s): conduct and context

A typical assessment may be conducted as follows:

- establish contact with the beneficiary;

- interview(s) with the beneficiary.
The themes of the autonomy assessment form have been sequenced to allow a continuous and fluid exchange (grouping the physical and psychosocial aspect, graduated levels of information using sub-questions within each theme, etc.). However, the assessor need not follow the suggested sequence to the letter. Depending on the beneficiary's condition or on the assessment context, he may take up the themes in a different order.

The assessment process will extend over a period of time and take place over a number of contacts based on the beneficiary's condition, the urgency of the situation, the availability of the respondent(s), etc. In any assessment process, an important distinction must be made between the professional assessment procedure, and the requirements for transcribing the results of such a procedure using a medium such as the CTMSP autonomy assessment form. It is up to the assessor to decide the appropriate time(s) to undertake an assessment, the number of

contacts with the respondent(s), and when to complete the questionnaire and bring the assessment process to a close. The essential point is to obtain the information needed for the form under the best possible conditions for the beneficiary.

- The assessor notes his observations and impressions of the beneficiary in the spaces provided.

- interview(s) with:

  . the care-giver (in an STCHC or intermediary or institutional program).
  The assessor completes the shaded sections of the form with him.

  and, if necessary, with:

  . the significant person (in an STCHC or at home). In this case, the assessor makes use of the appropriate complementary autonomy assessment form according to the beneficiary's living situation at the time of the assessment.

- The assessor reads the completed form(s) closely and draws up an overall summary of the assessment which he transcribes in the "Summary of Problems and Recommendations" section. This is section:
  (C.16) of the A.A.F., "home-care" version;
  (23) of the A.A.F., "STCHC" version;
  (17) of the A.A.F., "intermediate or institutional programs" version.

The above procedure describes the usual assessment process. Although we consider the beneficiary as the first and "best" source of information, we are aware that in certain situations, the assessor may consider a consultation with the care-giver or significant person more appropriate. Whichever procedure is followed, he must always be sure to note his comments and impressions following a meeting with a respondent (beneficiary, care-giver or significant person) before proceeding to interview another respondent, so as not to be influenced by the latter.

The assessor's interview with the beneficiary is at the heart of the assessment process. It should be conducted in a quiet place, in as much comfort as possible. It should be impossible for anyone else to overhear. Unless the beneficiary expressly requests a third person to attend, the assessor's responsibility is to conduct a private interview and take the measures needed to achieve that goal.

The assessor's interview with the care-giver or significant person should also be private. The care-giver or significant person should not have access, before, during or after the interview, to the data obtained from the interview with the beneficiary.

5.3 Interview with the beneficiary not possible

We have just described how an assessment is normally conducted, with the beneficiary able to answer the assessor's questions. Although most persons suffering a loss of autonomy are capable of participating in an interview, for some, an interview may be completely out of the question (because of unconsciousness, serious illness, etc.) or not desirable (mental deficiency, confusion, refusal, etc.). Under these circumstances, the assessor is requested to note the beneficiary's inability to participate in an interview. If the beneficiary's condition is such that any interview, or even an attempt at an interview, is impossible, the assessor should indicate, in the "Context of the Interview" section of the form, that the person interviewed will be somebody other than the beneficiary, and identify that person (ex: care-giver). He should then write, in the same section, the reasons why an interview with the beneficiary is impossible.

For persons afflicted with psychological problems (confusion, disorientation, muteness, mental deficiency, ...), the assessor is encouraged to initiate an interview to confirm that it is indeed impossible to continue the process. No useful purpose is served by stubbornly continuing with the interview and writing the beneficiary's answers if the assessor observes the information provided is inconsistent and illogical. In this case, the assessor should end the interview, explain the situation in the form, following the procedure described above. However, if the beneficiary is able to provide logical and coherent information, with or without assistance from another person, the interview should be continued according to the normal procedure.

When it is concluded that an interview is impossible, and the details concerning the identification of the respondent and the reasons justifying the decision have been noted on the form, the assessor must then rely on a substitute person for the information which the beneficiary would normally have provided. In general, all the sections of the form usually addressed to the beneficiary should be completed, either with information provided by the substitute person, or with a note indicating the beneficiary's inability to answer (does not know, unable to tell, etc.). The committee charged with deciding which services are required will then be in a position to correctly evaluate the situation without having to query the lack of information.

Figure 9 outlines the assessment procedure according to facilities, for the situation in which an interview cannot be held with the beneficiary. The substitute source of information may be the significant person, the care-giver or another person who knows the beneficiary well. The procedure will vary depending on the version of the form that is used. The underlying rule is to complete the sections of the form addressed to the beneficiary with the substitute person to the extent possible. If the substitute person is neither the care-giver nor the significant person (in an STCHC or at home), the usual procedure is followed as far as these respondents (care-giver or significant person) are concerned. However, if the substitute person is the care-giver or significant person, there is no need to complete the themes normally reserved for them (care-giver section of the A.A.F., or C.A.A.F. for the significant person) which would already have been covered in the "beneficiary" part of the form.

FACILITY	SUBSTITUTE SOURCE A.A.F.	C.A.A.F.
HOME - significant person	- complete sections of the A.A.F. usually addressed to the beneficiary	- do not complete
- other person	- complete sections of the A.A.F. usually addressed to the beneficiary	- complete, if necessary with the significant person
- significant person	- complete sections of the A.A.F. usually addressed to the beneficiary, then the shaded areas addressed to the care-giver with him	- do not complete
- care-giver STCHC	- complete sections of the A.A.F. usually addressed to the beneficiary and the other sections not covering the same themes and usually addressed to the care-giver	- complete if necessary with the significant person
- other person	- complete sections of the A.A.F. usually addressed to the beneficiary, then the shaded areas addressed to the care-giver with him	- complete if necessary with the significant person
- care-giver INTERM. OR INSTITUT. PROGRAM	- complete sections of the A.A.F. usually addressed to the beneficiary and the other sections not covering the same themes and usually addressed to the care-giver	
- other person	- complete sections of the A A.F. usually addressed to the beneficiary, then the shaded areas addressed to the care-giver with him	

Figure 9: Assessment procedure, depending on the facility, if the interview cannot be completed with the beneficiary

5.4 The unity and integrity of the assessment process

As designed, the questionnaire does not contain important sections and less important sections, questions of fundamental importance and questions dealing with details. The assessor should pay equal attention to each section. The questionnaire is a set of interrelated and complementary articles. An exhaustive collection of data will contain much more information than a simple addition of the answers to each specific question. The importance of a particular question therefore cannot be judged without reference to the surrounding questions, since the answer to a single question often also completes many other questions.

An assessor will naturally tend to give more weight to certain sections of the form, according to his training, experience, his knowledge of the beneficiary and his subjectivity. He must therefore be on his guard against this tendency, as it may distort the information. It is sometimes easier to question the beneficiary on certain aspects of his life than others. The assessor must, nevertheless, force himself to obtain the same "quantity" and "quality" of information relative to the questions that he finds difficult as to those he finds easy.

Furthermore, the questions are arranged in the form in such a way as to enhance, as much as possible, the assessor-beneficiary relationship, rather than to organize data according to a sequence of narrowly defined and clearly demarcated themes. For example, closely related subjects could be dealt with at different points in the interview. This may indeed complicate the task of the multidisciplinary team which will subsequently have to summarize the information to assess the services the beneficiary needs. However, this is justified to the extent that we agree with the hypothesis that the most accurate information possible can only be obtained by structuring the interview in such a way that a climate of trust, a certain complicity, is created between the assessor and the beneficiary, even if this means not arranging the headings strictly by theme.

Similarly, although the "Identification" and "Sociodemographic Information" sections appear at the beginning of the form, they could be completed during the assessment process, or at its conclusion rather than at the outset. At that point, the beneficiary should feel more secure when these questions are asked, and less that he is simply "a case", especially if the assessor takes the trouble to explain that he is obliged to obtain this information to meet certain administrative requirements.

The assessor's task therefore consists of adjusting to each interview situation. If a voluble beneficiary tends to clothe his answer to a particular question with details important to another question, the assessor should avoid cutting him off with the excuse that "we'll come back to that later". Rather, he should try to make a mental note of the relevant information and, when the particular question comes up later in the interview, either skip that question or seek only those items of information still missing.

5.5 Substance and form of the questions

In general, the assessor is expected to put the questions to the beneficiary as they appear in the autonomy assessment form. However, to maintain the form's general nature and to keep as much space as possible for the answers, certain questions have been formulated in a succinct or elliptic manner. Although that kind of formulation may be adequate for the assessor, it does not necessarily promote a good understanding of the question by the beneficiary, the care-giver or the significant person, nor the establishment of a good rapport with the assessor. For such questions, the assessor is not expected to read the form's text word for word. His primary objective is to put the questions in such a way that the respondent understands the meaning. Whenever possible, the assessor brings the questions down to specifics. For instance, instead of asking the significant person if "the beneficiary...", the assessor should ask whether "Mr. Lyons...". In addition, if, from all indications, a question does not apply to the beneficiary, the assessor should simply omit it, writing NA (not applicable) in the corresponding space on the form.

Though the assessor has a certain amount of leeway in how he puts certain questions to the beneficiary, care-giver or significant person, he must, nevertheless, adhere fully to the questions' meaning. The assessor is not to substitute the questions he would like to ask for those contained in the assessment process. This firmness is not gratuitous. Moreover, the professional assessor does not view this as a constraint, since it guarantees the reliability of the assessments.

Should the assessor have some doubt as to the meaning of a question, the mini-guide explains the objectives and meaning of the themes raised in the form.

Open and closed questions, and comments

The questionnaire includes a number of items where it is simply a matter of checking the appropriate box. This is not the essential element in the assessor's information gathering task.

Rather, it is a matter of clarifying, nuancing, giving details and filling in the information in the many spaces (open questions, comments) provided for this purpose in the form. If space is insufficient to record all the relevant information with the necessary nuances, the assessor can attach an additional page or pages to the form.

It is especially important that the assessor comment on any contradictions which may emerge in the beneficiary's various answers, or between the answers given by the beneficiary and those of the key source(s) of information.

It is also important that the assessor note something in each section, even if nothing substantial emerges from that section of the interview. For instance, he could write: "impossible to obtain information" or "no problems" when relevant, rather than leaving a blank which the multidisciplinary team might have difficulty interpreting.

5.6 Bias introduced by the assessor-beneficiary relation

For the assessor and the beneficiary, the interview is but one act of communication among many. It is desired by the assessor, and more or less so by the beneficiary. Factors tending to block or deflect messages sent by each of these persons under other circumstances will also be at work during the assessment. It is up to the assessor to take steps to eliminate or at least mitigate their influence on the communication process. To do so, the assessor must have a good understanding of the dynamics of the relationship underlying any assessment interview, and know the potential sources of error that can influence the situation. It is impossible to fully explore this vast subject in these few pages. We must limit ourselves to a few important reminders, and leave it to the reader to consult the sources we have found useful (*), or any of the several other texts researchers have published on the subject, should he feel the need. It should be noted, however, that a program of reading and theoretical training, though it may be useful in controlling the interview situation, will never provide full and definitive training in assessment. A person learns to assess "in the fray" by observing and analysing how he interreacts with others. Assessment is more art than science, and the only way to master this art is through practice.

(*) Grawitz, M.: Méthodes des Sciences sociales, Précis Dalloz, Paris, 1979.
Mucchielli, R.: Le questionnaire dans l'enquête psychosociale, Editions Sociales françaises, Paris, 1968.
Hyman, H.H.: Interviewing in Social Research, Chicago, University Press, 1954.
Kahn, R.C., Cannell, C.F.: Dynamics of Interviewing, John Wiley, New York, 1957.

We shall now briefly analyze the problems and sources of the most frequently observed errors in the assessor-beneficiary relation.

Problems and errors attributable to the person being assessed

Grawitz maintains that the interview sets in motion a series of interreactions between the assessor and the beneficiary. Not only does each person's idea of the other come into play, but also what each one thinks the other is thinking of him. In this relationship, the beneficiary's defense mechanisms are predominant (*)

In the first place, these mechanisms come into play in his decision to accept or refuse to be assessed. In the situation we are dealing with, the assessor runs less of a risk of being perceived as an undesirable by the person being assessed than in a public opinion poll situation. The beneficiary will agree to the interview more readily because in a sense, he has raised the issue by submitting a service request to the network. It should be noted, however, that the person being assessed generally views the interview as a compromise in order to obtain assistance. In the vast majority of cases, if he could obtain the assistance without going through with the assessment, he would do so. And so, in spite of everything, the assessor will most often appear, at the outset, as an investigator, with all the understandable anxiety that raises in people, apt to fear inquisition and judgment and determined to defend their private life. This phenomenon is likely to be exaggerated in studies undertaken on a sample of individuals to determine the needs of a population, compared to an individual assessment of needs performed to direct a beneficiary toward the most appropriate program in the network. In the first case, the beneficiary is less aware of the advantages he may derive from an assessment he did not initiate, especially if, when it is carried out, he is not receiving services from the network.

(*) Grawitz, M.: op. cit.

The person being assessed will therefore be loath to accept the assessment, and his defense mechanisms will enter into play to the same degree. These mechanisms vary and play a more or less prominent role from person to person. Some will retreat into falsehood, rationalization disconnected from reality, and forgetfulness. However, the most dangerous defense mechanism is **identification;** the situation develops as if the individual were actively (and unconsciously) seeking the assessor's opinion, what the latter wants him to say. The respondent tries to conform to what he feel's is the assessor's idea of him. Although the opposite attitude is less frequent, it does exist. Here, the person being assessed tries to discover how he is perceived by the assessor, then systematically projects the opposite image.

Various means are available to the assessor to reduce defense reactions at the beginning of the interview and to avoid triggering these mechanisms during the interview. The first is to exploit everything that may motivate the respondent to answer truthfully: the obligation he may feel to be polite to a stranger (even if he eventually feels like showing him the door), the desire to see his situation improved, and the simple need to talk. Right from the outset of the interview, the assessor systematically reinforces everything he feels is pushing the beneficiary to answer. At the same time, he tries to eliminate or reduce defensive reactions by being reassuring: by identifying himself, guaranteeing the confidentiality of the answers, telling the respondent how the results of the interview will be used, and emphasizing that there are no "good" or "bad" answers. The assessor should also be sympathetic to the beneficiary, and show an interest in his problems. He should project the image of someone who understands, to whom one can tell everything without being judged. This last attitude is of fundamental importance, and if it is not picked up by the beneficiary, the identification mechanism mentioned earlier will tend to come into play, all the more so if the assessor is friendly toward the beneficiary. Torn by a desire to please and a wish for approval, the beneficiary will unconsciously but systematically warp reality.

Problems and errors attributable to the assessor

Anything in the assessor which tends to increase the defensive reactions of the beneficiary or to reduce his positive reactions can be considered a potential source of bias.

Research has provided ample documentary proof that the assessor's sex, age, and appearance exert a non-negligible influence on the interview situation and definitely affect the beneficiary's answers. If the interviews are conducted by network personnel on a routine basis and are part of the regular work load, there is relatively little that can be done to control these factors. Such is not the case if the assessment is performed by selected assessors as part of case-by-case assessment of a population's needs.

However, perhaps the most serious threat to the results of the assessment is posed by the assessor inducing answers, predicting the beneficiary's answers and how he records these anwers. In its most obvious form, the assessor direcily suggests answers. However, emulation, tone, general attitude, eye contact and vague gestures may all contribute. Induction is all the more effective if the beneficiary is receptive and is on the alert for indications enabling him to conform to how he feels the assessor perceives him. In particular, as already mentioned, if the assessor's attitude is excessively friendly (in trying to create a good rapport) toward beneficiaries who adopt an identification defense mechanism to please the assessor, this attitude necessarily acts as an inducing agent for "correct" (in the beneficiary's mind) answers.

Moreover, it is not so much the assessor's opinions and values that act as a source of bias in the assessment results as his idea of the beneficiary. The assessor may form this idea from a general impression he may have picked up from the beneficiary during their first contact, or he may have built it little by little from answers given during the course of several interviews. In both cases, the assessor will tend to anticipate, based on this idea, the beneficiary's answer, and eventually to "hear what he expects" rather than what the beneficiary said. He will therefore neglect what may be the most interesting and original answers, because they could not be anticipated.

Finally, the assessor's tendency to look for the answers he wants (induction) and to figure the beneficiary out ahead of time (anticipation) are necessarily reflected in the way he records the beneficiary's answers. The assessor who induces or anticipates will record his answers in preference to those of the beneficiary.

5.7 Managing autonomy and medical assessments

The assessment tools we are discussing are designed for use in assessing the needs of beneficiaries suffering a loss of autonomy in order to determine their program direction within the extended services network. They can also be used (and have been on several occasions) to assess the needs of beneficiaries as part of an investigation undertaken mainly for planning purposes within the extended services network. Although this is a very important application, it lies beyond the scope of this text. We shall be discussing only assessment for the purposes of program direction.

An assessment of the beneficiary's autonomy is undertaken when the beneficiary requests services or an increase/change in the services he already receives. It can also be performed at the request of a network organization which believes the services needed by a beneficiary under its care have changed significantly.

As we have seen, under the specific CTMSP process, three distinct stages are covered by the assessment:

- autonomy assessment (including the complementary assessment performed with the significant person in an STCHC or at home);

- medical assessment;

- determination of the services needed (by a multidisciplinary team).

Under the normal procedure, these three steps will be completed. Very little time should be allowed to elapse between the autonomy assessment and the medical assessment. The order in which they are done matters very little, but it is crucial that they be performed at almost the same time so that the beneficiary's condition does not change in the meantime. Similarly, the determination of services needed and the beneficiary's program direction should follow soon after. Delays of several weeks between the stages of the assessment/program direction procedure are unacceptable. Such delays could have a clearly negative impact on the beneficiary and his circle.

The normal procedure is applicable to all beneficiaries in intermediate or institutional programs (ex: foster family, pavilion, reception centre, extended care hospital centre, extended care unit of an STCHC) when their needs are to be (re)assessed.

As for beneficiaries hospitalized in short-term care hospital centre (STCHC), the assessment/program direction procedure is carried out as follows. Any person suffering a loss of autonomy who leaves an STCHC to return home and for whom support care is presumed or a necessity should be assessed using the autonomy assessment form (STCHC version) or, at least, referred to the LCSC in his region for assessment (*). The LCSC will then assess the person's situation and intervene if necessary. If there is a presumption of a change in the beneficiary's living situation (relocation in another home, housing or hospitalization within an intermediate or institutional program), the normal procedure must be followed: autonomy assessment (with the beneficiary and the caregiver), complementary autonomy assessment (with the significant person), medical assessment and determination of the services required.

(*) In this regard, efforts should be undertaken to develop systematic referral mechanisms among the partners of the network, to provide continuity of services.

The strategy for beneficiaries living at home who address a request to the home-care program consists, initially, of using the autonomy assessment form (home-care version) which is sequenced so as to adapt to various situations. As pointed out in the preceding chapter, the "home-care" version of the autonomy assessment form is divided into five parts (A to E), each part corresponding to different stages of the assessment process.

- Part A, "Reception and registration of the request" is completed for every request addressed to the home support program and then forwarded to the appropriate quarter.

- Part B, "Preliminary autonomy assessment", leads to four possible outcomes: the request is rejected, the person is directed to another resource, services are provided on a short-term basis, or the assessment is continued.

For example, a beneficiary who submits a request for services of a limited nature may be provided with the services requested without carrying out the other steps (i.e., C, D and E) of the assessment procedure, if the beneficiary satisfies the conditions required (as defined under the home-care program) to receive these services. Services of a limited nature mean a service that is requested only once, or eventually repeatedly, but either irregularly and very infrequently, or for a short period. For example: a thorough house cleaning, repair work or alteration to the dwelling, injections, bandages, etc.

- Part C of the autonomy assessment form (home-care version) is used when the beneficiary (or other mediator) submits a request for extended services (care or assistance), or when the worker considers a more detailed assessment is warranted, or in accordance with the home support program assessment guidelines.

This part begins with a list of the themes covered in the assessment. Depending on the beneficiary's situation, the assessor indicates the theme(s) to be investigated (ex: physical mobility, functional autonomy, support from the natural network). The assessment can be performed over a more or less lengthy time frame.

When a beneficiary presents major risk factors or if a change in living situation is contemplated, all the themes covered in part C of the form must be covered.

Once completed, the autonomy assessment form (parts A, B and C) is then forwarded to the multidisciplinary team which will determine which services (within the home support program) are required. On the basis of the

information gathered from the beneficiary, this team must decide whether to admit the beneficiary into a home support program or to request the normal assessment procedure.

- At this stage, part D, "Complementary assessment of the beneficiary's autonomy", completed with the significant person, and the medical assessment, may or may not be available to the team. As was pointed out earlier, these forms must be completed if there is a presumption of a change in living situation (or at the discretion of the organization receiving the request), but are optional in other situations.

If, after having studied the case, the home support team contemplates home-care or extended hospitalization for the beneficiary, it must then follow the normal assessment procedure. In this case, the complementary autonomy assessment and the medical assessment are carried out (if not already). The entire file (parts A, B, C and D and the medical assessment) is then forwarded to a multidisciplinary team at the regional or sub-regional level which in turn assesses the services needed. It is then up to the orientation committee to decide which program will be offered to the beneficiary. This is illustrated in Figure 10.

- When a beneficiary receives home support services over a lengthy period of time, part E of the autonomy assessment form is used to update data concerning his autonomy, with a view to an eventual adjustment of the services provided.

This procedure helps to streamline and adapt the assessment procedure in the case of beneficiaries living at home.

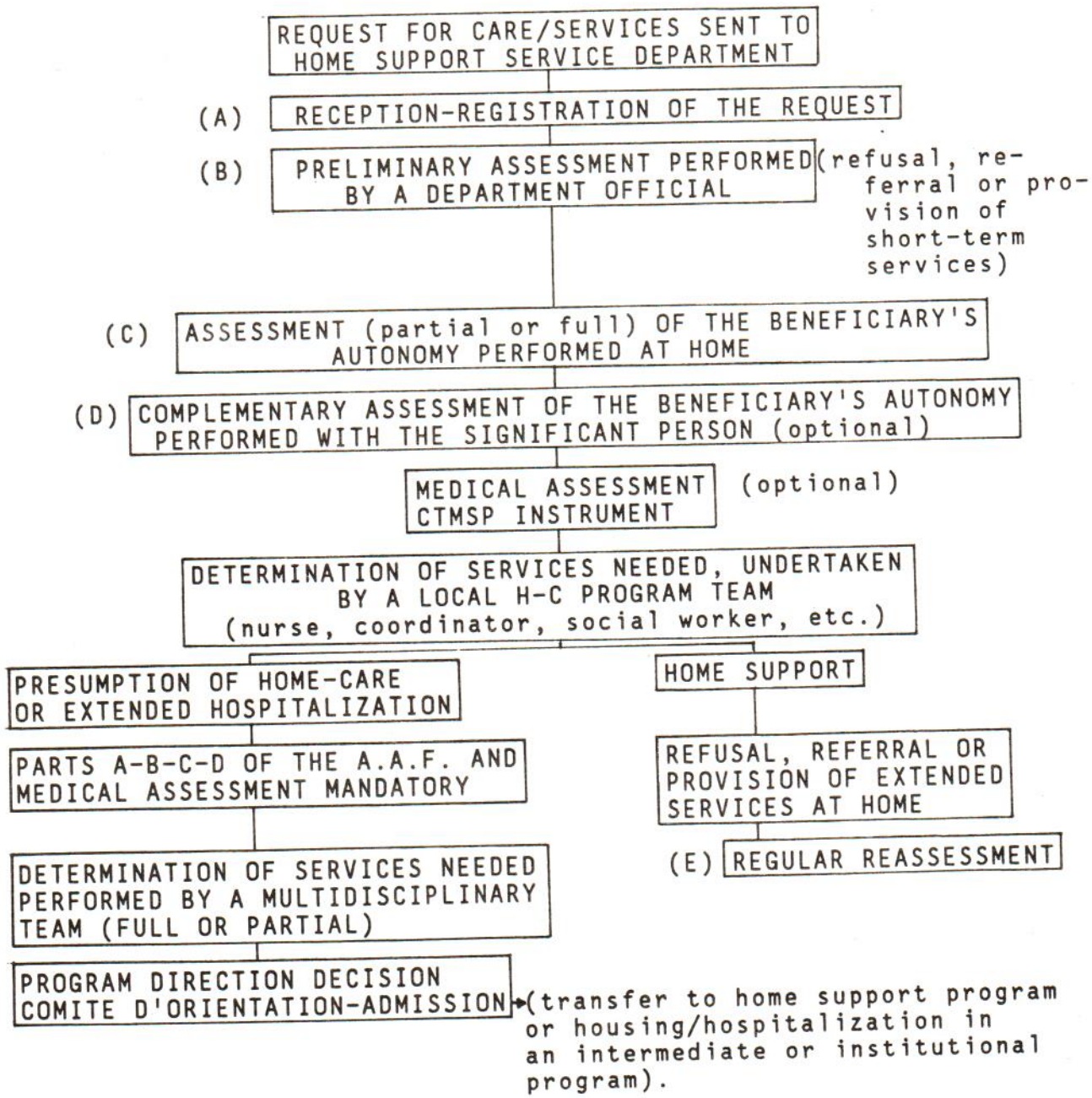

Figure 10: Procedure for assessing the needs of beneficiaries living at home

Occasions may arise in which the multidisciplinary team considers the information provided by the autonomy assessment and medical assessment forms is "insufficient". The data may be insufficient for two reasons:

a) because the information provided by the autonomy assessment and the medical assessment is unclear, inaccurate or ambiguous;

b) because the beneficiary's needs / capacities / disabilities, as well as the capacities of his circle (if applicable) could not be assessed as accurately, exhaustively and consistently as desirable, for reasons beyond the control of the assessor or physician, essentially because neither one had either the time or the means to obtain the information needed.

In situations in which the multidisciplinary team charged with deciding which services are needed feels the information it has been supplied with is insufficient, two options are available:

- it either continues with the assessment of the services required because it does not consider the shortfalls it has come across are such as to impair the quality of its assessment to the extent that the beneficiary's subsequent program direction would be decisively influenced. The multidisciplinary team simply informs the orientation committee of certain weaknesses in the autonomy/medical assessment and in its own determination of the services needed.

- or it decides it is impossible to continue with the determination of the services required. In this case, the source of the shortfalls will determine the subsequent sequence of events.

  . If the shortfalls are attributable to the quality of the assessment, the multidisciplinary team requests that the information submitted be completed.

  . However, if the shortfalls are attributable to limitations in the assessment procedure, the multidisciplinary team will request a more thorough assessment before proceeding. The more thorough assessment may be performed in various ways, depending on the problems presented by the case in question: consultation with a specialist, tests, examinations, admission to an assessment unit, detailed assessment of the capacities of the circle, assessment by a physiotherapist or ergotherapist, etc.

In both cases, the multidisciplinary team will continue with its determination of the services the beneficiary needs once it has received the additional information requested.

5.8 Standardization of the assessment procedure

An assessment process can be legitimately examined from the standpoint of its awkwardness, as to the time needed for an assessment (in passing, it should be noted that the number of pages in an assessment questionnaire is not always a good indicator of the time needed to complete it). The awkwardness of the assessment cannot be measured in isolation. It can only be measured by referring to the information the assessment supplies: half an hour may be excessive to obtain a certain quantum of information, while three hours spent obtaining a different quantum of information may be quite justified. Ultimately, it is up to the experts to decide, based on the relevance and reliability of the information obtained from the assessment, or, from the opposite point of view, on its lack of utility, its redundance and poor credibility. The problem is to decide whether the information gathered by the assessment process could be obtained using a different method, at lower cost and ensuring the same level of "quality".

In answering this question, we cannot ignore the constraints imposed on an assessment procedure by the requirement that it be uniform. When we look at the assessment from the point of view of an individual beneficiary, it is rather obvious that it is always possible to find an individual assessment process that is less cumbersome, for the same quality, than the single process applied to everyone. However, this benefit would be at the expense of the standardization of the assessment procedure. As we indicated above, the price is too high in the kind of situation we are dealing with.

While retaining the principle of uniformity, it could be tempting, again in order to reduce the awkwardness of the assessment process, to introduce certain exemptions to the overall standardization, in the sense that different processes would apply to different categories of beneficiaries. The methodological problem posed by this kind of approach is very difficult. The beneficiary would have to be assigned to a category on an a priori (i.e., prior to the assessment of his needs) basis. As we have mentioned above, we apply this approach only for a very specific category of beneficiaries, the "exceptional" beneficiaries who request very few services, of a limited nature, in other words, beneficiaries who do not make up the regular clientele of the extended services network. As for the network's "regular" clientele, we feel it is dangerous to attempt to categorize individuals a priori in order to select the assessment process to apply to them. In general, such a categorization is based on a request for care or services submitted by the beneficiary. However, such a request is a poor indicator of the beneficiary's real needs. Quite often, the request is primarily a call for help; the form in which it is couched (what is being requested) often means nothing other than: "I need help". There is a risk of being led astray by reading a precise meaning into a request which essentially has no clear focus. Furthermore, the

literature is quite emphatic in stressing that elderly persons (the major clientele of the extended services network) tend to underestimate their condition, and to neglect their health with the excuse that the problems they are experiencing are part of the normal aging process. At the same time, the literature is just as emphatic in stressing that a great deal can be done to improve or maintain the health and quality of life of persons suffering a loss of autonomy, especially for the elderly.

Hence, if it is accepted that a systematic needs assessment process is the first stage in any prevention strategy, then it becomes difficult to justify a categorization of beneficiaries prior to assessment based on the requests they submit and the conditions they report. We therefore believe, for reasons of equity (tied to the methodological problem described above), but especially because we are concerned for the reliability of information, and in view of its impact from a prevention standpoint, that all beneficiaries should undergo the same process for the assessment of their needs.

APPENDICES

APPENDIX I

REVISION OF THE AUTONOMY ASSESSMENT AND MEDICAL ASSESSMENT FORMS

This appendix discusses the agreements reached between the M.S.S.S. and the designers of the system, and the process used in revising and testing the CTMSP during 1984-85.

A - Historical background at the M.S.S.S., and agreements with the system's designers

The Ministère de la Santé et des Services sociaux has, for many years, been concerned with standardizing admission procedures to home-care and extended care resources. In 1974, the M.S.S.S. adopted form AH-250 for admission of beneficiaries into extended care establishments. In 1976, it acknowledged the information file as an assessment tool for admission to home-care resources.

In 1979, as a result of a recommendation from network representatives, the M.S.S.S. decided to undertake an assessment of 1 519 beneficiaries housed in home-care centres and extended care hospital centres, using the CTMSP assessment tool.

And indeed, various representatives of the network (RHSSC, establishment associations, corporations, workers, etc.) had been pressing the M.S.S.S. for quite some time to adopt a standard assessment tool that would be more credible and more reliable than the tools then in use.

During the summer of 1983, the M.S.S.S. formed the Groupe de coordination des services aux personnes âgées, consisting of representatives from the sections of the M.S.S.S. involved, and a representative of the RHSSCs. Selecting a standard assessment and program direction tool for beneficiaries was high on the group's list of priorities.

A working committee consisting of M.S.S.S. professionals and a representative of the RHSSCs analyzed a certain number of tools for assessing needs and recommended that the Groupe de coordination recognize the CTMSP system as the standard tool for the assessment and program direction of beneficiaries in the network. In this way, this tool was recognized as the one best able to meet the objectives of the M.S.S.S., both by the Groupe de coordination

des services aux personnes âgées and by the Comité des sous-ministres.

Following this recommendation, the Comité des sous-ministres entrusted the following mandate to the Groupe de coordination des services aux personnes âgées:

- negotiate with the chief researcher of the system to reach an agreement so that the CTMSP tool could be made available to the regions of Québec;

- begin revising the CTMSP system with the designers, in association with the Comité de normalisation des formules of the M.S.S.S.

An agreement was reached in the summer of 1984, providing for:

- the acquisition by the M.S.S.S., for the token sum of one dollar, of certain of the system's attributes and interests, namely all rights relating to the literary use of the work (printing, publication, distribution, etc.), English translation and transcription onto the following media (microfilm, video, etc.) within the boundaries of the province of Québec;

- the revision of the CTMSP system performed jointly by the M.S.S.S. and the designers of the system.

Although the M.S.S.S. adopted the CTMSP system as a standard tool, the draft "guideline on the organization and administration of establishments" provides that the regions are to select the assessment tool they will use. Currently, use of the system is widespread throughout the network (Québec City, Montréal, Gaspésie). At time of writing, the other regions, with one exception, have confirmed their choice of the CTMSP system. Implementation of the system is scheduled for 1985-86.

B- Revising the CTMSP system (1981 version)

The process of revising the CTMSP system (1981 version) began in April 1984. Responsibility for the undertaking was given to Mr. Pierre-André Bernier, chairman of the Groupe de coordination des services aux personnes âgées (*), Dr. Pierre St-Georges, chairman of the Comité de normalisation des formules du M.S.S.S., and Professor Charles Tilquin, chief researcher of CTMSP and principal science consultant for the revision of the system.

(*) Following the departure of Mr. Pierre-André Bernier, Mrs. Odile Bédard was given co-responsibility for the CTMSP-81 revision process.

Two revision committees were formed, one for the autonomy assessment form and the other for the medical assessment form. The mandates of both committees included a review of the user manual provided with the forms. It was agreed at that time that the forms for the determination of the services needed would be reviewed at a later date, if necessary, based on the results produced by the revision of the autonomy assessment and medical assessment forms.

The two revision committees included network resource persons, users of the system and representatives of various professions and establishments. They were selected by either the Comité de normalisation des formules du M.S.S.S., or by the Groupe de coordination des services aux personnes âgées. The committee charged with revising the autonomy assessment form was made up of one representative from each of five professional corporations, namely, a social worker, a physician, a nurse, an ergotherapist, and a physiotherapist; the other members represented the regions already using the CTMSP system (Montréal, Québec City, Gaspésie) as well as the types of establishments (L.C.S.C., S.S.C., H.C., R.C.). The committee charged with revising the medical assessment form included four physicians, a nurse and a representative of a region using the system. The designers of the system were represented on both committees. The members of the two committees are listed in Appendices II and III.

The major task facing the two committees was to improve the system so that it would better meet the objectives of the M.S.S.S., as well as those of the network and of the beneficiaries.

The objectives of the revision were as follows:

1) improve the structure, arrangement and content of the autonomy assessment and medical assessment forms (CTMSP-81) and the accompanying guide, so as to more accurately pinpoint the beneficiary's illnesses, deficiencies, capacities, disabilities and handicaps (*). Improved instruments would provide a better basis for the multidisciplinary team to determine the services needed, and for the admission/program direction committee to accomplish its work.

(*) For further information concerning the autonomy assessment and medical assessment forms developed in 1981 and the accompanying guide, the following work is recommended:
Tilquin, C., Sicotte, C., et al: CTMSP-81: L'évaluation de l'autonomie et l'évaluation médicale du bénéficiaire, EROS, Université de Montréal, Montréal, 1981, 115 pages.

2) maintain the multi-dimensional character of autonomy assessment by ensuring the tool covers all the person's dimensions and their areas of intersection;

3) ensure that the autonomy assessment form and, when applicable, the medical assessment form, allow persons to be directed, to the extent possible, to the full range of programs (i.e. from home support to institutionalization).

The committees carried on their work with advice and reports from the designers and the users of the CTMSP system, together with various documents from the field covering the assessment of persons suffering a loss of autonomy.

At the department's request, the network bodies concerned (regional boards, associations of establishments, etc.) furnished the committees with criticisms and recommendations concerning the CTMSP tool. This consultation generated sixteen reports (Appendix IV) for the revision committees to study. These reports were submitted by the Conseils Régionaux (3), associations of establishments (4), professional corporations (3), establishments (5) and the Equipe de recherche opérationnelle en santé (EROS). Taken together, these reports amounted to over 400 pages of comments, suggestions, and recommendations, dealing with CTMSP system forms and the utilization of the system, as well as the organization of network services.

The committees debated at length the criticisms, suggestions and recommendations contained in the various reports submitted to them. The themes which generated the greatest amount of discussion included:

- the awkwardness of the CTMSP system (the desirability of a shorter yet more exhaustive form);

- the psychosocial aspect, which some consider "weak" and others would like to split off from the rest of the autonomy assessment form to make up a separate form.

- the relevance of turning to a key information source, i.e. the significant person or the care-giver (the desirability of a more detailed description of this person's role);

- the issue of using the autonomy assessment form for persons hospitalized in an STCHC (the '81 forms were designed for the assessment either of persons in a home-care situation or hospitalized for extended periods, or of persons living at home);

- the issue of using the autonomy assessment form for home service requests (i.e. a desire was expressed to

facilitate the use of the tool as soon as a service request is received, and to simplify the process of directing a person to home support programs);

- lack of information concerning rehabilitation;

- having the assessment completed by one or more workers;

- information and training for workers using the CTMSP system;

- the feasibility of a single instrument (common core) for all facilities, with various sections to be used when needed;

- a more flexible set of utilization guidelines (relaxation of directions addressed to the assessor);

- the development of tools for reassessing a person's autonomy over time (dynamic assessment process);

It can be seen from the above that not only was the structure and content of the forms discussed, but also the conditions for the utilization of the instruments, the adaptation of the assessment process to the various facilities in which the beneficiary may reside, training for workers, etc. In all cases, decisions were arrived at by consensus.

In August 1984, the first amended version of the autonomy assessment (home-care and establishment) and medical assessment forms was submitted to the committees. The (autonomy) revision committee rejected a merger of the two forms (home-care and establishment) into one (common core with specific sections) because it presented major disadvantages in regard to presentation (ex: questions would have to be formulated differently depending on the facility) and utilization (ex: several sections to handle).

Following an examination of the first amended version, the committee members suggested some further changes (ex: grouping by theme, changing the sequence of the themes, reformulating some questions). In addition to the changes sought in regard to structure and content, discussions at this stage focussed on four specific points:

- the need to prepare a separate autonomy assessment form adapted to the STCHC context;

- the best adaptation of the "home-care" autonomy assessment form to the needs of home-care programs;

- the incorporation of an explanatory mini-guide on the back of the forms to ensure better understanding and uniform utilization of the instruments;

- testing the modified forms and consultation with user groups.

The desired changes were made in the (home-care and establishment) forms in October 1984. A third form was developed to meet the requirements of assessments undertaken in an STCHC, and a mini-guide was included on the back of each form. The committee members then decided to go ahead and test the new instruments with the users of the system.

C- Testing the revised forms

C.1 Objectives

The major objectives sought from the test program for the revised forms were as follows:

1) check the structure, content and arrangement (sequence, organization) of the new autonomy assessment form (home-care, STCHC, and intermediary or institutional programs) and of the revised medical assessment form;

2) check whether the new forms provided the data needed by the home support program to allocate services;

3) check whether the new forms provided the data needed by the multidisciplinary teams to assess services needed (improvement compared to the former version from the standpoint of the multidisciplinary teams);

4) check whether the new forms provided the data needed by the admission-program direction committees to carry out their work (improvement compared to the former version from the standpoint of the admission-program direction committees).

C.2 Implementation

Testing was made possible thanks to cooperation from the Conseils Régionaux designated to take part in the operation (Montréal (06A), Québec City (03), Laurentides-Lanaudière (06B) and Bas St-Laurent-Gaspésie (01)). Meetings were held in late December 1984 with representatives of these regional councils to advise them of the test procedure.

Under the procedure, the regional councils, assisted by the participating establishments, were to select assessors already familiar with the CTMSP system (*). As far as possible, the selection was to be representative of the professions and establishments involved. In addition, they were to ensure that the medical assessments were performed (preferably by the attending physician) and the files forwarded to the multidisciplinary teams and admission-program direction committees. They were also responsible for holding information meetings on the testing program and meetings to assess the operation.

In January 1985, six information sessions involving the designated assessors, the coordinators involved and representatives from the multidisciplinary teams and admission-program direction committees were held in each of the participating regions (**). The meetings were held to present an overview of how the matter was progressing within the M.S.S.S., the work accomplished by the revision committees, the objectives and the implementation of the testing program for the new forms. Training sessions were subsequently held for the autonomy assessors and coordinators to acquaint them with how to use the revised forms.

When the testing program was complete, all the assessors involved, all the coordinators, representatives from each multidisciplinary team and from each admission-program direction committee were to provide comments using a questionnaire prepared for this purpose, or verbally during the sessions held in each region.

C.3 Results

In March 1985, following two months of testing, workers were invited to meetings held to assess the test results. The committee was thus able to meet with about 70 assessors who performed almost 200 assessments.

The major comments expressed by the users dealt with the structure, the content and the mini-guide of the autonomy assessment and medical assessment forms.

(*) In each sub-region (14 in all for the 4 regional councils), 5 assessors were to perform 23 assessments distributed as follows: 10 at home, 10 in an STCHC and 3 in an intermediate or institutional resource. In all, 70 assessors were to participate in the testing, and 322 assessments were to be performed.

(**) Testing began only in January 1985 because of delays in composing and printing the new forms.

Content:

- the majority agreed that the content of the autonomy assessment form had been improved. It was described as full, though some complained it was excessively long;

- the grouping of psychosocial themes was well appreciated. The fact that the "rehabilitation" aspect was further developed was also mentioned;

- some suggested that, rather than interviewing a beneficiary hospitalized in an STCHC, the care-giver and the significant person could be questioned instead;

- further details were requested concerning the roles of the significant person and the care-giver in the assessment process;

- the autonomy assessment form was used only infrequently for home support programs and the few comments from professionals failed to agree on the relevance of the content of the form;

- some professionals were of the opinion that a properly completed medical certificate would be sufficient for program orientation in many cases;

- it was generally felt that the medical assessment form had been greatly improved; it need only be properly completed in the future;

- it was recommended that users (assessor, physician, members of the multidisciplinary teams, etc.) be thoroughly trained to better understand the system.

Structure:

- some professionals asked for a sequence of themes such as would permit the division of the autonomy assessment form into two distinct parts: the assessment of functional autonomy and the so-called psychosocial assessment;

- the forms' visual aspect was criticized: the forms appeared heavy, difficult to handle, the print was too small, etc.

The mini-guide:

- the inclusion of the mini-guide in the form was appreciated. However, additional instructions were requested regarding, among others, the choice of autonomy assessment form (home-care, establishment, STCHC) as well as in

regard to the procedure to follow in the event the beneficiary cannot participate in the assessment.

Following the testing program, the committees also noted, from the comments made by the users and from meetings with them:

- the lack of knowledge as to the procedure for the overall assessment;

- the shortage of information on the CTMSP system and of training in the use of the instruments;

- the workers' lack of information on regional organizational structures, in particular with regard to assessment and admission-program direction mechanisms.

Until 1984, the regions used the CTMSP system almost exclusively to assess and direct beneficiaries toward institutional resources. The testing program sought to involve home support program workers. In this regard, however, the results were not significant, given the limited number of assessments performed in the latter program and the contradictory results obtained (*).

D- The committees' work after the testing program

Once the testing was complete, the committee revising the autonomy assessment form held five meetings to finalize the document. Henceforth, the document will be available in three versions adapted to the facility in which the beneficiary resides at the time of his assessment:

- cared for or hospitalized in an intermediate (foster family, pavilion) or institutional (HCC or STCHC) program;
- hospitalized in a short-term care hospital centre (STCHC);
- home-care.

(*) Since the form has never been used systematically under the home support program, the revision was not based on field test results. We therefore suggest that the M.S.S.S. closely monitor the implementation of the CTMSP system in home support programs and eventually, if a need to do so should become apparent, undertake a revision of the corresponding version of the form.

The "home-care" autonomy assessment form has undergone major changes as to its structure, so that it is now more closely aligned with the realities of the assessment process in home-care programs (*). The questions put to the significant person have been removed from the autonomy assessment form (home-care and STCHC) and grouped in a separate complementary form. However, the questions addressed to the care-giver remain part of the autonomy assessment form for "STCHC" and "intermediary and institutional programs" facilities. Finally, corrections were made in the form's content and structure (ex: more room for answers, larger print, ...).

Following the completion of the testing program, the committee charged with revising the medical assessment form was able to finalize its work at a single meeting.

The committees' work extended over a much longer period than had been anticipated (14 months rather than 6), because, in particular, the consultation undertaken by the M.S.S.S., in April 1984, generated a significant quantity of comments which forced the committees to discuss the same themes more than once, as the recommendations submitted were far from unanimous, and frequently even contradictory. Furthermore, objectives of the various workers in the network are not necessarily harmonious.

Despite the improvements in the forms and the directions for their use, the members of the committees are aware that they were not able to satisfy all the requests submitted to them. However, they remain convinced that the new instruments, the outcome of the 84-85 revision, are operational and must be tested over a long period of time before a further revision can be usefully undertaken (**).

(*) The revised "home-care" autonomoy assessment form was presented during the conference held February 20, 1985 on the theme "Grille commune d'évaluation en maintien à domicile", organized by the Direction des Services Communautaires of the Montréal RHSSC. The comments expressed by the participants at the conference, as well as those of workers who took part in the testing program for the revised CTMSP forms unanimously agreed on the necessity of a sequenced assessment process for home support services.

(**) For further information concerning the 1984-85 CTMSP revision process, the reader is referred to the "Rapport du Comité de révision du Formulaire d'évaluation de l'autonomie, Système CTMSP", submitted to the M.S.S.S. by the revision committees in June 1985.

APPENDIX II

MEMBERS OF THE COMITE DE REVISION DU FORMULAIRE D'EVALUATION DE L'AUTONOMIE

1. Appointed by the groupe de coordination des services aux personnes âgées

Bédard, Odile	Groupe de coordination des services aux personnes âgées, M.S.S.S. - head of the Comité de révision
Bilodeau, Claude	Directeur des ressources du Troisième âge - Centre de services sociaux du Montréal Métropolitain, appointed by the Montréal R.H.S.S.C.
Boulet, Ginette	Director of nursing services - Foyer de Loretteville
Desgagnés, Janine	Regional coordinator, Programme d'évaluation et de coordination des admissions (PECA) - RHSSC-03 (Québec City)
Lemasson, Mireille	Head of the Programme de gérontologie et de maintien à domicile - DSC Maisonneuve-Rosemont (Montréal)
Poulin, Chantale	Social worker - CLSC Malauze, Gaspésie

2. Appointed by the Comité de normalisation des formules du M.S.S.S.

Bouffard, Louiselle	Comité de normalisation des formules - Ordre des infirmières et infirmiers du Québec
Dionne, Claire	Corporation professionnelle des travailleurs sociaux du Québec, head of social service, CH Notre-Dame, Montréal
Drolet, Dr. Michel	General practitioner, head of the extended care unit, Hôpital du St-Sacrement

Dubé, Annie	Corporation des ergothérapeutes - CH Henri Charbonneau, Montréal
Lavoie, Agathe	Corporation des physiothérapeutes, DSC - CH de l'Université Laval, Sainte Foy
Lemay, Louise F.	Ordre des infirmières et infirmiers - CLSC La Source, Québec

3. Representatives of the Equipe de recherche opérationnelle en santé (EROS), Département d'administration de la Santé, Université de Montréal

Tilquin, Charles	CTMSP researcher and science consultant
Fournier, Johanne	Research worker

APPENDIX III

MEMBERS OF THE COMITE DE REVISION DU FORMULAIRE D'EVALUATION MEDICALE

1. Appointed by the groupe de coordination des services aux personnes âgées

Desgagnés, Janine	Regional coordinator, Programme d'évaluation et de coordination des admissions (PECA) - RHSSC 03 (Québec City)
Drolet, Dr. Michel	General practitioner, head of the extended care unit, Hôpital du St-Sacrament
Lambert, Louise	Member of a multidisciplinary team, liaison nurse, Hôpital Maisonneuve-Rosemont

2. Appointed by the Comité de normalisation des formules du M.S.S.S.

Grand'Maison, Dr. Yvon	Representative of the Fédération des médecins omnipraticiens du Québec
Patry, Dr. Paul-Emile	Representative of the Fédération des médecins spécialistes du Québec
St-Georges, Dr. Pierre	Chairman of the Comité de normalisation des formules du M.S.S.S. - head of the Comité de révision

APPENDIX IV

LIST OF REPORTS SUBMITTED TO THE COMMITTEES REVISING THE AUTONOMY ASSESSMENT AND MEDICAL ASSESSMENT FORMS

Health and social service councils (3)

. Québec City region
. Metropolitan Montréal region:
  - Housing section
  - Community service section (June 1985)

Associations of establishments (4)

. Fédération des CLSC du Québec
. Association des centres d'accueil du Québec
. Association des hôpitaux du Québec
. Association des centres de services sociaux du Québec

Professional corporations (3)

. ergotherapists
. physiotherapists
. speech therapists and audiologists (February 1985)

Establishments (5)

. Centre de services sociaux de Québec
. Centre de services sociaux du Montréal Métropolitain
. Centre de services sociaux Laurentides-Lanaudière
. Baie des Chaleurs sub-region (CH- Baie des Chaleurs and Pavillon Benoît-Martin (CHSP) - CAH, Résidence St-Joseph - CA- de la Baie, CLSC Malauze, CLSC Chaleurs, CSS- GIM, Bonaventure branch)
. Comité de liaison de la sous-région Maisonneuve-Rosemont, Montréal

Equipe de recherche opérationnelle en santé de l'université de Montréal

Gouvernement du Québec
Ministère de la Santé et des Services sociaux

APPENDIX V

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

BIO-PSYCHO-SOCIAL AUTONOMY ASSESSMENT FORM

(Facility: intermediate or institutional resources)

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General Instructions: This form is to be used for a beneficiary already placed in an intermediate (foster home, pavilion, etc.) or institutional facility. Home Care Center (HCC), Extended Care Hospital Center (ECHC), etc.

MINI-GUIDE

Note: *The masculine form is used to designate both men and women.*

The first four sections are used to obtain general information concerning the beneficiary.

1- The first section is used to identify the beneficiary, resource-person, care-giver, other professional(s) who participated in the assessment and finally, the assessor.

BENEFICIARY'S FAMILY NAME AND GIVEN NAME AT BIRTH, AND FAMILY NAME OF SPOUSE.
If a woman beneficiary is separated, divorced or a widow but continues to use the name of her spouse, be sure to record the name she normally uses.

The **RESOURCE-PERSON** is defined as the person upon whom the beneficiary can call in time of need (ex: a child, friend, neighbour, etc.). During the assessment and orientation process, this person may also act as intermediary between the assessor or health/social worker and the beneficiary.

The **CARE-GIVER** belongs to the staff of the establishment where the beneficiary resides. He knows the beneficiary well and may also be a key source of information in assessing autonomy. The care-giver is called upon to provide information concerning the beneficiary's sensory-motor capacity, his functional autonomy, the specific care he requires, his habits, intellectual capacities, emotional condition and behaviour.

During the assessment process, the assessor in charge of the case may call upon the services of one or more **PARTICIPATING PROFESSIONAL(S)**. In such cases, the assessor must indicate his(their) name(s) and profession(s).

The **ASSESSOR** is the person in charge of the process of assessing the beneficiary. He must record his name, specify the establishment he is attached to, provide his telephone number at work and indicate the date of the assessment.

The **ASSESSMENT DATE** is the date on which the assessment process is completed, more specifically, the date the form is filled in. It is very important that all the information entered on the form at that time reflect the beneficiary's current condition.

1- IDENTIFICATION

Name and family name of the beneficiary at birth	Name of spouse

Health insurance no.	Social insurance no. (if available)

Name of the establishment	Date of admission

Resource-person: .....

Address: .....

Telephone no.: (home) ..... (office) .....

Relation to beneficiary: .....

Comments: .....

.....

Care-giver: ..... Telephone: .....

Professional(s), other than the assessor and the care-giver, who have participated in the assessment of the beneficiary's autonomy:

Name: ..... Profession: .....

Name: ..... Profession: .....

Assessor: .....

Establishment: ..... Telephone: .....

Assessment date: .....

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For a beneficiary with **NO SCHOOLING**, you are requested to indicate whether he is able to read and write.

The assessor specifies the beneficiary's **ETHNIC ORIGIN** and **RELIGION** if he feels this information is relevant to the assessment and eventual placement. If need be, he provides details on these aspects if he feels they may have a significant impact on placement.

MAIN OCCUPATION(S) means the activity (remunerative or not) to which the majority of the beneficiary's time is (or was) devoted.

ection 3 is reserved for information concerning the beneficiary's current residence and former residence. In part A, ıe assessor indicates the beneficiary's current residence type, the beneficiary's reasons for seeking this accomoda-on and finally, the reasons given by the establishment for his admission. The second part is reserved for information ılative to the beneficiary's former residence.

ıB- The purpose of the question "...is that **PLACE** still **IMPORTANT** to you?" is to learn whether the beneficiary is still attached to the place where he spent the greater part of his life, whether he still lives there or not (ex. family or friends, feeling of belonging, attachment to surroundings, etc.) This information may be relevant for the beneficiary's placement.

2- SOCIODEMOGRAPHIC INFORMATION

Date of birth (year / month / day)	Age	Sex	Place of birth
		☐F ☐M	

MARITAL STATUS ☐single ☐widowed ☐divorced ☐separated ☐religious

☐married ☐de facto union → age of spouse_____

for how many years, (excluding single)? _____

LANGUAGE ☐French ☐English ☐other, specify: _____

SCHOOLING ☐no schooling → can he read? ☐yes ☐no can he write? ☐yes ☐no

☐elementary /primary ☐high school ☐vocational/technical ☐collegiate/classical ☐university

Ethnic origin (if relevant)	Religion (if relevant)

Main occupation(s)

3- TYPE OF RESIDENCE/REASONS FOR ADMISSION

A- CURRENT RESIDENCE

☐Foster home ☐Pavilion ☐Home-care centre ☐Rehabilitation centre

☐Extended care unit of a short-term HC ☐Extended care HC

How long have you been here? _____

REASONS FOR ADMITTING THE BENEFICIARY: in your own words, outline the reasons *(health or social)* for your admission:

.....

.....

.....

.....

.....

.....

.....

.....

.....

REASON(S) FOR ADMITTING THE BENEFICIARY ACCORDING TO THE ESTABLISHMENT: .....

.....

.....

.....

.....

.....

B- FORMER RESIDENCE

Where did you live before you were admitted here?

☐private residence ☐institution, type: .....

place: ..... place: ..... for how long:.....

In which city *(region, municipality,...)* did you live for the longest period of time?.....

Is that place still important to you? ☐yes ☐no

If yes, why? .....

.....

.....

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4 - The **MEDIATOR OF THE REQUEST** is the person who requests the service on behalf of the beneficiary. This could be the beneficiary himself, a member of his family (spouse, child, etc.), a person from his circle (friend, neighbour, etc.) a staff member of the establishment or another organization: Local Community Service Center (LCSC), Social Service Center (SSC) etc.

FACTORS TRIGGERING THE SERVICE REQUEST OR PROBLEMS AS DESCRIBED BY THE BENEFICIARY.

The assessor indicates the factors which, according to the beneficiary, have led him to submit a service request. These factors may relate to health (ex: mental or physical problems) or be of a social nature (ex: problem with family, with the staff, etc.).

If the mediator is not the beneficiary, the assessor completes the section entitled **REASONS GIVEN BY THE MEDIATOR, OTHER THAN THE BENEFICIARY, IN SUPPORT OF THE SERVICE REQUEST.**

*Section 5 is reserved for information concerning the beneficiary's sensory abilities, **here understood as his "Eyesight, hearing and speech". In the event of a particular sensory problem, the assessor is requested to attach any specific examination report available (ex: speech therapy).***

5- A **MINOR LIMITATION** means a reduction in capacity which has very little or no affect on the beneficiary's ability to carry out his usual activities. The **MAJOR LIMITATION** category is used when the impairment is sufficiently serious to hinder the beneficiary's ability to carry out normal activities necessary for his well-being.

Examples of **TYPE OF AID/SUBSTITUTION**

— sight: eyeglasses, contact lenses, magnifying glass, large print, etc.
— hearing: loud voice, shouts, hearing aid, lip reading, telephone amplifier, TV decoder, etc.
— speech: written communication, gestures, sign language, shouts, sighs, etc.

4- CONTEXT OF THE REQUEST

Mediator of the request

☐ Beneficiary ☐ other person

Date of the request

_____

Name: ..... Telephone .....

Relation to beneficiary: .....

Has the beneficiary been informed of the request made for him?

☐ yes, does he agree? .....

.....

☐ no, why? .....

.....

Factor(s) triggering the service request or problems *(health or social)* as described by the beneficiary

.....

.....

.....

.....

.....

.....

Reason(s) given by the mediator, other than the beneficiary, in support of the service request.

.....

.....

.....

.....

Service(s) requested by the mediator: .....

.....

.....

5- EYESIGHT, HEARING AND SPEECH

Do you (does he) have difficulty:		Excluding the aid(s) /substitution(s) used				Aid(s)/substitution(s)?				
		Adequate	LIMITATION Minor	LIMITATION Major	TOTAL LOSS	NO	YES	ADEQUATE?	INADEQUATE?	Type of aid(s)/substitution(s) used? Comments
SEEING?	Beneficiary									
	Care-giver									
HEARING?	Beneficiary									
	Care-giver									
SPEAKING?	Beneficiary									
	Care-giver									

Comments:

.....

.....

.....

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.....

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Section 6 is used to obtain detailed information as to the beneficiary's "Physical Mobility". This is assessed in relation to three aspects: limitation or loss of one or more limbs or parts of the body, rehabilitation and range of mobility. The first aspect (6A) concerns physical impairments that limit the beneficiary's movements. The second aspect (6B) specifies any rehabilitation program already undertaken in regard to the mobility problems identified. Finally, the last aspect (6C) is used to assess the beneficiary's ability to move about on his own within his environment, i.e. without help from others but taking the aid(s) used into account.

6A- A description of the nature of the problem must be given for each part of the body affected by a **LIMITATION** (ex: trembling, problems with gripping, pain, etc.). An indication must also be given as to **HOW LONG** the beneficiary has been affected by the problem. Since mobility problems are to a large degree progressive in nature, it will not always be possible to give a precise date. In such cases, an estimate of when the problem first appeared should be given.

The question "Are you... (the beneficiary is...) **RIGHT-HANDED OR LEFT-HANDED?**" provides an essential item of information for rehabilitation workers. When related to data concerning the impairments, this information helps to more accurately determine how serious the loss of autonomy is and thus to better assess what type of intervention is required. For example, a right-handed person suffering from hemiplegia on the right side does not experience the same type of difficulties as a left-handed person with the same affliction. He may therefore, by that very fact, need services of a different nature.

In the **AID(S) USED** section, it is important to indicate only those the beneficiary actually uses. For example, he may own a walker, but never use it.

Also, if the beneficiary uses a **PROSTHESIS or ORTHOPEDIC APPLIANCE**, the assessor is requested to specify the type.

An **ORTHOPEDIC APPLIANCE** is used to correct a limb or part of the body suffering from a limitation (ex: orthopedic shoe).

A **PROSTHESIS** acts as a full or partial replacement for a limb or organ (ex: an artificial leg).

When the beneficiary uses one or more aid(s), you must indicate whether he **NEEDS ASSISTANCE** to use it. This may involve help:

— in installing (ex: putting on, removing, attaching, adjusting a prosthesis, etc.)

— in transferring (ex: from a wheelchair to a bed, the bath, the toilet, the car, etc.)

— in moving (support, pushing a wheelchair, etc.)

6- PHYSICAL MOBILITY

A- Limitation or loss of one or more limbs or parts of the body

BENEFICIARY: Do you have difficulty with certain movements? ☐yes ☐no

CARE-GIVER: Does the beneficiary have difficulty with certain movements? ☐yes ☐no

Part(s) of the body	Description of the limitation for each part affected; for how long?	
	Beneficiary	Care-giver
Right or left hand		
Right or left arm		
Right or left hip		
Right or left leg		
Right or left foot		
Right or left side of body		
Cervical region		
Spinal column		
Generalized		

Are you... (Is the beneficiary...)? right-handed? B ☐ C-G ☐ left-handed? B ☐ C-G ☐

Do you use (does he use) any of these aids?

B	C-G		B	C-G	
☐	☐	none	☐	☐	orthopedic appliance:.....
☐	☐	cane	☐	☐	prosthesis:.....
☐	☐	walker	☐	☐	wheelchair (manual)
☐	☐	tripod, quadripod	☐	☐	motorized wheelchair
☐	☐	ramps, support bars	☐	☐	other:.....

Does he own it? C-G ☐yes C-G ☐no

If any aid is used: do you (does he) need help to use it?

(ex.: for moving, transfer, installation, etc.)

B ☐ C-G ☐no

☐ ☐yes, specify the type of assistance required: .....

.....

.....

Comments:

.....

.....

.....

.....

.....

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6B- This part covers the **REHABILITATION** aspect.
The assessor attaches any relevant rehabilitation report.

6C- The beneficiary's **RANGE OF MOBILITY** refers to the "distance" he is able to move on his own from a fixed point, in this case, his bed. A person's range of mobility can change with age. The normal range of mobility is then considered as the usual range of mobility for persons of the same age group. In the following scale, the first three categories cover a normal range of mobility while the remaining categories correspond to a progressively more restricted range of mobility.

The categories are mutually exclusive, so the two respondents are to indicate only one each. If the "full mobility" category is indicated (by either respondent), the assessor moves directly to section 7 (for the responcent in question). If not, he completes the other questions of section 6C.

The categories are defined as follows:

- **Full mobility:** persons in this category have a normal range of mobility.

- **Full mobility with occasional restrictions:** this category includes persons with intermittent disabilities (changing course of the illness, for instance, in the case of rheumatoid arthritis or osteoarthrosis, persons suffering from bronchitis whose mobility is restricted by temporary climatic constraints, persons with severe asthma....) Except for periods of temporary disability, these persons have a normal range of mobility.

- **Full mobility at reduced speed:** this category includes persons with a normal range of mobility except that they move more slowly as a result of, for example, poor eyesight, insecurity, or, in an urban setting, because of difficulties in using public transportation, although the person always manages to overcome these difficulties without assistance from others.

- **Full mobility over a reduced range:** this category includes persons whose mobility is reduced as a result of, for example, problems with eyesight, insecurity, fragility, weakness, cardiac or respiratory problems; or in an urban setting, as a result of their inability to use public transportation at all times. These persons can move about without assistance beyond the immediate surroundings of their residence, but cannot go everywhere "without assistance". Their range of mobility is thus more restricted than a normal range.

- **Mobility restricted to the establishment and its surroundings:** this category includes persons whose movements are ordinarily limited to the area surrounding the establishment.

- **Mobility restricted to the establishment:** persons in this category normally can move about only within the establishment.

- **Mobility restricted to the floor the room is located on:** persons in this category normally can move about only on the floor where their room is located.

- **Mobility restricted to the room:** persons in this category are restricted to their room.

- **Mobility restricted to the chair:** persons in this category are confined to their chair.

- **Mobility nil:** persons in this category are confined to a bed.

Note: *the preceding scale was adapted from the ICIDH - WHO - 1980.*

FACTORS RESTRICTING MOBILITY designate the indicators that may help to understand what is restricting the beneficiary's mobility. Factors inherent to the beneficiary do not necessarily correspond to an established medical diagnosis

6- PHYSICAL MOBILITY (continued)

B- REHABILITATION (if mobility problems have been previously indicated)

Have you (has he) previously undergone rehabilitation for your (his) mobility problems?

Beneficiary

☐ yes, specify: .....

☐ no, why? .....

Care-giver

☐ yes, specify: .....

☐ no, why? .....

Comments: .....

C- RANGE OF MOBILITY

Bearing the aid(s) in mind, BUT EXCLUDING ASSISTANCE FROM OTHERS:

Beneficiary: how freely can you move about?

Care-giver: how freely can the beneficiary move about?

B	C-G	
☐	☐	full mobility → **Move to 7**
☐	☐	full mobility with occasional restrictions
☐	☐	full mobility at reduced speed
☐	☐	full mobility over a reduced range
☐	☐	mobility restricted to the establishment and its surroundings

B	C-G	
☐	☐	mobility restricted to the establishment
☐	☐	mobility restricted to the floor the room is located on
☐	☐	mobility restricted to the room
☐	☐	mobility restricted to a chair
☐	☐	mobility null/confined to bed

Specify the factor(s) restricting mobility

Inherent to the beneficiary

B	C-G	
☐	☐	restriction in the mobility of one or more limbs
☐	☐	amputation of one or more limbs
☐	☐	problems with balance
☐	☐	psychological problems
☐	☐	cecity

B	C-G	
☐	☐	obesity
☐	☐	cardiac problems
☐	☐	respiratory problems
☐	☐	inactivity, low activity level
☐	☐	other, specify: .....

Independent of the beneficiary

B	C-G	
☐	☐	structural barriers, specify: .....
☐	☐	lack of physical resources, specify: .....
☐	☐	other, specify: .....

If the factor(s) is(are) independent of the beneficiary, specify what his range of mobility might be if such obstacle(s) were removed.

.....

.....

.....

Comments: .....

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Section 7. "Functional Autonomy", is designed to assess the beneficiary's ability to perform a number of everyday tasks. The tasks included in this section were chosen to represent the range of tasks a person regularly carries out to maintain health and well-being. They are grouped by theme.

7- For each activity, the beneficiary is graded according to the four following degrees of autonomy:

- The beneficiary performs the activity **UNAIDED.**
- The beneficiary requires **ASSISTANCE FROM OTHERS** to perform the activity.

This may involve supervision, monitoring, partial assistance, etc. In each case, the assessor must obtain the information from the care-giver relative to the type of assistance given.

- The beneficiary does not perform the activity, somebody else does it for him. In other words, the activity is performed **BY OTHERS.**

- The category **ACTIVITY NOT PERFORMED** covers a situation in which the activity is simply not performed, neither by the beneficiary nor by somebody else. (ex: going out of doors in winter)

As indicated on the right side of the table, if an activity is performed **WITH ASSISTANCE FROM OTHERS, BY OTHERS or NOT PERFORMED,** it is important that the assessor obtain from the care-giver the reasons for this situation. If the reasons are independent of the beneficiary (ex: rules of the establishment, structural barriers, etc.), the care-giver must give some indication of the beneficiary's POTENTIAL to perform the activity in question.

The activities we are concerned with are as follows:

Serving a meal: preparing a plate or tray, sitting down to eat.

Eating: cutting or otherwise manipulating food, eating and drinking during meals and snacks.

Preparing light meals: preparing snacks, lunch,...

Preparing full meals: preparing adequate and substantial dishes (combining, mixing, cooking, ... food).

Taking medicine: following the instructions of the prescription(s), opening the container(s) and taking the medicine.

Washing oneself: preparing the sink or basin, the toiletry articles, washing and dressing oneself regularly.

Shaving: shaving, rinsing.

Taking a bath/shower: running the bath, entering the bathtub (or shower), washing oneself, getting out of the bathtub (or shower), drying oneself.

Washing one's hair: preparing the articles required, washing the hair, drying, storing the articles.

Dressing/undressing: preparing the clothes to be worn, putting them on, tying one's shoes, putting on accessories, undressing and storing the clothes.

Using the toilet: undressing (as needed), settling oneself on the toilet or commode, cleaning, getting up, dressing.

Getting up/lying down: moving from a lying position to a standing position and getting back into bed.

Walking: going from on place to another, moving on foot (with or without mechanical aid) (excluding going up/down the stairs and getting about in a wheelchair).

Going outside - summer: walking at least a short distance outside in the summer and returning with little difficulty.

Going outside - winter: walking at least a short distance outside in the winter and returning with little difficutly.

Going up/down the stairs: using the stairs either to go up or come down.

Shopping: going outside to do one's shopping.

Using the telephone: picking up the receiver, dialing the number and communicating.

Doing regular housework: performing the usal household tasks such as dusting, ironing, etc.

7- FUNCTIONAL AUTONOMY

Do you (does he) perform the following activities?	BENEFICIARY Act. performed: Unaided	BENEFICIARY Act. performed: With assistance from others	BENEFICIARY Act. performed: By others	BENEFICIARY: Activity not performed	CARE-GIVER Act. performed: Unaided	CARE-GIVER Act. performed: With assistance from others	CARE-GIVER Act. performed: By others	CARE-GIVER: Activity not performed	If "**With assistance from others**", specify the type of assistance given. If "**Activity performed with assistance from others, by others or not performed**", indicate the reason(s) and if independent of the beneficiary, mention his potential to perform the activity in question.
- serve your own meals									
- eat									
- prepare light meals (lunch)									
- prepare full meals									
- take care of your medicine									
- wash yourself									
- shave									
- take a bath/shower									
- wash your hair									
- dress, undress									
- use the toilet									
- get up/lie down									
- walk									
- go outside - summer									
- go outside - winter									
- go up/down the stairs									
- do your shopping									
- use the telephone									
- do regular housework									
- other									
-									
-									

Comments:

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SHORT-TERM refers to a period of less than three months.

In section 8, "Elimination", the assessor must specify the frequency with which incidents of incontinence occur, either on a daily or weekly basis. Regardless of whether the beneficiary uses an aid or not the assessor must specify whether an aid is needed, and give details of any problem(s) related to incontinence, such as: the person must be taken to the toilet regularly, access to the toilet is restricted by structural barriers or distance, the person is unable to clean himself, etc.

Section 9, "Specific Care Required" is to be completed with the care-giver. If the beneficiary needs a particular type of care, it is important to provide as much information as possible concerning the administration of such care. For instance, the beneficiary needs some form of assistance to clean a stomy at regular intervals.

7- FUNCTIONAL AUTONOMY (continued)

To be answered by the beneficiary and the care-giver

During the past year, your ability to perform these various activities...	B	C-G
has improved	☐	☐
has not changed	☐	☐
has decreased	☐	☐
has decreased markedly	☐	☐

Explain: .....

To be answered by the care-giver

Do you anticipate any improvement in the short term in the beneficiary's ability to perform these activities? ☐yes ☐no

If yes, specify: .....

Comments: .....

8- ELIMINATION

Beneficiary

Do you suffer from incontinence...?

Urinary ☐no ☐yes→ ☐diurnal ☐nocturnal

frequency: .....

☐no aid
☐condom ☐catheter
☐incontinence pad

☐no aid required
☐aid required, specify: .....

Fecal ☐no ☐yes→ ☐diurnal ☐nocturnal

frequency: .....

☐no aid
☐colostomy
☐incontinence pad

☐no aid required
☐aid required, specify: .....

Give details of any problem: .....

Care-giver

Does the beneficiary suffer from incontinence?...

Urinary ☐no ☐yes→ ☐diurnal ☐nocturnal

frequency: .....

☐no aid
☐condom ☐catheter
☐incontinence pad

☐no aid required
☐aid required, specify: .....

Fecal ☐no ☐yes→ ☐diurnal ☐nocturnal

frequency: .....

☐no aid
☐colostomy
☐incontinence pad

☐no aid required
☐aid required, specify: .....

Give details of any problem: .....

Comments: .....

9- SPECIFIC CARE REQUIRED (if relevant)

Care-giver

Indicate the specific care the beneficiary currently requires *(attach nursing report, if relevant)*

☐gastric feeding tube ☐oxygen ☐suction of secretions ☐insulin ☐stomy ☐disimpacting ☐bandage(s)

☐other .....

Remarks *(ex.: beneficiary is autonomous or needs assistance, type of assistance, frequency, etc.)* .....

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Section 10 deals with the beneficiary's "Habits". Quality of sleep, tobacco use, consumption of alcohol, diet and the associated events are important facets of everyday life. The beneficiary's opinions on these aspects are an indication of his well-being and, when related to other information from the autonomy assessment, are useful in gauging the scope of some of his problems or their consequences on his health (ex: quality of sleep versus consumption of soporifics, type of diet versus financial problems, etc).

10- TOBACCO-ALCOHOL

If the beneficiary smokes or consumes alcohol, the assessor must pay particular attention to the problems which may accompany these habits.

TOBACCO: "Is MONITORING needed when the beneficiary smokes?"

Monitoring means the presence of or assistance by another person or any form of protection (ex: protective apron).

The beneficiary's **DIET** is entered under the major food categories. With this information, it should be possible to detect any eventual deficiencies compared to the categories of food needed for a balanced diet.

SUBSTITUTES include eggs, cheese and leguminous plants (ex: chickpeas), among others.

The **BREAD AND CEREALS** category also includes starchy foods (ex: rice, pasta).

10- HABITS

Beneficiary

REST-SLEEP

In general, are you satisfied with your sleep? ☐yes ☐no

If not, why? .....

Do you take a nap during the day? ☐yes ☐no

TOBACCO-ALCOHOL

Do you smoke? ☐yes ☐no

Comments: .....

Do you consume alcohol (beer, wine, spirits)? ☐yes ☐no

Comments: .....

APPETITE - FOOD - DIET

Do you USUALLY have a good appetite when you eat? ☐yes ☐no

Where do you usually eat?

☐cafeteria
☐common room ☐room { ☐chair ☐bed

Did you consume...?	Dly.	Wkly.	Rarely or never
• milk and milk products	☐	☐	☐
• meat and substitutes	☐	☐	☐
• fruits/vegetables	☐	☐	☐
• bread and cereals	☐	☐	☐
• sweets, dessert, soft drinks,	☐	☐	☐
• water	☐	☐	☐
• coffee, tea	☐	☐	☐
• others			

Remarks: .....

Are you currently on a diet? ☐yes ☐no

If yes, what kind of diet? .....

Was it prescribed by a physician ☐yes ☐no

DENTITION

Do you have problems with your teeth (natural or dentures)?

☐yes ☐no If yes, specify: .....

Care-giver

REST-SLEEP

In general, does the beneficiary sleep well? ☐yes ☐no

If not, why? .....

Does he take a nap during the day? ☐yes ☐no

TOBACCO-ALCOHOL

Does the beneficiary smoke? ☐yes ☐no

If yes, is monitoring needed? ☐no

☐yes, type of monitoring and why: .....

Does the beneficiary consume alcohol? ☐yes ☐no

If yes, is monitoring required? ☐no

☐yes, type of monitoring and why: .....

APPETITE - FOOD - DIET

Does the beneficiary usually have a good appetite when he eats? ☐yes ☐no

Is the beneficiary currently on a diet? ☐yes ☐no

If yes, what type of diet? .....

Was the diet prescribed by a physician? ☐yes ☐no

DENTITION

Does the beneficiary have problems with his teeth

(natural or dentures)? ☐yes ☐no If yes, specify: .....

Comments: .....

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Section 11 covers the beneficiary's "Family and Social Relations". This is an important aspect of his psychosocial situation. The assessor explores this aspect with the beneficiary, using the indicated themes and records the latter's answers, impressions and comments in the appropriate spaces.

The assessor is asked to pay particular attention to the beneficiary's emotional and sexual life. In addition, he must be alert to any sign of violence, exploitation, etc.

11- FAMILY AND SOCIAL RELATIONS

Do you have:	No	Yes	How often are you in touch with them (visits, phone calls etc...)?
• children?		No.	
• grandchildren?		No.	
• relatives?			
• friends?			

NATURE OF CONTACTS AND BENEFICIARY'S SATISFACTION

Specify the nature of the relations the beneficiary maintains with his family on the one hand and with other members of his circle on the other. Indicate his opinion as to his satisfaction with these contacts.

Relations with family *(spouse, children relatives)*

Other social relations *(friends, residents, staff, etc.)*

HOW THE BENEFICIARY PERCEIVES HIS CURRENT SITUATION VIS-A-VIS HIS CIRCLE

Specify how the beneficiary perceives the impact of his loss of autonomy on his circle.

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11- **PARTICULAR EVENT(S)** may be associated with the beneficiary himself or with any other person in his circle.

Section 12, "Personal and Community Activities", provides information concerning the beneficiary's usual activities or occupations, as well as his centres of interest. This information reveals another aspect of the "psychosocial situation".

11- FAMILY AND SOCIAL RELATIONS (continued)

Has the beneficiary experienced one or more PARTICULAR EVENTS that has(have) a continuing impact on his current situation? ☐ yes ☐ no

If yes, specify the(se) event(s), when it(they) occurred and the beneficiary's reaction to it (them).

Comments:

12- PERSONAL AND COMMUNITY ACTIVITIES

How do you spend your time during the day?

Do you go outside for these *(personal, recreation, social, etc.)* activities?

☐ yes, specify for which activities:

☐ no, why not?

Are you satisfied with how you spend your days? ☐ yes ☐ no

Are there any activities you would like to do and miss doing? ☐ yes ☐ no

If yes, specify:

What is preventing you from doing it(them) now *(ex.: concerns about money, structural barriers, etc.)*

CARE-GIVER

How does the beneficiary generally spend his days?

Would you say the beneficiary's usual activities indicate problems for himself alone *(ex.: isolation, lack of interest, etc.)* or for the people around him *(ex: demands a lot of time, attention, etc.)*?

Comments:

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Section 13 deals with the beneficiary's economic situation. Particular attention is paid to the "Budget Management" aspect.

13- If the beneficiary does not manage his own BUDGET, it is important to accurately identify who (name of person, PUBLIC or PRIVATE GUARDIAN) has assumed this responsibility on his behalf.

PRIVATE GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property. The application for interdiction must be submitted by a member of the family before the family council and confirmed by a judge.

PUBLIC GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property on the basis of a medical certificate of mental incapacity issued by a psychiatrist.

Section 14 concerns "The Beneficiary's Opinion With Respect to His Situation and Placement, and the Assessor's Remarks". The assessor provides an indication as to the beneficiary's eventual reactions in regard to one or more possible placements (return to the home, other intermediate or institutional resource).

13- BUDGET MANAGEMENT

Do you manage your own budget? ☐ yes ☐ no

If not, who manages it for you? ☐ spouse ☐ child ☐ parent ☐ friend ☐ public guardian ☐ private guardian ☐ other,

Name:

reason(s):

Are you satisfied with how your budget is being managed? ☐ yes ☐ no

If not, why?

What is(are) your main source(s) of income?

Do you have money available for everyday expenditures? ☐ yes ☐ no

Comments:

14- THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION, AND THE ASSESSOR'S REMARKS

At the present time, what major problem(s) would you like to see settled as a first priority?

Have you previously taken any steps to solve this(these) problem(s)? ☐ yes ☐ no

If yes, specify for which problem(s) and with what result?

What solution(s) do you currently contemplate to improve your situation? *(Give your opinion on the advantages and disadvantages of the solution(s) contemplated).*

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Section 15 groups certain information concerning the beneficiary's intellectual capacities, his emotional condition and his behaviour.

The beneficiary's psychological and behavioural profiles are key factors in assessing his autonomy. The assessor is requested to provide as much documentation as possible concerning any problem noted.

15A- INTELLECTUAL CAPACITIES

- TIME ORIENTATION: ability to situate himself in time, that is, to separate past, present and future, day and night, morning and afternoon, etc.

- SPACE ORIENTATION: ability to situate himself in space, that is, to know where he is physically.

- ORIENTATION WITH RESPECT TO PERSONS: ability to make good contact with people and reality, that is, to distinguish between imaginary or desired events and actual facts.

- LONG-TERM MEMORY: ability to remember past events and their associations.

- SHORT-TERM MEMORY: ability to remember recent events and their associations.

- ATTENTION: ability to concentrate on an a particular object or item of information.

- COMPREHENSION: ability to receive information and process it (grasp and interpret the meaning).

- JUDGMENT: ability to take a stand, make a decision in regard to an event or item of information.

- ADAPTABILITY: ability to become accustomed and adjust to a new environment or surroundings, to new situations.

14- THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION, AND THE ASSESSOR'S REMARKS (continued)

How would the beneficiary react to an eventual change of living environment?

If the beneficiary must move to a different environment, specify his wishes, if any, and the reasons for his choice.

15- INTELLECTUAL CAPACITIES, EMOTIONAL CONDITION AND BEHAVIOUR

(For the assessor and the care-giver) **A- INTELLECTUAL CAPACITIES**		No problem	Problem: How does this problem affect the beneficiary, and since when?
Time - orientation	A		
	C-G		
Space - orientation	A		
	C-G		
Orientation with respect to persons	A		
	C-G		
Short-term memory	A		
	C-G		
Long-term memory	A		
	C-G		
Attention	A		
	C-G		
Comprehension	A		
	C-G		
Judgment	A		
	C-G		
Adaptibility	A		
	C-G		

Comments:

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15B- and C- The assessor completes the "**EMOTIONAL CONDITION**" and "**BEHAVIOUR**" sections based on his own observations and information supplied by the care-giver.

Section 16, "Assessment Context", is used to identify the person(s) questioned during the assessment, and for comments on the conditions under which the assessment took place (ex: beneficiary very cooperative).

16- **BENEFICIARY ALONE:** indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically.

BENEFICIARY ALONE IN THE PRESENCE OF ANOTHER PERSON:
indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically, but that his answers were given in the presence of another person.

BENEFICIARY WITH HELP FROM ANOTHER PERSON: indicates another person participated in the assessment interview(s) with the beneficiary and this person helped him answer.

If this category is indicated, the assessor must provide the name and telephone number of the person who helped the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

PERSON OTHER THAN THE BENEFICIARY: indicates the beneficiary did not participate in the assessment interview(s) and another person answered the questions normally addressed to the beneficiary.
If this category is indicated, the assessor must provide the name and telephone number of the person who substituted for the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

15- INTELLECTUAL CAPACITIES, EMOTIONAL CONDITION AND BEHAVIOUR (continued)

FOR THE ASSESSOR

B- EMOTIONAL CONDITION

Describe what best characterizes the beneficiary's emotional condition *(feelings, humour, emotions, will, motivation, etc.)*

C- BEHAVIOUR

Does the beneficiary exhibit any behaviour problems? ☐ yes ☐ no → **Move to 16**

If yes, describe his problem(s) *(manifestations, relations with others, attitudes to objects, etc.)*

Identify the factors that trigger the beneficiary's problem behaviour.

Identify what appear to be the most effective means for controlling this problem behaviour.

Does the beneficiary require means of physical protection ☐ yes ☐ no

If yes, specify:

Comments:

16- ASSESSMENT CONTEXT

Identify the person(s) interviewed during the assessment process

☐ beneficiary alone
☐ beneficiary alone IN THE PRESENCE of another person, who? _____
☐ beneficiary with HELP from another person
☐ PERSON OTHER than the beneficiary

→ Main reason(s):

Helping or substitute respondent Name: Telephone:

Relation to beneficiary

Assessment context *(mood, beneficiary's attitude, difficulties encountered...)*

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In section 17, "Summary of Problems and Recommendations", the assessor summarizes his assessment interview(s) with the beneficiary, identifying the latter's major problem(s), action(s) already taken and the results obtained, and formulates recommendations.

The assessor's role is crucial here. Because of his special position (direct contact with the beneficiary), he has the opportunity to isolate the major items of information the multidisciplinary team needs to take into consideration when it studies the beneficiary's case and assesses the services required, those which require closer attention.

The assessor is therefore requested to proceed on a PROBLEM BY PROBLEM basis, indicating in each instance if any action has been taken to achieve a solution and if so, by whom (within the network or otherwise), the results obtained and, finally, he is requested to suggest which means should be used to try to solve the problem(s) observed.

17- SUMMARY OF PROBLEMS AND RECOMMENDATIONS

Based on the information gathered from the respondent(s),

A- What would you say are the beneficiary's major problems?

B- To your knowledge, have any steps been taken to try to reach a solution? If yes, specify. What were the results?

C- In view of the beneficiary's current situation, what do you recommend?

A- Major problems (biological, psychological, social)	B- Action taken and results	C- Recommendations

Assessor's signature: _____

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18- AUTHORIZATION OF BENEFICIARY

I authorize _____ appointed by _____
Name of assessor — Name of referring establishment

to release the information contained in this form to the persons responsible for evaluating my application for services, as well as to the establishment where I may eventually be referred.

_____
Signature of beneficiary

_____
Signature of authorized representative if beneficiary is incapacitated

CAPACITY OF REPRESENTATIVE?

☐ parent or person responsible ☐ public guardian

☐ private guardian ☐ legally authorized person

_____
Date of authorization

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Gouvernement du Québec
Ministère de la Santé et des Services sociaux

APPENDIX VI

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

BIO-PSYCHO-SOCIAL AUTONOMY ASSESSMENT FORM

(Facility: short-term care hospital centre)

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CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

(Facility: short-term care hospital centre)

A: Assessment of the beneficiary's autonomy

B: Complementary assessment of the beneficiary's autonomy undertaken with the significant person

USE OF FORMS A AND B

Situation 1 Any person for which there is a presumption of a change of living environment

- Forms A and B are mandatory

Situation 2 Any person presenting major risk factors

- Form A is recommended
- Form B is optional

Special directions: in the event the beneficiary is unable to answer because of his condition (confusion)

- Complete for A with the care-giver

MINI-GUIDE

Note: *The masculine form is used to designate both men and women.*

The first five sections are used to obtain general information concerning the beneficiary.

1- The first section is used to identify the beneficiary, resource-person, care-giver, other professional(s) who participated in the assessment and finally, the assessor.

BENEFICIARY'S FAMILY NAME AND GIVEN NAME AT BIRTH, AND FAMILY NAME OF SPOUSE.
If a woman beneficiary is separated, divorced or a widow but continues to use the name of her spouse, be sure to record the name she normally uses.

The **RESOURCE-PERSON** is defined as the person upon whom the beneficiary can call in time of need (ex.: a child, friend, neighbour, etc.). During the assessment and orientation process, this person may also act as intermediary between the assessor or health/social worker and the beneficiary.

The **CARE-GIVER** is on the staff of the establishment where the beneficiary is hospitalized. He knows the beneficiary well and may also be a key source of information in assessing autonomy. The care-giver is called upon to provide information concerning the beneficiary's sensory-motor capacity, his functional autonomy, the specific care he requires, his habits, intellectual skills, emotional state and behaviour.

During the assessment process, the assessor in charge of the case may call upon the services of one or more participating professional(s). In such cases, the assessor must indicate his(their) name(s) and profession(s).

The **ASSESSOR** is the person in charge of the process of assessing the beneficiary. He must record his name, specify the establishment he is attached to, provide his telephone number at work and indicate the date of the assessment.

The **ASSESSMENT DATE** is the date on which the assessment process is completed, more specifically, the date the form is completed. It is very important that all the information entered on the form at that time reflect the beneficiary's current condition.

1- IDENTIFICATION

Name and family name of the beneficiary at birth	Name of spouse

Health insurance no.	Social insurance no. (if available)

Name of the establishment	Date of admission

Resource-person: .....

Address: .....

Telephone no.: (home) ..... (office) .....

Relation to beneficiary: .....

Comments: .....

.....

Care-giver: ..... Telephone: .....

Professional(s), other than the assessor and the care-giver, who have participated in the assessment of the beneficiary's autonomy:

Name: ..... Profession: .....

Name: ..... Profession: .....

Assessor: .....

Establishment: ..... Telephone: .....

Assessment date: .....

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2- For beneficiaries with **NO SCHOOLING**, you are requested to indicate whether he is able to read and write.

The assessor specifies the beneficiary's **ETHNIC ORIGIN** and **RELIGION** if he feels this information is relevant to the assessment and eventual placement. When required, he provides details on these aspects if he feels they may have a significant impact on the placement.

MAIN OCCUPATION(S) means the activity (remunerative or not) to which the majority of the beneficiary's time is (or was) devoted.

3- The **USUAL RESIDENCE** refers to the beneficiary's permanent domicile.

Generally, a distinction is made between an **APARTMENT and a FLAT.** An apartment is part of a building (with many apartments) with a common entrance for all the residents, while a flat has its own private entrance.

A **TEMPORARY RESIDENCE** indicates where the beneficiary was housed on a provisional basis prior to his admission to the STCHC, while his usual residence remained available. For example, a person living in his own dwelling may be faced with certain difficulties and decide to reside temporarily with a relative. He is admitted to the STCHC during his stay with them. The beneficiary's personal address is entered under "**Usual Residence**", and the relative's address under "**Temporary Address**".

The **FORMER RESIDENCE** refers to where the beneficiary lived for the longest period of time. This may turn out to be his current residence.

The purpose of the question "... is that **PLACE** still **IMPORTANT** to you?", is to learn whether the beneficiary is still attached to the place where he spent the greater part of his life, whether he still lives there or not (ex: family or friends, feeling of belonging, attachment to surroundings, etc.). This information may be pertinent for the beneficiary's placement.

Section 4 is used to enter the reasons which, according to the beneficiary, led to his hospitalization in the STCHC. It is quite possible that this information may not agree with what the establishment has recorded on the beneficiary's file. Here, we are concerned with the beneficiary's version.

2- SOCIODEMOGRAPHIC INFORMATION

Date of birth (year / month / day)	Age	Sex	Place of birth
		☐F ☐M	

MARITAL STATUS ☐single ☐widowed ☐divorced ☐separated ☐religious

☐married ☐de facto union → age of spouse _____

for how many years (excluding single)? _____

LANGUAGE ☐French ☐English ☐other, specify: _____

SCHOOLING ☐no schooling → can he read? ☐yes ☐no can he write? ☐yes ☐no

☐elementary /primary ☐high school ☐vocational/technical ☐collegiate/classical ☐university

Ethnic origin (if pertinent)	Religion (if pertinent)

Main occupation(s)

3- CURRENT PLACE OF RESIDENCE

A- USUAL RESIDENCE

Address of permanent residence: .....

Postal Code .....

TYPE ☐apartment ☐flat ☐private house ☐rooming house ☐HLM ☐other: .....

STATUS ☐owner ☐tenant ☐boarder

You live there...? ☐alone ☐with others, Whom? .....

For how long have you lived in this neighbourhood (municipality)? .....

B- TEMPORARY RESIDENCE

At the time you were admitted here, were you living at your usual residence? ☐yes → **Move to 3C** ☐no

If not, where did you live? address .....

residence of...? ..... for how long? .....

reason(s) .....

C- FORMER RESIDENCE

In which city (region, municipality,...) did you live longest? .....

Is that place still important to you? ☐yes ☐no

If yes, why? .....

4- REASONS FOR ADMISSION TO THE STCHC

What do you feel are the reasons for your hospitalization here?

.....

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5- The **MEDIATOR OF THE REQUEST** is the person who requests the service for the beneficiary. This could be the beneficiary himself, a member of his family (spouse, child, etc.), a person from his circle (friend, neighbour, etc.) or a staff member of the establishment or another organization: Local Community Service Center (LCSC), Social Service Center (SSC) etc.

FACTORS TRIGGERING THE SERVICE REQUEST OR PROBLEMS AS DESCRIBED BY THE BENEFICIARY.

The assessor indicates the factors which, according to the beneficiary, have led him to submit a request for a particular service. These factors may relate to health (ex: mental or physical problems) or be of a social nature (ex: family problem, problems with housing, etc.) and may differ from those leading to hospitalization.

If the mediator is not the beneficiary, the assessor completes the section entitled **REASONS GIVEN BY THE MEDIATOR, OTHER THAN THE BENEFICIARY, IN SUPPORT OF THE SERVICE REQUEST.**

Section 6 is reserved for information concerning the beneficiary's sensory abilities, here understood as his "Eye-sight, hearing and speech". In the event of a specific sensory problem, the assessor is requested to attach any specific examination report available (ex: speech therapy).

6- A **MINOR LIMITATION** means a reduction in capacity which has very little or no affect on the beneficiary's ability to carry out his usual activities. The **MAJOR LIMITATION** category is used when the impairment is sufficiently serious to hinder the beneficiary's ability to carry out normal activities that are necessary for his well-being.

Examples of **TYPE OF AID/SUBSTITUTION:**

— sight: eyeglasses, contact lenses, magnifying glass, large print, etc.
— hearing: loud voice, shouts, hearing aid, lip reading, telephone amplifier, TV decoder, etc.
— speech: written communication, gestures, sign language, shouts, sighs, etc.

5- CONTEXT OF THE REQUEST

Mediator of the request

☐ beneficiary ☐ other person

Date of the request: _____

Name: ..... Telephone .....

Relation to beneficiary: .....

Has the beneficiary been informed of the request made for him?

☐ yes, does he agree? .....

☐ no, why? .....

Factor(s) triggering the service request or problems (health or social) as described by the beneficiary.

.....

Reason(s) given by the mediator, other than the beneficiary, in support of the service request.

.....

Service(s) requested by the mediator: .....

.....

6- EYESIGHT, HEARING AND SPEECH

Do you have (does he) have difficulty		Excluding the aid(s)/ substitution(s) used				Aid(s)/substitution(s)?				
		Adequate	LIMITATION Minor	LIMITATION Major	Total loss	NO	YES	ADEQUATE?	INADEQUATE?	Type of aid(s)/substitution(s) used? Comments
SEEING?	Beneficiary									
	Care-giver									
HEARING?	Beneficiary									
	Care-giver									
SPEAKING?	Beneficiary									
	Care-giver									

Comments

.....

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Section 7 is used to obtain detailed information as to the beneficiary's "Physical Mobility". This is assessed in relation to three aspects: limitation or loss of one or more limbs or parts of the body, rehabilitation and range of mobility. The first aspect (7A) concerns physical impairments that limit the beneficiary's movements. The second aspect (7B) specifies any rehabilitation program already undertaken in regard to the mobility problems identified. Finally, the last aspect (7C) is used to assess the beneficiary's ability to move about on his own within his environment, i.e. without help from others but taking the aid(s) used into account.

7A- A description of the nature of the problem must be given for each part of the body affected by a **LIMITATION** (ex: trembling, problems with gripping, pain, etc.). An indication must also be given as to **HOW LONG** the beneficiary has been affected by the problem. Since mobility problems are to a large degree progressive in nature, it will not always be possible to give a precise date. In such cases, an estimate of when the problem first appeared should be given.

The question "Are you... (the beneficiary is...) **RIGHT-HANDED OR LEFT-HANDED?**" provides an essential item of information for rehabilitation workers. When related to data concerning the impairments, this information helps to more accurately determine how serious the loss of autonomy is and thus to better assess what type of intervention is required. For example, a right-handed person suffering from hemiplegia on the right side does not experience the same type of difficulties as a left-handed person with the same affliction. He may therefore, by that very fact, need services of a different nature.

In the **AID(S) USED section**, it is important to indicate only those the beneficiary actually uses. For example, he may own a walker, but never use it.

Also, if the beneficiary uses a **PROSTHESIS or ORTHOPEDIC APPLIANCE**, the assessor is requested to specify the type.

An **ORTHOPEDIC APPLIANCE** is used to correct a limb or part of the body suffering from a limitation (ex: an orthopedic shoe).

A **PROSTHESIS** acts as a full or partial replacement for a limb or organ (ex: an artificial leg).

When the beneficiary uses one or more aid(s), you must indicate whether he **NEEDS ASSISTANCE** to use it. This may involve help:

- in installing (ex.: putting on, removing, attaching, adjusting a prosthesis, etc.)
- in transferring (ex: from a wheelchair to a bed, bath, toilet, car, etc.)
- in moving (support, pushing a wheelchair, etc.)
- etc.

7- PHYSICAL MOBILITY

A- Limitation or loss of one or more limbs or parts of the body

BENEFICIARY: Do you have difficulty with certain movements? ☐ yes ☐ no

CARE-GIVER: Does the beneficiary have difficulty with certain movements ? ☐ yes ☐ no

Part(s) of the body	Description of the limitation for each part affected; for how long?	
	Beneficiary	Care-giver
Right or left hand		
Right or left arm		
Right or left hip		
Right or left leg		
Right or left foot		
Right or left side of body		
Cervical region		
Spinal column		
Generalized		

Are you... (Is the beneficiary...)? right-handed? B ☐ C-G ☐ left-handed? B ☐ C-G ☐

Do you use (does he use) any of these aids?

B	C-G		B	C-G	
☐	☐	none	☐	☐	orthopedic appliance:.....
☐	☐	cane	☐	☐	prosthesis:.....
☐	☐	walker	☐	☐	wheelchair (manual)
☐	☐	tripod, quadripod	☐	☐	motorized wheelchair
☐	☐	ramps, support bars	☐	☐	other:.....

Does he own it? B ☐ C-G ☐ yes B ☐ C-G ☐ no

If any aid is used: do you (does he) need help to use it?
(ex.: for moving, transfer, installation, etc)

B	C-G	
☐	☐	no
☐	☐	yes, specify the type of assistance required:.....

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7B- This part covers the **REHABILITATION** aspect.
The assessor attaches any relevant rehabilitation report.

7B- This part covers the **REHABILITATION** aspect.
The assessor attaches any relevant rehabilitation report.

7C- The beneficiary's **RANGE OF MOBILITY** refers to the "distance" he is able to move on his own from a fixed point, in this case, his bed. A person's range of mobility can change with age. The normal range of mobility is then considered as the usual range of mobility for persons of the same age group. In the following scale, the first three categories cover a normal range of mobility while the remaining categories correspond to a progressively more restricted range of mobility.

The categories are mutually exclusive, so the two respondents are to indicate only one each. If the "full mobility" category is indicated (by either respondent), the assessor moves directly to section 8 (for the respondent in question). If not, he completes the other questions of section 7C.

The categories are defined as follows:

- **Full mobility:** persons in this category have a normal range of mobility.

- **Full mobility with occasional restrictions:** this category includes persons with intermittent disabilities (changing course of the illness, for instance, in the case of rheumatoid arthritis or osteoarthrosis, persons suffering from bronchitis whose mobility is restricted by temporary climatic constraints, persons with severe asthma,...) Except for periods of temporary disability, these persons have a normal range of mobility.

- **Full mobility at reduced speed:** this category includes persons with a normal range of mobility except that they move more slowly as a result of, for example, poor eyesight, insecurity, or, in an urban setting, difficulties in using public transportation, although the person always manages to overcome these difficulties without assistance from others.

- **Full mobility over a reduced range:** this category includes persons whose mobility is reduced as a result of, for example, problems with eyesight, insecurity, fragility, weakness, cardiac or respiratory problems; or in an urban setting, as a result of their inability to use public transportation at all times. These persons can move about without assistance beyond the immediate surroundings of their residence, but cannot go everywhere "without assistance". Their range of mobility is thus more restricted than a normal range.

- **Mobility restricted to the establishment and its surroundings:** this category includes persons whose movements are ordinarily limited to the area surrounding the establishment.

- **Mobility restricted to the establishment:** persons in this category normally can move about only within the establishment.

- **Mobility restricted to the floor the room is located on:** persons in this category normally can move about only on the floor where their room is located.

- **Mobility restricted to the room:** persons in this category are restricted to their room.

- **Mobility restricted to the chair:** persons in this category are confined to their chair.

- **Mobility nil:** persons in this category are confined to a bed.

Note: *the preceding scale was adapted from the ICIDH - WHO - 1980.*

FACTORS RESTRICTING MOBILITY designate the indicators that may help to understand what is restricting the beneficiary's mobility. Factors inherent to the beneficiary do not necessarily correspond to an established medical diagnosis.

B- REHABILITATION (if mobility problems have been previously indicated)

Have you (has he) previously undergone rehabilitation for your (his) mobility problems?

Beneficiary	Care-giver
☐ yes, specify:	☐ yes, specify:
☐ no, why?	☐ no, why?

Comments:

C- RANGE OF MOBILITY

Bearing the aid(s) in mind, BUT EXCLUDING ASSISTANCE FROM OTHERS:

Beneficiary: how freely can you move about?

Care-giver: how freely can the beneficiary move about?

B	C-G	
☐	☐	full mobility → **Move to 8**
☐	☐	full mobility with occasional restrictions
☐	☐	full mobility at reduced speed
☐	☐	full mobility over a reduced range
☐	☐	mobility restricted to the establishment and its surroundings

B	C-G	
☐	☐	mobility restricted to the establishment
☐	☐	mobility restricted to the floor the room is located on
☐	☐	mobility restricted to the room
☐	☐	mobility restricted to a chair
☐	☐	mobility null/confined to bed

Specify the factor(s) restricting mobility

Inherent to the beneficiary

B	C-G	
☐	☐	restriction in the mobility of one or more limbs
☐	☐	amputation of one or more limbs
☐	☐	problems with balance
☐	☐	psychological problems
☐	☐	cecity

B	C-G	
☐	☐	obesity
☐	☐	cardiac problems
☐	☐	respiratory problems
☐	☐	inactivity, low activity level
☐	☐	other, specify:

Independent of the beneficiary

B	C-G	
☐	☐	structural barriers, specify:
☐	☐	lack of physical resources, specify:
☐	☐	other, specify:

→ If the factor(s) is(are) independent of the beneficiary, specify what his range of mobility might be if such obstacle(s) were removed.

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Section 8. "Functional Autonomy", is designed to assess the beneficiary's ability to perform a number of everyday tasks. The tasks included in this section were chosen to represent the range of tasks a person regularly carries out to maintain health and well-being.

8- For each activity, the beneficiary is graded according to the four following degrees of autonomy:

- The beneficiary performs the activity **WITHOUT ASSISTANCE FROM OTHERS**, but may use a mechanical aid
- The beneficiary requires **ASSISTANCE FROM OTHERS to perform the activity.**

This may involve supervision, monitoring, partial assistance, etc. In each case, the assessor must obtain from the care-giver the information concerning the type of assistance needed.

- The beneficiary does not perform the activity, somebody else does it for him. In other words, the activity is performed **BY OTHERS.**
- The category **ACTIVITY NOT PERFORMED** covers a situation in which the activity is simply not performed, neither by the beneficiary nor by somebody else. (ex: going out of doors in winter)

As indicated on the right side of the table, if an activity is performed **WITH ASSISTANCE FROM OTHERS BY OTHERS or NOT PERFORMED**, it is important that the assessor obtain from the care-giver the reasons for this situation. If the reasons are independent of the beneficiary (ex: rules of the HC, structural barriers, etc.), the care-giver must give some indication of the beneficiary's POTENTIAL to perform the activity in question.

The activities we are concerned with are as follows:

Serving a meal: preparing a plate or tray, sitting down to eat.

Eating: cutting or otherwise manipulating food, eating and drinking during meals and snacks.

Preparing light meals: preparing snacks, lunch,...

Preparing full meals: preparing adequate and substantial dishes (combining, mixing, cooking... food).

Taking medicine: following the instructions of the prescription(s), opening the container(s) and taking the medicine.

Washing oneself: preparing the sink or basin, the toiletry articles, washing and dressing oneself regularly.

Shaving: shaving, rinsing

Taking a bath/shower: running the bath, entering the bathtub (or shower), washing oneself, getting out of the bathtub (or shower), drying oneself.

Washing one's hair: preparing the articles required, washing the hair, drying, storing the articles.

Dressing/undressing: preparing the clothes to be worn, putting them on, tying one's shoes, putting on accessories, undressing and storing the clothes.

Using the toilet: undressing (as needed), setting oneself on the toilet or commode, cleaning, getting up, dressing.

Getting up/lying down: moving from a lying position to a standing position and getting back into bed.

Walking: going from on place to another, moving on foot (with or without mechanical aid) (excluding going up/down the stairs and getting about in a wheelchair).

Going outside - summer: walking at least a short distance outside in the summer and returning with little difficulty.

Going outside - winter: walking at least a short distance outside in the winter and returning with little difficulty.

Going up/down the stairs: using the stairs either to go up or come down.

Shopping: going outside to do one's shipping.

Using the telephone: picking up the receiver, dialing the number and communicating.

Doing regular housework: performing the usual household tasks such as dusting, ironing, etc.

Doing the washing: gathering and sorting clothes, putting them in the machine, operating the machine, etc.

8- FUNCTIONAL AUTONOMY

Do you (does he) perform the following activities?	BENEFICIARY Act. performed: Unaided	BENEFICIARY Act. performed: With assistance from others	BENEFICIARY Act. performed: By others	BENEFICIARY Activity not performed	CARE-GIVER Act. performed: Unaided	CARE-GIVER Act. performed: With assistance from others	CARE-GIVER Act. performed: By others	CARE-GIVER Activity not performed	**If With assistance from others,** specify the type of assistance given. If **Activity performed with assistance from others or by others or not performed,** indicate the reason(s) and if independent of the beneficiary, mention his potential to perform the activity in question.
- serve your own meals									
- eat									
- prepare light meals (lunch)									
- prepare full meals									
- take care of your medicine									
- wash yourself									
- shave									
- take a bath/shower									
- wash your hair									
- dress, undress									
- use the toilet									
- get up/lie down									
- walk									
- go outside - summer									
- go outside - winter									
- go up/down the stairs									
- do your shopping									
- use the telephone									
- do regular housework									
- do the washing									
- other									
-									

Comments:

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SHORT-TERM, refers to a period of less than three months.

In section 9, "Elimination", the assessor must specify the frequency with which incidents of incontinence occur, either on a daily or weekly basis. Regardless of whether the beneficiary uses and aid or not, the assessor must specify whether an aid is needed, and give details of any problem(s) related to incontinence, such as: the person must be taken to the toilet regularly, access to the toilet is restricted by structural barriers or distance, the person is unable to clean himself, etc.

Section 10, "Specific Care Required", is to be completed with the care-giver. If the beneficiary needs a particular type of care, it is important to provide as much information as possible concerning the administration of such care. For instance, the beneficiary needs some form of assistance to clean his stomy at regular intervals.

8- FUNCTIONAL AUTONOMY (continued)

To be answered by the beneficiary and the care-giver

During the past year, your ability to perform these various activities...	B	C-G
has improved	☐	☐
has not changed	☐	☐
has decreased	☐	☐
has decreased markedly	☐	☐

Explain: .....

To be answered by the care-giver

Do you anticipate any improvement in the short term in the beneficiary's ability to perform these activities? ☐ yes ☐ no

If yes, specify: .....

Comments: .....

9- ELIMINATION

Beneficiary

Do you suffer from incontinence?

Urinary ☐ no ☐ yes → ☐ diurnal ☐ nocturnal

frequency: .....

☐ no aid
☐ condom ☐ catheter
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Fecal ☐ no ☐ yes → ☐ diurnal ☐ nocturnal

frequency: .....

☐ no aid
☐ colostomy
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Give details of any problem: .....

Care-giver

Does the beneficiary suffer from incontinence?

Urinary ☐ no ☐ yes → ☐ diurnal ☐ nocturnal

frequency: .....

☐ no aid
☐ condom ☐ catheter
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Fecal ☐ no ☐ yes → ☐ diurnal ☐ nocturnal

frequency: .....

☐ no aid
☐ colostomy
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Give details of any problem: .....

Comments: .....

10- SPECIFIC CARE REQUIRED (if relevant)

Care-giver

Indicate the specific care the beneficiary currently requires *(attach nursing report, if relevant)*

☐ gastric feeding tube ☐ oxygen ☐ suction of secretions ☐ stomy ☐ insulin ☐ disimpacting ☐ bandage(s)

☐ other .....

Remarks *(ex.: beneficiary is autonomous or needs assistance, type of assistance, frequency, etc.)* .....

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Section 11 deals with the beneficiary's "Habits". Quality of sleep, tobacco use, consumption of alcohol, diet and the associated events are important facets of everyday life. The beneficiary's opinions on these aspects are an indication of his well-being and, when related to other information from the autonomy assessment, are useful in gauging the scope of some of his problems or their consequences on his health (ex: quality of sleep versus consumption of soporifics, type of diet versus financial problems, etc.)

11- **TOBACCO-ALCOHOL** If the beneficiary smokes or consumes alcohol, the assessor must pay particular attention to the problems which may accompany these habits.

TOBACCO: "Is **MONITORING**" needed when the beneficiary smokes? Monitoring means the presence of or assistance by another person or any form of protection (ex: protective apron).

The beneficiary's **DIET** is entered under the major food categories. With this information, it should be possible to detect any eventual deficiencies compared to the categories of food needed for a balanced diet.

SUBSTITUTES include eggs, cheese and leguminous plants (ex: chickpeas) among others.

The **BREAD AND CEREALS** category also includes starchy foods (ex: rice, pasta).

11- HABITS

Beneficiary

REST-SLEEP

In general, are you satisfied with your sleep? ☐yes ☐no

If not, why? .....

Do you take a nap during the day? ☐yes ☐no

TOBACCO-ALCOHOL

Do you smoke? ☐yes ☐no

Comments: .....

Do you consume alcohol (beer, wine, spirits)? ☐yes ☐no

Comments: .....

APPETITE-FOOD-DIET

Do you USUALLY have a good appetite when you eat? ☐yes ☐no

At home, did you eat ☐alone ☐with others .....

Where did you usually eat?

☐dining room/kitchen ☐chair ☐bed

☐away from home, where? .....

Did you consume...?	Dly.	Wkly.	Rarely or never
• milk and milk products	☐	☐	☐
• meat and substitutes	☐	☐	☐
• fruits/vegetables	☐	☐	☐
• bread and cereals	☐	☐	☐
• sweets, dessert, soft drinks	☐	☐	☐
• water	☐	☐	☐
• coffee, tea	☐	☐	☐
• others			

Remarks: .....

Are you currently on a diet? ☐yes ☐no

If yes, what kind of diet? .....

Was it prescribed by a physician ☐yes ☐no

DENTITION

Do you have problems with your teeth (natural or dentures)?

☐yes ☐no If yes, specify: .....

Care-giver

REST-SLEEP

In general, does the beneficiary sleep well? ☐yes ☐no

If not, why? .....

Does he take a nap during the day? ☐yes ☐no

TOBACCO-ALCOHOL

Does the beneficiary smoke? ☐yes ☐no

If yes, is monitoring needed? ☐no

☐yes, type of monitoring and why: .....

Does the beneficiary consume alcohol? ☐yes ☐no

If yes, is monitoring required? ☐no

☐yes, type of monotoring and why: .....

APPETITE-FOOD-DIET

Does the beneficiary usually have a good appetite when he eats?

☐yes ☐no

Is the beneficiary currently on a diet? ☐yes ☐no

If yes, what type of diet .....

Was the diet prescribed by a physician? ☐yes ☐no

DENTITION

Does the beneficiary have problems with his teeth (natural or dentures)? ☐yes ☐no If yes, specify: .....

Comments: .....

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Section 12 "Utilization of Services" deals with the services the beneficiary received while he lived at home, and with accessibility of medical resources.

12- **AID SERVICES** refer to housekeeping, meal, companionship, etc.

OTHER includes: podiatry, nutrition, speech therapy services, etc.

ORGANIZATIONS capable of providing the services or care mentioned are: the LCSCs, SSCs, day centres, volunteer organizations, private organizations, etc.

12- UTILIZATION OF SERVICES PRIOR TO HOSPITALIZATION

While you were living at home, did you make use of...?	NO	YES			
		WHERE		from which organization(s)?	specify the nature of the services/ care received, and their frequency
		at home	outside		
• aid services					
• nursing care					
• social services					
• physiotherapy					
• ergotherapy					
• other _____					
• _____					

- Were you under the care of one or more family physicians? ☐yes ☐no

  If yes, give the name(s) of the physician(s), the frequency of his(their) visits, where they took place *(i.e. at home or in the physician's office)*, the date of your last visit and the reasons why you were under such care.

- Were you under the care of one or more specialists? ☐yes ☐no

  If yes, give the name(s) of the specialist(s), the frequency of his(their) visits, where they took place *(i.e. at home or in the physician's office)*, the date of your last visit and the reasons why you were under such care.

- Were you hospitalized during the past three years? ☐yes ☐no

  If yes, why?

  Where?

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Section 13 covers the beneficiary's "Family and Social Relations". This is an important aspect of his psychosocial situation. The assessor explores this aspect with the beneficiary, using the indicated themes and records the latter's answers, impressions and comments in the appropriate spaces.

The assessor is asked to pay particular attention to the beneficiary's emotional and sexual life. In addition, he must be alert to any sign of violence, exploitation, etc.

13- FAMILY AND SOCIAL RELATIONS

Do you have:	No	Yes	How often are you in touch with them (visits, phone calls, etc...)?
• children?		No.	
• grandchildren?		No.	
• relatives?			
• friends?			

NATURE OF CONTACTS AND BENEFICIARY'S SATISFACTION

Specify the nature of the relations the beneficiary maintains with his family on the one hand and with other members of his circle on the other. Indicate his opinion as to his satisfaction with these contacts.

Relations with family (spouse, children, relatives)

Other social relations (friends, neighbours, etc.)

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13- **PARTICULAR EVENT(S)** may be associated with the beneficiary himself or with any other person in his circle.

Section 14, "Contact with His Circle", is used to gather information on whether the beneficiary has any continuing contact with any members of his circle, or whether he is more or less isolated. It is also used to elicit his reactions to his specific situation. The assessor must be alert to any risk factors.

14- **HOME** is used to refer to the beneficiary's usual dwelling.

The beneficiary's **CIRCLE** is the group of people who are on familiar terms with the beneficiary.

An **UNEXPECTED SITUATION** is used in the broad sense, to cover any sudden event that could place the beneficiary in a situation in which he needs material or human assistance.

13- FAMILY AND SOCIAL RELATIONS (continued)

HOW THE BENEFICIARY PERCEIVES HIS CURRENT SITUATION VIS-A-VIS HIS CIRCLE

Specify how the beneficiary perceives the impact of his loss of autonomy on his circle.

Has the beneficiary experienced one or more PARTICULAR EVENTS that has(have) a continuing impact on his current situation? ☐ yes ☐ no

If yes, specify the event(s), when it (they) occurred and the beneficiary's reaction to it(them.)

Comments:

14- CONTACT WITH HIS CIRCLE

While you lived at home, were you usually (left) alone during...?

the day ☐ no ☐ yes, specify
the evening ☐ no ☐ yes, specify
the night ☐ no ☐ yes, specify

Person's attitude toward this situation (fear, insecurity, etc.)

On whom could you count in the event of an unexpected situation?

☐ could count on... name(s) relation
☐ could not count on anyone

Comments:

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Section 15. "Support from the Natural Assistance Network", is used to explore the support the beneficiary received from his circle while he was at home. The helper(s) is(are) identified, as well as the type of assistance he(they) provided. This section is also used to determine whether, in view of the beneficiary's current situation, it is possible to continue providing this assistance.

In section 16. "Beneficiary's Responsibilities", the responsibilities the beneficiary may have toward one or more persons in his circle (ex: material or financial assistance, moral support, dependent person, etc.) are identified.

Section 17. "Personal and Community Activities", provides information concerning the beneficiary's usual activities or occupations, as well as his centres of interest. This information reveals another aspect of the "psychosocial situation".

15- SUPPORT FROM THE NATURAL ASSISTANCE NETWORK

When you were at home, did those around you help you perform your daily activities? ☐yes ☐no→ **Move to 16**

which person(s)?

what did he(they) do for you?

In view of your current situation, do you think this(these) person(s) could continue to help you in the future?

☐yes, would this assistance be sufficient? ☐yes ☐no

If not, what other assistance would you need

Do you know any other person(s) who could provide this assistance? ☐yes, who and in what way?

☐no, explain:

Comments:

16- BENEFICIARY'S RESPONSABILITIES

Do you have responsibilities toward a person(s) of your circle (family or other)? ☐yes ☐no→ **Move to 17**

If yes, toward whom? name(s) relation age

what kind of responsabilities (material, financial, etc.)?

do you feel you can continue to meet these responsibilities? ☐yes ☐no

If not, why not?

Comments:

17- PERSONAL AND COMMUNITY ACTIVITIES

When you were at home, how did you spend your time during the day?

Were you particularly interested in any activity(ies)? ☐yes ☐no

If yes, specify?

did you participate in it(them)? ☐yes ☐no, why not?

Comments:

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Section 18 deals with the beneficiary's economic situation, one of the determining factors of his living conditions. The assessor begins by asking the beneficiary general questions (satisfaction, budget management, major source(s) of income and obligations). Only if the beneficiary admits he has difficulty fulfilling his obligations does the assessor proceed to a more detailed assessment of the economic aspect.

18- If the beneficiary does not manage his own **BUDGET**, it is important to accurately identify who (name of person, **PUBLIC or PRIVATE GUARDIAN**) has assumed this responsibility on his behalf.

PRIVATE GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property. The application for interdiction must be submitted by a member of the family before the family council and confirmed by a judge.

PUBLIC GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property on the basis of a medical certificate of mental incapacity issued by a psychiatrist.

Section 19 deals with the "Beneficiary's Housing Conditions". If the beneficiary still owns his own home, objective information is gathered as to the condition of the dwelling (number of rooms, access, floor plan, furniture arrangement, sanitary facilities), and his impressions of his home, his neighbourhood and, if applicable, the fact of sharing his residence with others. This information is indicative of the beneficary's quality of life.

18- ECONOMIC SITUATION

Do you feel your income is enough to enable you to live in a satisfactory manner? ☐yes ☐no

Do you manage your own budget ☐yes ☐no

If not, who manages it for you? ☐spouse ☐child ☐parent ☐friend ☐public guardian ☐private guardian ☐other,

Name:

reason(s):

Are you satisfied with how your budget is being managed? ☐yes ☐no

If not, why?

What is(are) your main source(s) of income (pension, supplement, annuity, social aid, etc.)?

Can you meet your current obligations with your current income (rent, food, clothing, medicine, etc.)? ☐yes → **Move to 19** ☐no

If not, with what are you having difficulty?

what would you estimate is your monthly income? _____ $

is it increased by the income of (an)other person(s)? ☐yes ☐no _____ $ / month

do you have any possessions (real estate, savings)? ☐yes, specify ☐no

How much do you spend per month for...?

. rent _____
. food _____
. or room and board _____
. other recurrent expense(s) _____
_____ _____
Total _____ $ / month

Do you share these expenses with (an)other person(s)?
☐yes ☐no

Comments:

19- HOUSING CONDITIONS - (if the beneficiary still owns his home)

Are you satisfied with your present housing? ☐yes ☐no

If not, how would you like to improve it?

How many rooms does your dwelling have?..... It is located ☐on the ground floor ☐in the basement ☐_____floor of the house or building → access by ☐an exterior stairway ☐an interior stairway ☐an elevator

Are the rooms functional for your purposes *(i.e. access is easy and you can use them)?* ☐yes ☐no, explain the problem:

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Section 20 concerns "The Beneficiary's Opinion With Respect to His Situation and Orientation, and the Assessor's Remarks". The assessor provides an indication as to the beneficiary's eventual reactions in regard to one or more possible placements (return to the home, other intermediate or institutional resource).

19- HOUSING CONDITIONS (continued)

Were you satisfied with your community *(environment, services, transportation, safety, etc.)*? ☐ yes ☐ no

If not, why not? .....

Comments *(ex.: landlord-tenant relation, cost of housing, cleanliness, environment, etc.)*: .....

N.B.: *The questions are to be put only to persons sharing housing with a number of others*

Does sharing housing with others inconvenience you? ☐ yes ☐ no

If yes, explain why: .....

Do you feel your current housing arrangements will last? ☐ yes / ☐ no, do you contemplate any changes? ☐ yes / ☐ no

If yes, specify: .....

When? .....

Comments:

20- THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION AND ASSESSOR'S REMARKS

At the present time, what major problem(s) would you like to see settled as a first priority? .....

Have you previously taken any steps to solve this(these) problem(s)? ☐ yes ☐ no

If yes, for which problem(s) and with what result? .....

What solution(s) do you currently contemplate to improve your situation?
(The beneficiary's opinions on the advantages and disadvantages of the solution(s) contemplated, and of an eventual utilization of the services of the network).

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Section 21 is used to obtain information concerning the beneficiary's intellectual capacities, his emotional condition and his behaviour.

The beneficiary's psychological and behavioural profiles are key factors in assessing his autonomy. The assessor is requested to provide as much documentation as possible concerning any problem noted.

21A- INTELLECTUAL CAPACITIES

- **TIME ORIENTATION:** ability to situate himself in time, that is, to separate past, present and future, day and night, morning and afternoon, etc.

- **SPACE ORIENTATION:** ability to situate himself in space, that is, to know where he is physically.

- **ORIENTATION WITH RESPECT TO PERSONS:** ability to make good contact with people and reality, that is, to distinguish between imaginary or desired events and actual facts.

- **LONG-TERM MEMORY:** ability to remember past events and their associations.

- **SHORT-TERM MEMORY:** ability to remember recent events and their associations.

- **ATTENTION:** ability to concentrate on an a particular object or item of information.

- **COMPREHENSION:** ability to receive information and process it (grasp and interpret the meaning).

- **JUDGMENT:** ability to take a stand, make a decision in regard to an event or item of information.

- **ADAPTABILITY:** ability to become accustomed and adjust to a new environment or surroundings, to new situations.

20- THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION AND ASSESSOR'S REMARKS (continued)

How does the beneficiary react to an eventual utilization of home services, day centre services, a change of residence, residence in a facility, etc.?

If the beneficiary must move to a different environment, specify his wishes, if any, and the reasons for his choice.

21- INTELLECTUAL CAPACITIES, EMOTIONAL CONDITION AND BEHAVIOUR

(For the assessor and the care-giver) A- INTELLECTUAL CAPACITIES		No problem	Problem: How does this problem affect the beneficiary, and since when?
Time orientation	C-G		
	A		
Space orientation	C-G		
	A		
Orientation with respect to persons	C-G		
	A		
Short-term memory	C-G		
	A		
Long-term memory	C-G		
	A		
Attention	C-G		
	A		
Comprehension	C-G		
	A		
Judgment	C-G		
	A		
Adaptibility	C-G		
	A		

Comments:

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21B-and C- The assessor completes the "**EMOTIONAL CONDITION and BEHAVIOUR**" sections based on his own observations and information supplied by the care-giver.

Section 22, "Assessment Context", is used to identify the person(s) questioned during the assessment, and for comments on the conditions under which the assessment took place (ex: beneficiary very cooperative).

22- **BENEFICIARY ALONE**: indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically.

BENEFICIARY ALONE IN THE PRESENCE OF ANOTHER PERSON:
indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically, but that his answers were given in the presence of another person.

BENEFICIARY WITH HELP FROM ANOTHER PERSON: indicates another person participated in the assessment interview(s) with the beneficiary and this person helped him answer.

If this category is indicated, the assessor must provide the name and telephone number of the person who helped the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

PERSON OTHER THAN THE BENEFICIARY: indicates the beneficiary did not participate in the assessment interview(s) and another person answered the questions normally addressed to the beneficiary. If this category is indicated, the assessor must provide the name and telephone number of the person who substituted for the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

FOR THE ASSESSOR

B- EMOTIONAL CONDITION

Describe what best characterizes the beneficiary's emotional condition *(feelings, humour, emotions, will, motivation, etc.)*

C- BEHAVIOUR

Does the beneficiary exhibit any behaviour problems? ☐ yes ☐ no → **Move to 22**

If yes, describe his problem(s) *(manifestations, relations with others, attitudes to objects, etc.)*

Identify the factors that trigger the beneficiary's problem behaviour.

Identify what appear to be the most effective means for controlling this problem behaviour

Does the beneficiary require means of physical protection? ☐ yes, ☐ no

If yes, specify:

Comments:

22- ASSESSMENT CONTEXT

Identify the person(s) interviewed during the assessment process

☐ beneficiary alone
☐ beneficiary alone IN THE PRESENCE of another person, who? _____
☐ beneficiary with HELP from another person
☐ PERSON OTHER than the beneficiary

→ Main reason(s):

Helping or substitute respondent: Name:

Relation to beneficiary Telephone:

Assessment context *(mood, beneficiary's attitude, difficulties encountered...)*

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In section 23, "Summary of Problems and Recommendations", the assessor summarizes his assessment interview(s) with the beneficiary, identifying the latter's major problem(s), action(s) already taken and the results obtained, and formulates recommendations.

The assessor's role is crucial here. Because of his special position (direct contact with the beneficiary), he has the opportunity to isolate the major items of information the multidisciplinary needs to take into consideration when it studies the beneficiary's case and assesses the services required, those which require closer attention.

The assessor is therefore requested to proceed on a PROBLEM BY PROBLEM basis, indicating in each instance if any action has been taken to achieve a solution and if so, by whom (within the network or otherwise); the results obtained and, finally, he is requested to suggest which means should be used to try to solve the problem(s) observed.

23- SUMMARY OF PROBLEMS AND RECOMMENDATIONS

Based on the information gathered from the respondent(s),

A- What would you say are the beneficiary's major problems?

B- To your knowledge, have any steps been taken to try to reach a solution? If yes, specify. What were the results?

C- In view of the beneficiary's current situation, what do you recommend?

A- Major problems (biological, psychological, social)	B- Action taken and results	C- Recommendations

Assessor's signature: _____

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24- AUTHORIZATION OF BENEFICIARY

I authorize _____ appointed by _____
Name of assessor — Name of referring establishment

to release the information contained in this form to the persons responsible for evaluating my application for services, as well as to the establishment where I may eventually be referred.

_____
Signature of beneficiary

_____
Signature of authorized representative if beneficiary is incapacitated

CAPACITY OF REPRESENTATIVE?

☐ parent or person responsible ☐ public guardian

☐ private guardian ☐ legally authorized person

_____
Date of authorization

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APPENDIX VII

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

COMPLEMENTARY AUTONOMY ASSESSMENT FORM

To be completed with the significant person

(Facility: Short-term hospital centre)

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Beneficiary:	Assessment date
Assessor:	

1- CONTEXT OF THE REQUEST

What would you say is(are) the reason(s) that have led the beneficiary (or other mediator) to submit a request for services?

2- BENEFICIARY'S FUNCTIONAL AUTONOMY AT HOME

While the beneficiary was at home, how did he organize his daily activities *(ex.: personal hygiene, meal preparation, housework, shopping, going out, etc.)?*

Did he exhibit any particular problems as to his sensory abilities, physical mobility or habits that could restrict his functional autonomy?

Over the past year, the beneficiary's ability to carry out various activities of daily life...?

☐ has improved ☐ has not changed ☐ has deteriorated ☐ has deteriorated markedly

Explain:

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3- SOCIAL AND FAMILY SITUATION

Describe the nature of the beneficiary's relations with his family and with other people in his circle.

- Relations with the family *(spouse, children, relatives)*

- Other relations *(friends, neighbours...)*

How does the beneficiary's circle view his loss of autonomy?

Comments:

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4- SUPPORT FROM THE NATURAL NETWORK

While the beneficiary was at home, did anyone from his circle provide support on a day to day basis (ex.: assistance with daily activities, hygiene and health care, contact with friends, moral support, feeling of reassurance, etc.)?

☐ yes → **Complete 4A** ☐ no → **Complete 4B**

4A- SUPPORT PROVIDED BY THE BENEFICIARY'S CIRCLE

Who provided support for the beneficiary, and what did he(they) do for him?

In view of the beneficiary's CURRENT SITUATION, do you feel the support described above can be maintained in the future?

☐ can be maintained, and in this case

☐ will be sufficient → **Move to 5**

☐ will not be sufficient: in this case, what additional assistance will the beneficiary require? **(then move to 4B)**

☐ cannot be maintained: in this case, why? **(then move to 4B)**

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4- SUPPORT FROM THE NATURAL NETWORK (continued)

4B- SUPPORT FROM BENEFICIARY'S CIRCLE INSUFFICIENT OR NONEXISTENT

Do you know anyone who would agree to make up for the lack of support the beneficiary will eventually be faced with?

☐ yes, specify whom and what he(they) could do for the beneficiary ☐ no

Comments:

5- INTELLECTUAL CAPACITIES, BEHAVIOUR AND EMOTIONAL CONDITION

Does the beneficiary exhibit any problems with respect to the following?

	No	Yes	If yes, how does this problem affect the beneficiary, and since when?
Orientation (time-space-persons)			
Memory (short and long-term)			
Judgment			
Adaptability			
Behaviour			

Describe what best characterizes the beneficiary's EMOTIONAL CONDITION *(feelings, humour, will...)*

Comments:

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6- OPINION OF THE SIGNIFICANT PERSON AS TO THE BENEFICIARY'S SITUATION AND PLACEMENT

What do you feel is(are) the beneficiary's major problem(s) at the present time?

How does the beneficiary react to an eventual use of home care services, day centre services, changing residence, or placement in a housing facility? What are the reactions of his circle?

- Beneficiary's reactions:

- Reactions of his circle:

Comments:

7- ASSESSMENT CONTEXT

COMPLEMENTARY ASSESSMENT PERFORMED:

By
- Assessor:
- Establishment ..... Tel :

With
- Significant person:
- Address:
- Tel: (res.) ..... (off.) .....
- Relation to beneficiary

Comments:

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APPENDIX VIII

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

AUTONOMY ASSESSMENT FORM

(Facility: in the home)

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INSTRUCTIONS FOR USE

Part A, receipt and registration of the request, is used to forward requests to the workers concerned.

Using **Part B,** the preliminary autonomy assessment:

- the request is either refused, or
- the person is referred to another resource, or
- short-term services are approved and/or
- the assessment process is continued

Part C, the assessment of the beneficiary's autonomy, begins by listing the themes covered in the assessment. The assessor checks the themes that require investigation. The assessment can be spread over a variable time frame, depending on the beneficiary's situation. Every theme must be covered when a change in living environment is contemplated or if the beneficiary presents major risk factors.

Part D, the complementary assessment of the beneficiary's autonomy, must be completed for every case involving a presumption of change in living environment; it is optional in other cases.

Part E, reassessment, is used to indicate those themes that have been reassessed and the reassessment dates.

MINI-GUIDE

Note: *The masculine form is used to designate both men and women.*

The **FILE NUMBER** is a code that is registered and used to identify the beneficiary. The code is usually assigned by the organization receiving the service request.

The **MEDIATOR OF THE REQUEST** is the person who submits the service request. This could be the beneficiary himself, a relative or friend (spouse, child, neighbour, etc.) or a worker in the network (social worker, nurse, ...). In the first two cases, the respondent is requested to indicate who referred him to the organization receiving the request.

If the request is considered admissible, the person who receives it completes the **IDENTIFICATION** section.

• **BENEFICIARY'S FAMILY NAME AND GIVEN NAME AT BIRTH, AND FAMILY NAME OF SPOUSE.** If a woman beneficiary is separated, divorced or a widow but continued to use the name of her spouse, be sure to record the name she normally uses.

• The **SOCIAL INSURANCE NUMBER and HEALTH INSURANCE NUMBER** can be filled in when the request is recorded or during subsequent contacts with the beneficiary (or other mediator).

•The beneficiary's permanent address refers to his own home. It may be that, at the time the service request is made, the beneficiary is temporarily living with another person (ex.: relative, friends...) but still maintains his own home. In this case, both the **PERMANENT** and the **TEMPORARY** address are indicated.

RECEIPT AND REGISTRATION OF THE REQUEST

Beneficiary: .....

Date of contact: .....

File no.: .....

REQUEST

Mediator of the request:

☐ beneficiary,

☐ friend, relative, etc.

referred by: .....

☐ worker in the network

Name: .....
Tel.: .....
Relation: .....

Name: .....
Tel.: .....
Establishment: .....

Nature of the request *(as expressed by the mediator)*

.....

.....

.....

.....

.....

.....

.....

.....

Is this the first request you have submitted to this organization (for the beneficiary)? ☐ yes ☐ no

If not, when was the most recent request submitted? .....

☐ services provided ☐ services not provided

IDENTIFICATION (If the request is admissible)

Name at birth _____ Given name: _____

Name of spouse: _____

Health insurance n°.: _____ Social insurance no. (if available): _____

Date of birth: _____ Age: _____ Sex: ☐ F ☐ M

Permanent address: _____

Postal code: _____ Tel.: _____

Temporary address (if applicable): _____

Postal code: _____ Tel.: _____

DECISION

Decision at reception

☐ request refused, no referral, give reasons

.....

.....

☐ request refused, referred to another resource, indicate which one and why?

.....

.....

☐ request approved for assessment: ☐ preliminary ☐ complete

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APPENDIX VIII

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN EXTENDED CARE AND SERVICE FACILITIES

AUTONOMY ASSESSMENT FORM

(Facility: in the home)

PART "B"

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PRELIMINARY ASSESSMENT

Beneficiary: .....

Assessment date: .....

Assessor: .....

File no.

CONTEXT OF THE REQUEST

BENEFICIARY (OR OTHER MEDIATOR OF THE REQUEST)

What factors or problems *(health or social)* have led you to submit a service request?

TYPE OF ASSISTANCE REQUESTED

Specify the expectations of the beneficiary or respondent.

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The **RESIDENTIAL CONTEXT** theme is used to learn whether the beneficiary lives at home or at another person's home, whether he lives alone or with one or more other persons, in other words, whether he is in regular contact with people in his circle or is more or less isolated. It is also used to determine his reactions to his particular situation. The assessor must be on the alert for risk factors.

The beneficiary's **CIRCLE**, is the group of people who are on familiar terms with the beneficiary.

An **UNEXPECTED SITUATION** is used in the broad sense, to cover any sudden event that could place the beneficiary in a situation in which he needs material or human assistance.

The assessor specifies the beneficiary's **ETHNIC ORIGIN and RELIGION** under the **SOCIODEMOGRAPHIC INFORMATION** theme, if he feels this information is relevant to the assessment and eventual placement. When required, he provides details on these aspects if he feels they may have a significant impact on the placement.

For beneficiaries with **NO SCHOOLING**, the assessor is requested to indicate whether he is able to read or write.

MAIN OCCUPATION(S) means the activity (remunerative or not) to which the majority of the beneficiary's time is (or was) devoted.

OTHER STEPS TAKEN

Have you taken other steps to try to resolve your problem?

☐ yes, specify which ones, with whom or which organization, and the results obtained:

.....

.....

.....

.....

.....

☐ no, why:

.....

.....

.....

RESIDENTIAL CONTEXT

Where do you currently live?

☐ your own residence
☐ another person's residence, specify:

Name: ..... Relation: .....

Reason(s) .....

..... Since when? .....

(Your own residence)

Do you live...? ☐ alone
☐ with one or more people (how many?) → ☐ spouse
☐ child(ren) ..... ☐ friend .....
☐ parent(s) ..... ☐ stranger(s) .....

Usually, were you alone during...?

the day ☐ no ☐ yes, specify: .....
the evening ☐ no ☐ yes, specify: .....
the night ☐ no ☐ yes, specify: .....

Person's attitude toward this situation (fear, insecurity, etc.) .....

.....

.....

On whom could you count in the event of an unexpected situation?

☐ could count on... name(s) ..... relation: .....
☐ could not count on anyone

SOCIODEMOGRAPHIC INFORMATION

MARITAL STATUS: ☐ single ☐ widowed ☐ divorced ☐ separated
☐ married de facto union, age of spouse:_____ ☐ religious

(If relevant) ETHNIC ORIGIN: ..... RELIGION: .....

SCHOOLING: ☐ no schooling → can he read? ☐ yes ☐ no can he write? ☐ yes ☐ no
☐ elementary/primary ☐ high school ☐ vocational /technical ☐ collegiate/classical ☐ university

MAIN OCCUPATION(S) .....

.....

.....

.....

.....

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The last two categories in the **DECISION** theme are not mutually exclusive.

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: .....

Address: .....

Tel : (at home) ..... (at work) .....

Relation to beneficiary: .....

RESPONDENT

Preliminary assessment performed with:

☐ the beneficiary

☐ other person, whom? .....

relation or status?: .....

has the beneficiary been advised of the request made on his behalf?

☐ yes, does he agree? .....

.....

.....

☐ no, why not? .....

.....

.....

DECISION

Assessor's decision

☐ request refused, no referral, give reasons

.....

.....

.....

.....

☐ request refused, referred to another resource, indicate which one and why

.....

.....

.....

.....

☐ request approved, short-term services required, specify:

.....

.....

.....

.....

☐ request approved for assessment of the beneficiary's autonomy,

scheduled for: .....

Assessor's signature: .....

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CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

AUTONOMY ASSESSMENT FORM

(Facility: in the home)

PART "C"

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Part C, **ASSESSMENT OF THE BENEFICIARY'S AUTONOMY**, begins with a list of themes covered in the assessment. The assessor checks those themes that require investigation. The assessment may be spread out over a variable time frame depending on the beneficiary's situation.

Any comments the assessor wishes to make concerning his decision to investigate a theme or not should be made under **REMARKS.**

ASSESSMENT OF THE BENEFICIARY'S AUTONOMY

Beneficiary: .....

Assessor: .....

File no.:

☐ Complete assessment ☐ Partial assessment

THEMES	Yes	No	Remarks	Section completed (date)
• Eyesight, hearing, and ability to speak (C.2)				
• Physical mobility (C.2, C.3)				
• Functional autonomy (C.4)				
• Elimination, specific care required, medication (C.5)				
• Habits (C.6)				
• Utilization of services (C.7)				
• Family and social relations (C.8, C.9)				
• Support from the natural network (C.9)				
• Beneficiary's responsibilities (C.10)				
• Personal and community activities (C.10)				
• Economic conditions (C.11)				
• Housing conditions (C.12)				
• Beneficiary's opinion with respect to his situation and placement (C.13)				
• Intellectual capacities, emotional condition and behaviour (C.14)				

N.B.: *Attach the page(s) dealing with the theme(s) investigated and pages C.15 and C.16.*

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EYESIGHT, HEARING AND SPEECH. In the event of a specific sensory problem, the assessor is requested to attach any specific examination report available (ex.: speech therapy).

• A **MINOR LIMITATION** means a reduction in capacity which has very little or no affect on the beneficiary's ability to carry out his usual activities. The **MAJOR LIMITATION** category is used when the impairment is sufficiently serious to hinder the beneficiary's ability to carry out normal activities that are necessary for his well-being.

• Examples of **TYPE OF AID/SUBSTITUTION**

— sight: eyeglasses, contact lenses, magnifying glass, large print, etc.

— hearing: loud voice, shouts, hearing aid, lip reading, telephone amplifier, TV decoder, etc.

— speech: written communication, gestures, sign language, shouts, sighs, etc.

The beneficiary's **PHYSICAL MOBILITY** is assessed in relation to three aspects: limitation or loss of one or more limbs or parts of the body, rehabilitation and range of mobility. The first aspect (A) concerns physical impairments that limit the beneficiary's movements. The second aspect (B) specifies any rehabilitation program already undertaken in regard to the mobility problems identified. Finally, the last aspect (C) is used to assess the beneficiary's ability to move about on his own within his environment, i.e. without help from others but taking the aid(s) used into account.

• A description of the nature of the problem must be given for each part of the body affected by a **LIMITATION** (ex: trembling, problems with gripping, pain, etc.). An indication must also be given as to **HOW LONG** the beneficiary has been affected by the problem. Since mobility problems are to a large degree progressive in nature, it will not always be possible to give a precise date. In such cases, an estimate of when the problem first appeared should be given.

• The question "Are you... **RIGHT-HANDED OR LEFT-HANDED?**" provides an essential item of information for rehabilitation workers. When related to data concerning the impairments, this information helps to more accurately determine how serious the loss of autonomy is and thus to better assess what type of intervention is required. For example, a right-handed person suffering from hemiplegia on the right side does not experience the same type of difficulties as a left-handed person with the same affliction. He may therefore, by that very fact, need services of a different nature.

• It is important to indicate under **AID(S) USED** only those aids the beneficiary actually uses. For example, he may own a walker, but never use it. Also, if the beneficiary uses a **PROSTHESIS or ORTHOPEDIC APPLIANCE**, the assessor is requested to specify the type.

AN **ORTHOPEDIC APPLIANCE** is used to correct a limb or part of the body suffering from a limitation (ex: an orthopedic shoe).

A **PROSTHESIS**, acts as a full or partial replacement for a limb or organ (ex: an artificial leg).

• When the beneficiary uses one or more aid(s), you must indicate whether he **NEEDS ASSISTANCE** to use it. This may involve help:
- in installing (ex: putting on, removing, attaching, adjusting a prosthesis, etc.)
- in transferring (ex.: from a wheelchair to a bed, the bath, the toilet, the car, etc.)
- in moving (ex.: support, pushing a wheelchair, etc.)

• The assessor may use the **COMMENTS** section for remarks on subjects such as: the beneficiary's acceptance of his situation, his recovery potential, the effectiveness of the aid, etc.

EYESIGHT, HEARING AND SPEECH

Do you have difficulty:	Excluding the aid(s)/ substitution(s) used				Aid(s)/substitution(s)?				
	Adequate	LIMITATION Minor	LIMITATION Major	TOTAL Loss	NO	YES	ADEQUATE?	INADEQUATE?	Type of aid(s)/substitution(s) used? Comments
SEEING?									
HEARING?									
SPEAKING?									

Comments .....

PHYSICAL MOBILITY

A- LIMITATION OR LOSS OF ONE OR MORE LIMBS OR PARTS OF THE BODY

Do you have difficulty with certain movements? ☐yes ☐no

Part(s) of the body	Description of the limitation for each part affected; for how long?
Right or left hand	
Right or left arm	
Right or left hip	
Right or left leg	
Right or left foot	
Right or left side of body	
Cervical region	
Spinal column	
Generalized	

Are you... ☐right-handed ☐left-handed?

Do you use any of these aids?

☐none
☐cane
☐walker
☐tripod, quadripod
☐ramps, support bars
☐orthopedic appliance.....
☐prosthesis.....
☐wheelchair (manual)
☐motorized wheelchair
☐other.....

} Do you own it? ☐yes ☐no

If any aid is used: do you (does he) need help to use it?

If yes, specify the type of assistance required: .....

Comments: .....

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B- Rehabilitation

The assessor attaches any relevant rehabilitation report.

C- The beneficiary's **RANGE OF MOBILITY** refers to the "distance" he is able to move from a fixed point, in this case, his bed. A person's range of mobility can change with age. The normal range of mobility is then considered as the usual range of mobility for persons of the same age group. In the following scale, the first three categories cover a normal range of mobility while the remaining categories correspond to a progressively more restricted range of mobility.

The categories are mutually exclusive, so only one is to be indicated. If the "full mobility" category is indicated, the assessor moves directly to following theme. Otherwise, he completes the other questions in the section.

The categories are defined as follows:

- **Full mobility:** persons in this category have a normal range of mobility.

- **Full mobility with occasional restrictions:** this category includes persons with intermittent disabilities (changing course of the illness, for instance, in the case of rheumatoid arthritis or osteoarthritis, persons suffering from bronchitis whose mobility is restricted by temporary climactic constraints, persons with severe asthma,...). Except for periods of temporary disability, these persons have a normal range of mobility.

- **Full mobility at reduced speed:** this category includes persons with a normal range of mobility except that they move more slowly as a result of, for example, poor eyesight, insecurity, or, in an urban setting, difficulties in using public transportation, although the person always manages to overcome these difficulties without assistance from others.

- **Full mobility over a reduced range:** this category includes persons whose mobility is reduced as a result of, for example, problems with eyesight, insecurity, fragility, weakness, cardiac or respiratory problems; or in an urban setting, as a result of their inability to use public transportation at all times. These persons can move about without assistance beyond the immediate surroundings of their home, but cannot go everywhere "without assistance". Their range of mobility is thus more restricted than a normal range.

- **Mobility restricted to the home and its surroundings:** this category includes persons whose movements are ordinarily limited to the area surrounding their home.

- **Mobility restricted to the home:** persons in this category normally can move about only within their home.

- **Mobility restricted to the room:** persons in this category are restricted to their room.

- **Mobility restricted to the chair:** persons in this category are confined to their chair.

- **Mobility nil:** persons in this category are confined to a bed.

Note: *the preceding scale was adapted from the ICIDH - WHO - 1980.*

FACTORS RESTRICTING MOBILITY designate the indicators that help to understand what is restricting the beneficiary's mobility. Factors inherent to the beneficiary do not necessarily correspond to an established medical diagnosis.

B- REHABILITATION (if mobility problems have been previously indicated)

Have you previously undergone rehabilitation for your mobility problems?

☐ yes, specify: type, duration, when, where, results: .....

☐ no, why? .....

Comments: .....

C- RANGE OF MOBILITY

Bearing the aid(s) in mind, BUT EXCLUDING ASSISTANCE FROM OTHERS. How freely can you move about?

- ☐ full mobility → **Do not complete the rest of the section**
- ☐ full mobility with occasional restrictions
- ☐ full mobility at reduced speed
- ☐ full mobility over a reduced range
- ☐ mobility restricted to the home and its surroundings
- ☐ mobility restricted to the home
- ☐ mobility restricted to the room
- ☐ mobility restricted to a chair
- ☐ mobility nil

Specify the factor(s) restricting mobility

Inherent to the beneficiary

- ☐ restriction in the mobility of one or more limbs
- ☐ amputation of one or more limbs
- ☐ problems with balance
- ☐ psychological problems
- ☐ cecity
- ☐ obesity
- ☐ cardiac problems
- ☐ respiratory problems
- ☐ inactivity, low activity level
- ☐ other, specify: .....

Independent of the beneficiary

- ☐ structural barriers, specify: .....
- ☐ lack of physical resources, specify: .....
- ☐ other, specify: .....

If the factor(s) is(are) independent of the beneficiary, specify what his range of mobility might be if such obstacle(s) were removed.

Comments: .....

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The "**Functional Autonomy**" theme is designed to assess the beneficiary's ability to perform a number of everyday tasks. The tasks included in this section were chosen to represent the range of tasks a person regularly carries out to maintain health and well-being. They have been grouped here by theme.

For each activity, the beneficiary is graded according to the following four degrees of autonomy:

- The beneficiary perfoms the activity **WITHOUT ASSISTANCE FROM OTHERS.**
- The beneficiary requires **ASSISTANCE FROM OTHERS** to perform the activity. This may involve supervision, monitoring, partial assistance, etc. In each case, the assessor must provide detailed information concerning the type of assistance needed.
- The beneficiary does not perform the activity, somebody else does it for him. In other words, the activity is performed **BY OTHERS.**
- The category **ACTIVITY NOT PERFORMED** covers a situation in which the activity is simply not performed, neither by the beneficiary nor by somebody else, for instance, going out of doors in winter.

As indicated on the right side of the table, if an activity is performed **WITH ASSISTANCE FROM OTHERS, BY OTHERS or NOT PERFORMED,** it is important to give the reasons for this situation. If the reasons are independent of the beneficiary (ex: structural barriers), some indication of the beneficiary's POTENTIAL to perform the activity in question must be given.

The activities we are concerned with are as follows:

Serving a meal: preparing a plate or tray, sitting down to eat.

Eating: cutting or otherwise manipulating food, eating and drinking during meals and snacks.

Preparing light meals: preparing snacks, lunch,...

Preparing full meals: preparing adequate and substantial dishes (combining, mixing, cooking... food).

Washing oneself: preparing the sink or basin, the toiletry articles, washing and dressing oneself regularly.

Shaving: shaving, rinsing.

Taking a bath/shower: running the bath, entering the bathtub (or shower), washing oneself, getting out of the bathtub (or shower), drying oneself.

Washing one's hair: preparing the articles required, washing the hair, drying, storing the articles.

Dressing/undressing: preparing the clothes to be worn, putting them on, tying one's shoes, putting on accessories, undressing and storing the clothes.

Using the toilet: undressing (as needed), settling oneself on the toilet or commode, cleaning, getting up, dressing.

Getting up/lying down: moving from a lying position to a standing position and getting back into bed.

Walking: going from on place to another, moving on foot (with or without mechanical aid) (excluding going up/down the stairs and getting about in a wheelchair).

Going outside - summer: walking at least a short distance outside in the summer and returning with little difficulty.

Going outside - winter: walking at least a short distance outside in the winter and returning with little difficulty.

Going up/down the stairs: using the stairs either to go up or come down.

Shopping: going outside to do one's shopping.

Using public transportation - summer: during the summer, planning a route, going to the service area, entering and leaving the vehicle (ex.: bus, subway, train).

Using public transportation - winter: during the winter, planning a route, going to the service area, entering and leaving the vehicle (ex.: bus, subway, train).

Using the telephone: picking up the receiver, dialing the number and communicating.

Doing regular housework: performing the usual household tasks such as dusting, ironing, etc.

Doing the washing: gathering and sorting clothes, putting them in the machine, operating the machine, etc.

Doing heavy housework: doing the heavy work involved in household upkeep (washing the floors, the walls, changing windows, moving furniture, etc.).

The assessor may use the **COMMENTS**, section for remarks on subjects such as: the assessment of the beneficiary's dependence, the risks to which he is exposing himself, his potential, the results of action already taken, etc.

Do you perform the following activities?	Act. performed: Unaided	Act. performed: With assistance from others	Act. performed: By others	Activity not performed	If the activity is performed unaided: specify whether the beneficiary must make a particular effort to perform the activity unaided. If the activity is performed with assistance from others: specify the type of assistance given, and who is providing it. If the activity is performed with assistance from others by others or is not performed; indicate the reason(s) and, if they are independent of the beneficiary, mention his POTENTIAL to perform the activity in question.
- serve your own meals?					
- eat					
- prepare light meals (lunch)					
- prepare full meals					
- wash yourself					
- shave					
- take a bath/shower					
- wash your hair					
- dress, undress					
- use the toilet					
- get up/lie down					
- walk					
- go outside - summer					
- go outside - winter					
- go up/down the stairs					
- do your shopping					
- use public transportation in the summer					
- use public transportation in the winter					
- use the telephone					
- do regular housework					
- do the washing					
- do heavy housework					
- other					

During the past year, your ability to perform these various activities...

☐ has improved ☐ has not changed ☐ has decreased ☐ has decreased markedly

Explain: .....

Comments: .....

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Under the theme **ELIMINATION**, the assessor must specify the frequency with which incidents of incontinence occur, either on a daily of weekly basis. Regardless of whether the beneficiary uses an aid or not, the assessor must specify whether an aid is needed, and give details of any problem(s) related to incontinence, such as: the person must be taken to the toilet regularly, access to the toilet is restricted by structural barriers or distance, the person is unable to clean himself, etc.

If the beneficiary needs **SPECIFIC CARE**, it is important to provide as much information as possible concerning the administration of such care. For instance, the beneficiary needs some form of assistance to clean his stomy at regular intervals.

A **GASTRIC FEEDING TUBE** is used to administer a special liquid nutrient formula.

OXYGEN may be administered on a continuous or intermittent basis. It may be taken using a mask or nasal prongs. Aerosol therapy treatments (medication administered using a spray) must also be reported.

SUCTION OF SECRETIONS from the oral or nasal cavity is performed using a catheter attached to a suction machine. Tracheal secretions may be eliminated from a beneficiary with a tracheostomy (surgical opening in the trachea) using suction.

INSULIN is administered by subcutaneous injection.

A **STOMY** is a surgical opening made in the stomach (gastrostomy), the trachea (tracheostomy), the colon (colostomy), the bladder (cystostomy) etc... and requires specific care.

DISIMPACTING consists of manually removing fecal matter from the rectal cavity.

BANDAGING consists of applying protective material to a wound. When it is time to change the bandage, it may be necessary to apply medication, change a tent, clear a drainage tube, wash the wound, remove stitches, etc.

ELIMINATION

Do you suffer from incontinence...?

Urinary

☐ yes → ☐ diurnal ☐ nocturnal
☐ no frequency: .....

☐ no aid
☐ condom ☐ catheter
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Fecal

☐ yes → ☐ diurnal ☐ nocturnal
☐ no frequency: .....

☐ no aid
☐ colostomy
☐ incontinence pad

☐ no aid required
☐ aid required, specify: .....

Give details of any problem: .....

Comments: .....

SPECIFIC CARE REQUIRED (if relevant)

Indicate the specific care the beneficiary currently requires *(attach nursing report, if relevant):*

☐ gastric feeding tube ☐ oxygen ☐ suction of secretions ☐ stomy ☐ insulin ☐ disimpacting ☐ bandage(s)

☐ other .....

Remarks *(ex.: beneficiary is autonomous or needs assistance, type of assistance, frequency, etc.)*

MEDICATION

Do you take medicine? ☐ yes ☐ no → **Do not complete the rest of this section**

Name	Dosage	For what problems?	Prescription yes	Prescription no

Do you need assistance to take your medication? ☐ yes ☐ no

If yes, what difficulties do you have *(ex.: opening the container, identifying the medicine, etc.)*?

Comments: .....

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This theme deals with the beneficiary's "**Habits**". Quality of sleep, tobacco use, consumption of alcohol, diet and the associated events are important facets of everyday life. The beneficiary's opinions on these aspects are an indication of his well-being and, when related to other information from the autonomy assessment, are useful in gauging the scope of some of his problems or their consequences on his health (ex: quality of sleep versus consumption of soporifics, type of diet versus financial problems, etc.).

TOBACCO-ALCOHOL

If the beneficiary smokes or consumes alcohol, the assessor must pay particular attention to the problems which may accompany these habits.

TOBACCO: "Is **MONITORING** needed when the beneficiary smokes?" Monitoring means the presence of or assistance by another person or any form of protection (ex: protective apron).

• The beneficiary's **DIET** is entered under the major food categories. With this information, it should be possible to detect any eventual deficiencies compared to the categories of food needed for a balanced diet.

SUBSTITUTES include eggs, cheese and leguminous plants (ex: chickpeas), among others.

The **BREAD AND CEREALS** category also includes starchy foods (ex: rice, pasta).

HABITS

REST-SLEEP

Are you satisfied with your sleep? ☐yes ☐no

If not, why? .....

Do you take a nap during the day? ☐yes ☐no .....

.....

TOBACCO

Do you smoke? ☐yes ☐no

Comments: .....

.....

.....

.....

ALCOHOL

Do you consume alcohol (beer, wine, spirits)? ☐yes ☐no

Comments: .....

.....

.....

.....

APPETITE - FOOD - DIET

Do you USUALLY have a good appetite when you eat? ☐yes ☐no .....

Do you eat? ☐alone ☐with others: .....

Where do you usually eat? ☐kitchen/dining room ☐chair ☐bed

☐away from home: where? .....

Do you consume...?

	Dly.	Wkly.	Rarely or never		Dly.	Wkly.	Rarely or never
• milk and milk products	☐	☐	☐	• sweets, dessert, soft drinks	☐	☐	☐
• meat and substitutes	☐	☐	☐	• water	☐	☐	☐
• fruits/vegetables	☐	☐	☐	• coffee, tea	☐	☐	☐
• bread and cereals	☐	☐	☐	• others			

Remarks: .....

.....

.....

.....

Are you currently on a diet? ☐yes ☐no

If yes, what kind of diet? .....

Was it prescribed by a physician ☐yes ☐no .....

.....

DENTITION

Do you have problems with your teeth (natural or dentures)? ☐yes ☐no

If yes, specify: .....

.....

.....

Comments:

.....

.....

.....

.....

.....

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The theme **UTILIZATION OF SERVICES** deals with the services the beneficiary receives and with the accessibility of medical resources.

- **AID SERVICES** refer to housekeeping, meal, companionship, etc. services.

- **OTHER** includes: podiatry, nutrition, speech therapy, psychology, psychogeriatric services, etc.

- **ORGANIZATIONS** capable of providing the services or care mentioned are: the LCSCs, SSCs, day centres, volunteer organizations, private organizations, etc.

UTILIZATION OF SERVICES PRIOR TO HOSPITALIZATION

Do you currently make use of...?	NO	YES			
		WHERE? at home	outside	from which organization(s)?	specify the nature of the services/care received, and their frequency
• aid services					
• nursing care					
• social services					
• physiotherapy					
• ergotherapy					
• other					
•					

If yes, are you satisfied with the services/care your receive *(quality and quantity)*?

• Are you under the care of one or more family physicians? ☐yes ☐no

If yes, give the name(s) of the physician(s), the frequency of their visits, where they took place *(i.e. at home or in the physician's office)*, the date of your last visit and the reasons why you were under such care.

• Are you under the care of one or more specialists? ☐yes ☐no

If yes, give the name(s) of the specialist(s), the frequency of their visits, where they took place *(i.e. at home or in the physician's office)*, the date of your last visit and the reasons why you were under such care.

• Were you hospitalized during the past three years? ☐yes ☐no

If yes, why?

Where?

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The theme **FAMILY AND SOCIAL RELATIONS** is an important aspect of the beneficiary's psychosocial situation. The assessor explores this aspect with the beneficiary, as indicated in the form, and records the latter's answers, impressions and comments in the appropriate spaces.

The assessor is asked to pay particular attention, where appropriate, to the beneficiary's relations with his spouse, with a view to detecting any sexual problems, problems of violence, exploitation, etc.

FAMILY AND SOCIAL RELATIONS

Do you have:	No	Yes	How often are you in touch with them (visits, phone calls, outings...)
• children?		No.	
• grandchildren?		No.	
• relatives?			
• friends?			

NATURE OF CONTACTS AND BENEFICIARY'S SATISFACTION

Specify the nature of the relations the beneficiary maintains with his family on the one hand and with qther members of his circle on the other. Indicate his opinion as to his satisfaction with these contacts.

Relations with family *(spouse, children, relatives)*

Other social relations *(friends, neighbours, etc.)*

HOW THE BENEFICIARY PERCEIVES HIS CURRENT SITUATION VIS-A-VIS HIS CIRCLE

Specify how the beneficiary perceives the impact of his loss of autonomy on his circle.

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PARTICULAR EVENT(S) may be associated with the beneficiary himself or with any other person in his circle.

The theme **SUPPORT FROM THE NATURAL NETWORK** is used to explore the support the beneficiary receives from his circle. The helper(s) is(are) identified, as well as the type of assistance he(they) provide. This section is also used to determine whether, in view of the beneficiary's current situation, it is possible to continue providing this assistance.

PARTICULAR EVENTS

Has the beneficiary experienced one or more PARTICULAR EVENTS that has(have) a continuing impact on his current situation? ☐yes ☐no

If yes, specify the event(s), when it(they) occurred and the beneficiary's reaction to it(them)

Comments:

SUPPORT FROM THE NATURAL NETWORK

Does the beneficiary receive support from anyone in his circle for his daily activities?
(ex: assistance for daily activities, health care and hygiene, friendship, moral support, reassurance, etc.)

☐yes → **Complete A** ☐no → **Complete B**

A- SUPPORT FROM THE BENEFICIARY'S CIRCLE

Specify which persons(s) provide(s) support and what he(they) do.

☐see information provided under "Functional autonomy" (C.4)
☐other information, specify:

Will the assistance the beneficiary is now receiving be available in the future? ☐yes ☐no

If yes, does asking for help make the beneficiary uncomfortable?

☐yes, why? ☐no

Is the assistance he is now receiving adequate? ☐yes → **Do not complete the rest of this section** ☐no → **Complete B**

If the assistance the beneficiary is now receiving will not be available in the future, explain why and complete B.

B- NONEXISTENT (or insufficient) SUPPORT FROM THE BENEFICIARY'S CIRCLE

What (additional) assistance does he require?

Does he know anyone who would agree to provide the support that is lacking (or nonexistent)?

☐yes, specify whom and what he(they) could do ☐no

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The theme **BENEFICIARY'S RESPONSIBILITIES** is used to identify responsibilities the beneficiary may have toward one or more persons in his circle (ex: material or financial assistance, moral support, dependent person, etc.).

Information concerning the beneficiary's usual activities or occupations, as well as his centres of interest, is grouped under the theme **PERSONAL AND COMMUNITY ACTIVITIES.**

BENEFICIARY'S RESPONSIBILITIES

Do you have responsibilities toward a person(s) of your circle (family or other)?

☐ yes ☐ no → **Do not complete the rest of this section**

If yes, toward whom? name(s) ..... relation ..... age .....

what kind of responsibilities *(material, financial, etc.)?* .....

do you feel you can continue to meet these responsibilities? ☐ yes ☐ no

If no, why not? .....

is(are) this(these) person(s) directly concerned by this request? ☐ yes ☐ no

if yes, give details: .....

Comments: .....

PERSONAL AND COMMUNITY ACTIVITIES

How do you spend your time during the day? .....

Do you go out for certain activities *(personal, recreational, social, etc.)?*

☐ yes, specify for which one(s): .....

☐ no, why not? .....

Are you satisfied with how you spend your time during the day? ☐ yes ☐ no

Is there any activity you like and miss doing? ☐ yes ☐ no

If yes, what is it(are they)? .....

what is keeping you from doing it(them) *(ex.: money problems, structural barriers, etc.)*

Comments: .....

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This theme deals with the **BENEFICIARY'S ECONOMIC SITUATION.** The assessor begins by asking the beneficiary general questions (satisfaction, budget management, major source(s) of income and obligations). *Only if the beneficiary admits he has difficulty fulfilling his obligations does the assessor undertake a more detailed assessment of the economic aspect.*

If the beneficiary does not manage his own **BUDGET,** it is important to accurately identify who (name of person, PUBLIC or PRIVATE GUARDIAN...) has assumed this responsibility on his behalf.

PRIVATE GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property. The application for interdiction must be submitted by a member of the family before the family council and confirmed by a judge.

PUBLIC GUARDIANSHIP is awarded in cases in which a person is judged to be incapable of administering his property on the basis of a medical certificate of mental incapacity issued by a psychiatrist.

ECONOMIC SITUATION

Do you feel your income is enough to enable you to live in a satisfactory manner? ☐yes ☐no

Do you manage your own budget? ☐yes ☐no

If not, who manages it for you? ☐spouse ☐child ☐parent ☐friend
☐public guardian ☐private guardian ☐other,

Name:

reason(s):

Are you satisfied with how your budget is being managed? ☐yes ☐no

If not, why?

What is(are) your main source(s) of income *(pension, supplement, annuity, social aid, etc.)*?

Can you meet your current obligations with your current income *(rent, food, clothing, medicine, etc.)*?

☐yes → **Do not complete the rest of this section** ☐no

If not, with what are you having difficulty?

what would you estimate is your monthly income? $

is it increased by the income of (an) other person(s)? ☐yes, $ / month ☐no

do you have any possessions *(real estate, savings)*? ☐yes, specify
☐no

How much do you spend per month for...?

. rent

. heating-electricity

. taxes

. food

. or room and board

. other recurrent expense(s)

Total $ / mth

Do you share these expenses with (an) other person(s)? ☐yes ☐no

Comments:

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The theme **BENEFICIARY'S HOUSING CONDITONS** is used to gather objective information as to the condition of the beneficiary's dwelling (number of rooms, access, floor plan, arrangement of furniture, sanitary facilities, etc.), and his impressions of his home, his neighbourhood and, if applicable, the fact of sharing his residence with others.

HOUSING CONDITIONS

How long have you been living in your current residence? .....

Type of dwelling... ☐ apartment ☐ private house ☐ rooming house
☐ HLM ☐ other .....

Are you...? ☐ owner ☐ tenant ☐ boarder

Are you satisfied with your present housing? ☐ yes ☐ no

If not, how would you like to improve it? .....

How many rooms does your dwelling have?.....

It is located ☐ on the ground floor ☐ in the basement
☐ _____ floor of the house or building →

access by
☐ an exterior stairway
☐ an interior stairway
☐ an elevator

Are the rooms functional for your purposes *(i.e. access is easy and you can use them)*? ☐ yes ☐ no, explain the problem:

When did you first move into this neighbourhood *(municipality)*? .....

Are you satisfied with your community *(environment, services, transportation, safety, etc.)*? ☐ yes ☐ no

If not, why not? .....

Where have you lived the longest *(region, city)*? .....

Is that place still significant for you today? ☐ yes ☐ no

If yes, why? .....

N.B.: *These questions are to be put only to persons sharing housing with a number of others*

Does sharing housing with others inconvenience you? ☐ yes ☐ no

If yes, explain why: .....

Do you feel your current housing arrangements will last? ☐ yes ☐ no
If not, do you contemplate any changes? ☐ yes ☐ no

If yes, specify: .....

when? .....

Comments: *(ex.: landlord-tenant relation, cost of housing, cleanliness, environment, etc.)*: .....

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This theme explores **THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION, AND THE ASSESSOR'S REMARKS.** The assessor provides an indication as to the beneficiary's eventual reactions in regard to one or more possible placements (return to the home, other intermediate or institutional resource).

THE BENEFICIARY'S OPINION WITH RESPECT TO HIS SITUATION AND ORIENTATION, AND THE ASSESSOR'S REMARKS

At the present time, what major problem(s) would you like to see settled as a first priority?

Have you previously taken any steps to solve this(these) problem(s)? ☐ yes ☐ no

If yes, for which problem(s) and with what result?

What solution(s) do you currently contemplate to improve your situation?
(The beneficiary's opinions on the advantages and disadvantages of the solution(s) contemplated, and of an eventual utilization of the services of the network).

ASSESSOR'S REMARKS

How does the beneficiary react to an eventual utilization of home care services, day centre services, a change of residence, residence in a facility, etc.?

If the beneficiary must move to a different environment, specify his wishes, if any, and the reasons for his choice.

Comments:

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This theme is used to record information concerning **THE BENEFICIARY'S INTELLECTUAL CAPACITIES, HIS EMOTIONAL CONDITION AND HIS BEHAVIOUR.**

The beneficiary's psychological and behavioural profiles are key factors in assessing his autonomy. The assessor is requested to provide as much documentation as possible concerning any problem noted.

INTELLECTUAL CAPACITIES

- **TIME ORIENTATION:** ability to situate himself in time, that is, to separate past, present and future, day and night, morning and afternoon, etc.

- **SPACE ORIENTATION:** ability to situate himself in space, that is, to know where he is physically.

- **ORIENTATION WITH RESPECT TO PERSONS:** ability to make good contact with people and reality, that is, to distinguish between imaginary or desired events and actual facts.

- **LONG-TERM MEMORY:** ability to remember past events and their associations.

- **SHORT-TERM MEMORY:** ability to remember recent events and their associations.

- **ATTENTION:** ability to concentrate on an a particular object or item of information.

- **COMPREHENSION:** ability to receive information and process it (grasp and interpret the meaning).

- **JUDGMENT:** ability to take a stand, make a decision in regard to an event or item of information.

- **ADAPTABILITY:** ability to become accustomed and adjust to a new environment or surroundings, to new situations.

The assessor completes the EMOTIONAL CONDITION and BEHAVIOUR sections based on his own observations and, if possible, information obtained from another person.

INTELLECTUAL CAPACITIES, EMOTIONAL CONDITION AND BEHAVIOUR

Based on your meetings with the beneficiary give an opinion with respect to the following three aspects:

INTELLECTUAL CAPACITIES	No problem	Problem How does this problem affect the beneficiary, and since when?
Time orientation		
Space orientation		
Orientation with respect to persons		
Short-term memory		
Long-term memory		
Attention		
Comprehension		
Judgment		
Adaptibility		

Comments: .....

.....

.....

EMOTIONAL CONDITION

Describe what best characterizes the beneficiary's emotional condition *(feelings, humour, emotions, will, motivation, etc.)*

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BEHAVIOUR

Does the beneficiary exhibit any behaviour problems? ☐ yes ☐ no

If yes, describe his problem(s) *(manifestations, relations with others, attitudes to objects, etc.)*

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Comments: .....

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The **ASSESSMENT CONTEXT** theme is used to identify the assessor who performed the assessment, any persons who participated in the assessment, and the person(s) who were interviewed. It is also used to record comments on the conditions under which the assessment took place (ex: beneficiary very cooperative).

The **ASSESSOR** is the person in charge of the process of assessing the beneficiary. He must record his name, profession, the establishment he is attached to and his telephone number at work.

During the assessment process, the assessor in charge of the case may call upon the services of one or more **PARTICIPATING PROFESSIONAL(S).** In such cases, the assessor must indicate his(their) name(s) and profession(s).

Concerning the respondent(s):

BENEFICIARY ALONE: indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically.

BENEFICIARY ALONE IN THE PRESENCE OF ANOTHER PERSON: indicates the beneficiary was the sole source of information with respect to questions addressed to him specifically, but that his answers were given in the presence of another person.

BENEFICIARY WITH HELP FROM ANOTHER PERSON: indicates another person participated in the assessment interview(s) with the beneficiary and this person helped him answer the questions addressed to him specifically.

If this category is indicated, the assessor must provide the name and telephone number of the person who helped the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

PERSON OTHER THAN THE BENEFICIARY: indicates the beneficiary did not participate in the assessment interview(s) and another person answered the questions normally addressed to the beneficiary. If this category is indicated, the assessor must provide the name and telephone number of the person who substituted for the beneficiary, his relation to the beneficiary and the main reason(s) for this situation.

ASSESSMENT CONTEXT

ASSESSMENT PERFORMED:

By:

Assessor: .....

Profession: ..... Tel.: .....

Organization: .....

Other professional(s) who PARTICIPATED in the assessment

Name: ..... profession: .....

Name: ..... profession: .....

With:

☐ beneficiary alone

☐ beneficiary alone IN THE PRESENCE of another person, who? .....

☐ beneficiary with HELP from another person

☐ PERSON OTHER than the beneficiary

→ Who assisted the beneficiary or answered for him during the assessment interview?

Name: ..... relation: .....

Reason(s): .....

Assessment performed:

☐ at the beneficiary's home ☐ by telephone

☐ at home care service

☐ other: .....

Assessment context *(mood, beneficiary's attitude, difficulties encountered...)*

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Under the theme **SUMMARY OF PROBLEMS AND RECOMMENDATIONS**, the assessor summarizes his assessment interview(s) with the beneficiary, identifying the latter's major problem(s), action(s) already taken and the results obtained, and formulates recommendations.

The assessor's role is crucial here. Because of his special position (direct contact with the beneficiary), he has the opportunity to isolate the major items of information the multidisciplinary team needs to take into consideration when it studies the beneficiary's case and assesses the services required, those which require closer attention.

The assessor is therefore requested to proceed on a PROBLEM BY PROBLEM basis, indicating in each instance if any action has been taken to achieve a solution and if so, by whom (within the network or otherwise), the results obtained and, finally, he is requested to suggest which means should be used to try to solve the problem(s) observed.

SUMMARY OF PROBLEMS AND RECOMMENDATIONS

Based on the information gathered from the respondent(s),

A- What would you say are the beneficiary's major problems?

B- To your knowledge, have any steps been taken to try to reach a solution? If yes, specify. What were the results?

C- In view of the beneficiary's current situation, what do you recommend?

A- Major problems (biological, psychological, social)	B- Action taken and results	C- Recommendations

Date: _____

Assessor's Signature: _____

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AUTHORIZATION OF BENEFICIARY

I authorize _____ appointed by _____
Name of assessor — Name of referring establishment

to release the information contained in this form to the persons responsible for evaluating my application for services, as well as to the establishment where I may eventually be referred.

_____
Signature of beneficiary

_____
Signature of authorized representative if beneficiary is incapacitated

CAPACITY OF REPRESENTATIVE?

- ☐ parent or person responsible
- ☐ public guardian
- ☐ private guardian
- ☐ legally authorized person

_____
Date of authorization

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APPENDIX VIII

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN EXTENDED CARE AND SERVICE FACILITIES

AUTONOMY ASSESSMENT FORM

(Facility: in the home)

PART "E"

AS-525E (A)

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REASSESSMENT

Beneficiary .....

File no. .....

Reassessment date .....

Assessor ..... Tel: .....

REASSESSMENT CONTEXT

Factors that have made a reasessment necessary:

- ☐ regular reassessment (section directive)
- ☐ indication(s) of deterioration in the beneficiary's situation
- ☐ indication(s) of improvement in the beneficiary's situation
- ☐ explicit request from the beneficiary
- ☐ other, specify: .....

Explain: .....

OVERAL PICTURE OF THE BENEFICIARY'S SITUATION

Indicate how the beneficiary's situation has changed in regard to each of the following aspects compared to the situation at the time of the most recent assessment (date:.....).

Indicate whether his situation has remained stable (↔), has deteriorated (↓), or has improved (↑). In the last two cases, specify whether a new assessment of the aspect in question has been performed.

THEMES	(section)	Situation ↔	Situation ↓	Situation ↑	Reassessed Yes	Reassessed No
• Eyesight, hearing, and ability to speak	(C.2)					
• Physical mobility	(C.2, C.3)					
• Functional autonomy	(C.4)					
• Elimination, specific care required, medication	(C.5)					
• Habits	(C.6)					
• Utilization of services	(C.7)					
• Family and social relations	(C.8, C.9)					
• Support from the natural network	(C.9)					
• Beneficiary's responsibilities	(C.10)					
• Personal and community activities	(C.10)					
• Economic conditions	(C.11)					
• Housing conditions	(C.12)					
• Beneficiary's opinion with respect to his situation and placement	(C.13)					
• Intellectual capacities, emotional condition and behaviour	(C.14)					

Comments: .....

AS 525E (A)

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APPENDIX IX

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

COMPLEMENTARY AUTONOMY ASSESSMENT FORM

To be completed with the significant person
(Facility: in the home)

PART "D"

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Beneficiary's name:	Assessment date
Assessor's name:	

1- CONTEXT OF THE REQUEST

What would you say is(are) the reason(s) that have led the beneficiary (or other mediator) to submit a request for services?

2- BENEFICIARY'S FUNCTIONAL AUTONOMY AT HOME

At home, how does the beneficiary organize HIS DAILY ACTIVITIES
(ex.: personal hygiene, meal preparation, housework, shopping, going out, etc.)?

Over the past year, the beneficiary's ability to carry out various activities of daily life...?

☐ has improved ☐ has not changed ☐ has deteriorated ☐ has deteriorated markedly

Explain:

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2- BENEFICIARY'S FUNCTIONAL AUTONOMY AT HOME (continued)

Does the beneficiary have specific problems in regard to the following aspects:

SENSORY CAPACITY *(eyesight, hearing, speech and associated aid(s))*

PHYSICAL MOBILITY *(moving, getting about, aid, rehabilitation, etc.)*

HABITS *(sleep, tobacco or alcohol, food, etc.)*

MEDICATION *(indications of excess consumption, problems in administering his own medication, etc.)*

ELIMINATION *(urinary or fecal incontinence and associated aid(s))*

ECONOMIC SITUATION *(income, expenses, budget management, etc.*

HOUSING CONDITIONS *(cleanliness, functionality, etc.)*

Comments:

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3- SOCIAL AND FAMILY SITUATION

Describe the nature of the beneficiary's relations with his family and with other people in his circle.

- Relations with the family *(spouse, children, relatives)*

- Other relations *(friends, neighbours...)*

How does the beneficiary's circle view his loss of autonomy?

Comments:

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4- SUPPORT FROM THE NATURAL NETWORK

Does anyone from the beneficiary's circle provide support on a day to day basis
(ex.: assistance with daily activities, hygiene and health care, contact with friends, moral support, feeling of reassurance, etc.)?

☐ yes → **Complete 4A** ☐ no → **Complete 4B**

4A- SUPPORT PROVIDED BY THE BENEFICIARY'S CIRCLE

Who provides support for the beneficiary, and what does he (do they) do for him?

Do you feel the support described above can be maintained in the future?

☐ can be maintained, and in this case

☐ will be sufficient → **Move to 5**

☐ will not be sufficient: in this case, what additional assistance will the beneficiary require? **(then move to 4B)**

☐ cannot be maintained: in this case, why? **(then move to 4B)**

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4- SUPPORT FROM THE NATURAL NETWORK (continued)

4B- SUPPORT FROM BENEFICIARY'S CIRCLE INSUFFICIENT OR NONEXISTENT

Do you know anyone who would agree to make up for the lack of support the beneficiary will eventually be faced with?

☐ yes, specify whom and what he(they) could do for the beneficiary ☐ no → **Move to 5**

Comments:

5- INTELLECTUAL CAPACITIES, BEHAVIOUR AND EMOTIONAL CONDITON

Does the beneficiary exhibit any problems with respect to the following?

	No	Yes	If yes, how does this problem affect the beneficiary, and since when?
Orientation (time-space-persons)			
Memory (short and long-term)			
Judgment			
Adaptability			
Behaviour			

Describe what best characterizes the beneficiary's EMOTIONAL CONDITION *(feelings, humour, will...)*

Comments:

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6- OPINION OF THE SIGNIFICANT PERSON AS TO THE BENEFICIARY'S SITUATION AND PLACEMENT

What do yo feel is(are) the beneficiary's major problem(s) at the present time?

How does the beneficiary react to an eventual use of home care services, day centre services, changing residence, or placement in a home care facility? What are the reactions of his circle?

- Beneficiary's reactions:

- Reactions of his circle:

Comments:

7- ASSESSMENT CONTEXT

COMPLEMENTARY ASSESSMENT PERFORMED:

By
- Assessor:
- Establishment ..... Tel :

With
- Name of significant person:
- Address:
- Tel: (res.) ..... (off.) .....
- Relation to beneficiary

Comments:

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APPENDIX X

CTMSP

CLASSIFICATION BY TYPES OF PROGRAM IN
EXTENDED CARE AND SERVICE FACILITIES

MEDICAL ASSESSMENT FORM

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MINI-GUIDE

N.B.: *If the space provided for an answer is insufficient, the physician is requested to use a separate sheet to be attached to the form. This applies to all sections of the form.*

Section 1 "Identification"

The beneficiary and his main sociodemographic characteristics are identified. The address and telephone number of the physician who performs the medical assessment are also recorded in this section. This information is important should the members of the multidisciplinary team require further details.

Section 2 "Current Situation"

The physician specifies the biological, psychological and social factors that have given rise to the service request submitted by the beneficiary (or other person acting on his behalf) and which have initiated the autonomy assessment process.

Setion 3 "Illness or Health Problems"

The physician provides his opinion as to the beneficiary's biological, psychological and social condition. This information is vital for the multidisciplinary team in its assessment of the services required.

Section 4 "Additional Data"

This section is for information concerning the beneficiary's weight, height, blood pressure, any allergies or wounds he may have, and certain habits. Use of tobacco, alcohol and drug consumption and dietary habits are all aspects of everyday life that provide an indication of the beneficiary's well-being. On the other hand, they may point to certain physical or psychological problems. The physician should pay particular attention to problems associated with these habits.

1- IDENTIFICATION

Beneficiary's name at birth	Health insurance no.	Date of birth (year / month / day)	Sex ☐F ☐M

Spouse's name

Physician's name	Telephone	License no.	Assessment date

2- CURRENT SITUATION

Specify the biological, psychological and social factors that have given rise to this service request.

3- ILLNESS OR HEALTH PROBLEMS

List any MAJOR illnesses or health problems, beginning with the most serious.
Specify the type of intervention undertaken for each *(for instance, hospitalization, surgery, physiotherapy, ergotherapy, etc.)* and after-effects.

Year	Illness or problem	Intervention	After-effects

4- ADDITIONAL DATA

Approximate weight: ..... Approximate height: ..... Allergies: .....

B.P.: ..... Possibility of orthostatic hypotension: ☐yes ☐no

Wounds: location ..... duration: .....

description *(dimension/seriousness)* ..... weeping wound: ☐yes ☐no

Habits	No	Yes	Give details of any problem *(physical, mental, social)* related to this habit
Tobacco use			
Consumption of alcohol			
Drug abuse (prescribed or not)			
Poor nutrition			

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Section 5 "Summary Assessment of Functional Autonomy"

This is a summary of information relevant to an assessment of the services the beneficiary requires, and to the selection of the program which can best meet his needs. The physician is requested to describe the beneficiary's condition in regard to each of the aspects indicated, and to give a precise description of each problem noted.

5- SUMMARY ASSESSMENT OF FUNCTIONAL AUTONOMY

This section is of vital importance.
It provides information that is crucial in directing the beneficiary toward the most appropriate program *(at home or other)* in view of his needs.
Give details in regard to each of the following aspects, **stating the relation with the illnesses and health problems** *(etiology, interventions, prognosis)* identified..

PHYSICAL MOBILITY *(Transfer, getting about, stairs, endurance, aids, falls, etc.)* and DAILY ACTIVITIES *(washing, dressing, feeding oneself, etc.)*

URINARY INCONTINENCE (Frequency, recurring or permanent, type: paradoxical, effort, reflex)

FECAL INCONTINENCE *(Frequency, recurring or permanent.)*

ABILITY TO COMMUNICATE *(Specify the diagnosis associated with the handicap)*

Eyesight:

Hearing:

Speech:

MENTAL FUNCTIONS

Cognitive *(orientation, memory, judgment, concentration, comprehension)*

Affective *(temperament, emotions, will, etc.)*

BEHAVIOUR *(agressiveness, violence, tendency to give way to fugue, exhibitionism, etc.)*

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Section 8 "Prognosis"

The physician is requested to give his opinion on how the beneficiary's biological, psychological and social condition can be expected to change. This information is indispensible for the multidisciplinary team assessing the services needed.

Section 9 "Physician's Opinion as to Most Appropriate Services for the Beneficiary"

The physician is requested to provide his opinion as to the most appropriate services to meet the beneficiary's needs.

The physician should realize that his assessment is part of an overall assessment procedure designed to select the most appropriate program for the beneficiary. As a result, and so that the beneficiary will not form any specific expectations, the physician is requested not to make any commitments to the beneficiary with respect to a placement or program.

Section 10 "Other Information Deemed Important or Specific Recommendation(s) by the Physician"

The physician enters any other information he feels is important to the multidisciplinary teams's assessment of services needed and to the future program direction of the beneficiary. Once he has completed the form, the physician signs it and enters the date the form was completed.

Section 11 "Beneficiary's Authorization"

This is to be signed by the beneficiary or, if he is unable to do so, by an authorized person. The form must also be witnessed.

6- RELEVANT REPORTS FROM COMPLEMENTARY EXAMINATIONS AND CONSULTATIONS

(Laboratory, X-ray, physiotherapy, neurology, psychiatry, etc. Attach report, if deemed advisable.)

7- PROPOSED INTERVENTIONS

A. MEDICATION For each prescription medicine, provide

Name - dose - posology - how administered - anticipated duration

Has the beneficiary been observed to have difficulty administering his medication? ☐ yes ☐ no

If yes, specify:

B. FOOD AND DIET

☐ balanced ☐ high fibre content ☐ low sugar ☐ no salt

☐ other, specify

C. CARE/SERVICES

	No	Yes	If yes, specify the care/service needs and restrictions
• physiotherapy			
• ergotherapy			
• respiration therapy			
• oxygen therapy			
• speech therapy			
• specific nursing care			
• social service			
• other(s)			

D. OTHER *(further assessment, etc.)*

Comments:

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Section 6 "Relevant Reports from Complementary Examinations and Consultations"

The physician is requested to report the results of any examinations which would inform the members of the multi-disciplinary team assessing the services required of the type of investigation already made and the results obtained, including results which indicate there is no problem. A complete picture of the beneficiary's condition depends just as much on knowing the examinations which failed to detect any problem as on being aware of those which produced a positive result. When he feels it is important, the physician may attach the examination report(s) to the medical assessment form.

Section 7 "Proposed Interventions"

The physician provides information concerning:

a) the beneficiary's medication *(name of medicine, dose, posology...),*

b) his diet and any particular features,

c) the care and services he needs because of his condition and the associated restrictions. The "other" category refers, for example, to assistance services *(meals, companionship, etc.)* and to specific care or services *(laboratory, monitoring, etc.).*

8- PROGNOSIS

The beneficiary's { **biological condition is** ☐stable ☐unstable; **psychological condition is** ☐stable ☐unstable; **social condition is** ☐stable ☐unstable }

What is your prognosis as to how his biological, psychological and social condition can be expected to change?

.....

9- PHYSICIAN'S OPINION AS TO THE MOST APPROPRIATE SERVICES FOR THE BENEFICIARY

In view of the beneficiary's current situation *(health, living conditions, etc.)*, what type of services do you feel are best suited to his needs?

☐continuation *(return to)* the home *(day centre, day hospital, home care/services, temporary accomodation)*
☐intermediate resources *(foster family, pavilion...)*
☐institutional resources *(ECHC, HCC, STCHC...)*

Give details as to the type of services and under what condition(s): .....

.....

10- OTHER INFORMATION DEEMED IMPORTANT OR SPECIFIC RECOMMENDATIONS BY THE PHYSICIAN

.....

Are you the beneficiary's physician? ☐yes ☐no How long have you known him? _____

Did you have the necessary medical information when you performed your assessment? ☐yes ☐no

_____ Physician's signature _____ Date

11- BENEFICIARY'S AUTHORIZATION

I authorize _____ to release the information contained in
name of physician

this form to the persons responsible for evaluating my application for services.

_____ Beneficiary's signature (IN CASE OF INCAPACITY) _____ Signature of legally authorized person _____ Capacity

_____ Witness

_____ Date of authorization

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