



# *How is the need for care and its allocation determined in Europe?*

*A fact-finding study into measuring procedures for the assessment of needs and allocation of chronic care in five European countries*





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*A fact-finding study into measuring procedures for the assessment of needs and allocation of chronic care in five European countries*

*Carried out on behalf of the CIZ*

*Wynand Ros  
Anna van der Zalm  
Johan Eijlders  
Guus Schrijvers*

*UMC Utrecht  
Julius Centre for Health Sciences and Primary Care*

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# *Preface*

This report contains the results of an exploratory investigation carried out on behalf of the CIZ (Dutch central organization for care needs assessment).

The assignment was to investigate the procedures and measuring instruments used in surrounding countries to assess chronic care needs for adults and allocate care.

This investigation was carried out as a follow-up to a study carried out earlier in 2009 into the developments in the area of needs assessment and chronic care allocation in seven European countries, the results of which were recorded in the report 'Hoe komt de burger in Europa aan zorg?' [How do Europeans get access to care?], (Eijlders, Ros and Schrijvers, 2009).

The final responsibility for this investigation lay with Dr Wynand Ros.

We are grateful to the CIZ for providing the assignment.

Wynand Ros  
Anna van der Zalm  
Johan Eijlders  
Guus Schrijvers



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# *Report structure*

This report contains the findings of an exploratory study into procedures and measuring instruments for needs assessment and care allocation in five European countries (the United Kingdom, France, Germany, Belgium and Sweden).

In chapter 1, we describe the background to the study and the way in which information was gathered.

Chapter 2 contains the country reports. This chapter covers which procedures and measuring instruments are used to determine chronic needs and to allocate care. The process of needs assessment and care allocation is illustrated in a flowchart per country, and an indication is given at which moment decisions are carried out. If possible, it is also reported here which measuring instruments are used in these situations.

In chapter 3, a link is made between the measuring instruments that were used and the domains of ICF (International Classification of Functioning, Disability and Health).

In chapter 4, several specific themes are covered relating to the measurement of care needs and the allocation of chronic care. This chapter concludes with a consideration about the measuring instruments used and a review of new developments.

In this report, a number of different concepts are used. Some of these concepts are mentioned below, together with the meaning given to them in this report.

- *Medical care*: care that can only be provided by a medical professional
- *Personal care*: help with ADL activities
- *Other care*: help with instrumental ADL activities



# *1. Background and method of working*

This investigation into measuring instruments supplements a study previously carried out into developments in the area of needs assessment and allocation of long-term care in seven European countries (the Netherlands, Belgium, Germany, the United Kingdom, France, Sweden, Switzerland). In this study, it emerged that there were quite a number of differences with regard to the organization of needs assessment and care allocation, with reference to the roles of the patient, the government (authorities) and the professional care provider. The procedures used to determine needs and care allocation turned out to differ as well. In some situations, there was a question of strict fixed criteria, guidelines and measuring instruments. In other situations, the procedures appeared to be much less transparent. Local authorities seemed to have their own responsibility and many aspects seemed to be left to the discretionary powers of the assessor or the professional care provider.

In our study, we have limited ourselves to five countries: the United Kingdom, France, Germany, Belgium and Sweden.

A decision was made to focus on the needs assessment for adults with a handicap or chronic condition and older people.

The process of assessment and care allocation consists of a series of decisions. For every decision to be taken, we investigated what led to this decision and if use was made of measuring instruments during the decision-making process. During the study, we limited ourselves to measuring instruments that are actually being used by assessors and professional care providers to determine needs during the process of assessment and care allocation. Measuring instruments being developed and tested as part of scientific research, but not being used in practice, have therefore been left out of consideration.

We first went in search of documents describing the procedures for assessment and allocation that apply in a particular country. This turned out to be a laborious process. Often there was no question of explicit procedures that applied throughout the country; we found many local differences.

As a result, we took an alternative route for our search.

The investigators took on the role of someone with chronic care needs. They attempted to find out via internet and other sources where they needed to apply for long-term care and assistance in each country, and which procedures needed to be followed during this process. By looking at the websites of ministries, local councils and care provision counters and via telephone contact with people involved in assessment (officials, employees at health insurance companies, employees at care and welfare organizations), a picture was obtained about how the process of needs assessment works in practice, and which measuring instruments are actually used for needs assessment and care allocation. In each country, the websites and employees at several different local councils and other relevant organizations were consulted. Furthermore, inquiries were also made to experts.

The investigation was not intended to provide a complete picture. The aim of the report was to provide examples of procedures and measuring instruments used in other European countries to determine needs and allocate care. The insights described in this report can act as building blocks for initiatives designed to improve needs assessment and care allocation in the Netherlands.



## 2. Procedures and measuring instruments in five European countries

In this chapter, the procedures for needs assessment and care allocation in five European countries are examined. The United Kingdom, Germany, France, Belgium and Sweden are covered in succession.








The review of the countries has the following structure.

First of all, a *flowchart* is used to illustrate the process that has to be followed by a disabled person, someone with a chronic condition or an older person in need of care, in order to obtain care and/or financial support. In this flowchart, the moments at which measuring takes place are also indicated. See below for the key to the symbols used in the flowcharts.

Next, there is an *explanation* of the flowchart, and the measuring instruments used are described further.

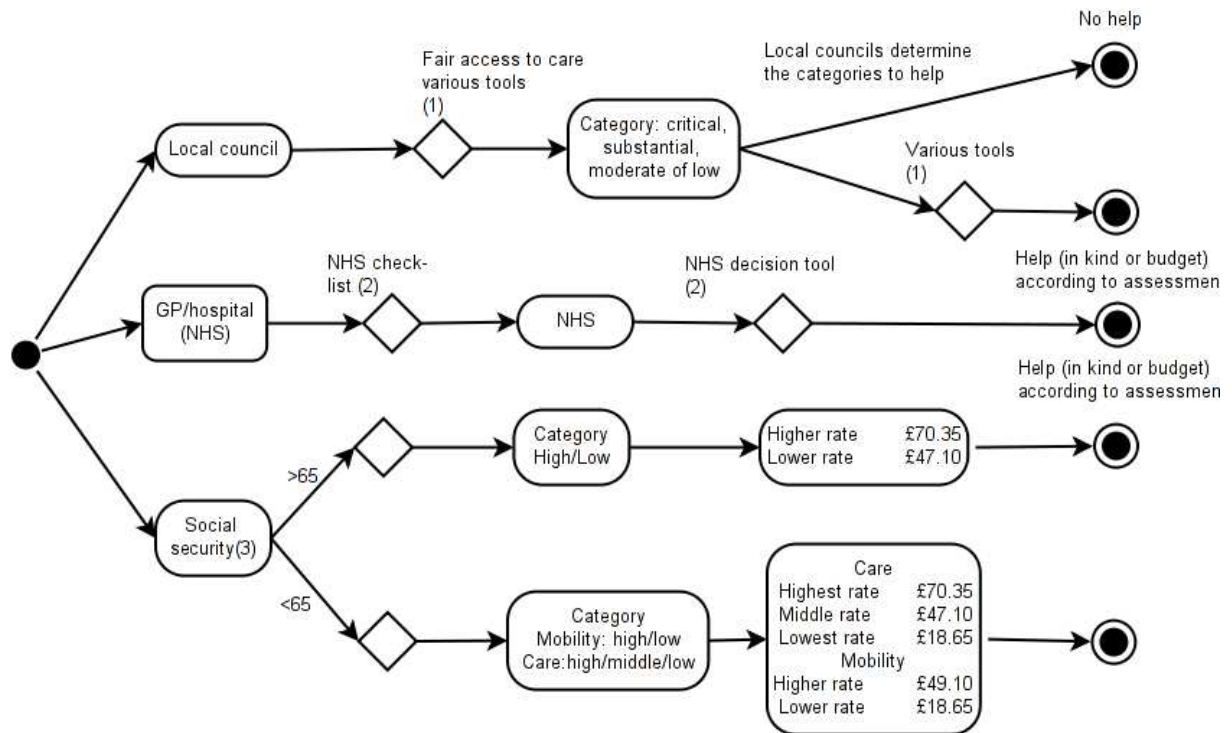
The section relating to each country is completed with a list of sources consulted.

### Key to flowchart symbols

	Starting point (individual older or disabled person with care needs)
	Procedure for/ that can be followed by both older and disabled people
	Procedure that can only be followed by older people
	Procedure that can only be followed by disabled people younger than 6
	Organization or result
	Decision point
	End point



## 2.1. United Kingdom



### *The system in the United Kingdom*

The system in the United Kingdom has three branches: the Local Council, the NHS and the department of Social Security (see flowchart).

The first branch relates to the *Local Council*.

When someone submits an application for assistance to the council, he or she is first placed in one of four urgency categories: 'critical', 'substantial', 'moderate' or 'low'. There are national criteria for placement in urgency categories (see appendix 1). However, the criteria do allow room for interpretation by the needs assessor.

Every year, councils determine individually which of the four urgency categories they will provide assistance to. If an individual falls into one of the categories that are eligible for assistance, a multidisciplinary team of professionals carries out an additional assessment to determine the amount of care. Different tools are available for this assessment. Councils differ in the extent to which they make use of these tools.

Up until recently, councils provided only care in kind, but in many places it is now possible to receive a personal budget. The plan is to allocate only personal budgets in the future.

The second branch relates to the *NHS (National Health Service)*.

The NHS provides all medical care and, in certain situations, personal care as well. In order to qualify for help from the NHS, the person must be referred by a medical professional (GP, hospital). The medical professional can make use of a checklist ('NHS Checklist Continuing Care' (2)) for this purpose. This checklist is primarily intended to give medical professionals insight into the group of people eligible for help from the NHS. The checklist can also be used to prevent large numbers of people being referred, who do not qualify for help from the NHS.

Once the person applying for care has been referred, an additional assessment is carried for the allocation of care; this assessment is carried out by a professional from the NHS who is trained for this purpose. There is a tool available for this process as well: the 'NHS Decision Support Tool' (2), used to record care needs in more detail.

The ultimate decision about the amount and type of care that the applicant will receive, cannot be directly derived from this assessment, but is largely based on the discretionary powers of the professional.

The third branch relates to '*Social Security*'.

For people who need care as a result of a handicap, financial allowances are available. In order to qualify for an allowance, the person applying is assigned to a category related to the extent of the care needs, and their handicap. The amount of this allowance depends on the category to which the applicant is assigned, as shown in the diagram. The exact criteria for assignment to a particular category did not emerge during this investigation.

Local councils and the NHS make no distinction between older people (aged 65 or older) and younger people (under 65s). Social Security however, does make a distinction: over 65s can claim less allowances.

What is also noticeable is that a large number of tools are available in the United Kingdom (often several for the same task) and that the availability of these tools is seen as a valuable resource.

## Measuring instruments in the United Kingdom

The diagram shows an overview of the moments when a decision has to be taken, with an indication if a decision support tool is available and who can use it.

Decision points and support tools United Kingdom		
Decision point	Carried out by	Support tool
1. Determine category FACS	Local council official	Depends on the individual local council; global national criteria exist
2. Determine amount of care	Local council official	Various tools available, utilization depends on individual council
3. Determine referral NHS	Primary care/ hospital	Discretionary powers professional/ NHS Checklist Continuing Care (2)
4. Determine access to and amount of NHS care	Medical professional (NHS)	NHS Decision Support Tool (2)
5. Determine category for allowance	Social security	--- (no tool found)

The table shows that decision support tools are available at four points.

### 1) Criteria for 'FACS Fair Access to Care System' (the national system).

These criteria are not formulated very precisely, for example: "Critical – when significant health problems have developed or will develop". Their purpose is to place an individual in one of the four urgency categories ('critical', 'substantial', 'moderate' or 'low')(see also appendix 1).

### 2) Determining the amount of care by the local council. This is about allocation of care facilities to the applicant ('resource allocation'). Local councils can make use of the tools available for this purpose: Resource Allocations Systems (RAS) and, especially for older people, the Single Assessment Processes (SAP).

Both measuring instruments are part of a larger process with various programmes (such as 'Putting People First'), which is aimed at providing tailor-made integral care, corresponding to the needs of the individual applicant. As a result, questions are asked in the measuring instruments about a wide variety of subjects, ranging from medical needs (limitations or handicaps) to psychosocial circumstances (informal or family care), and from assistance with ADL and instrumental ADL to emotional state. The measuring instruments do not always give a specific result (for example an exact amount for a Personal Health Budget); they are also used as a checklist for the care provider so that he or she gathers information about all the relevant aspects.

Local councils are left free in their use of such measuring instruments. Some councils develop their own RAS or SAP (9), but there are also instances of measuring instruments developed by private companies (10, 11).

Instruments such as RAS or SAP are not just used to determine the individual care needs of an applicant, and for the ultimate allocation of care. Such instruments can also be used at other levels in the care system, for example to support policy decisions at local council level (including financial and organizational decisions), and decisions about the set-up of the organization and personnel management by care agencies.

With regard to the SAP, it must be mentioned that an accreditation process was launched by the government (the Department of Health). That led in July 2004 to the accreditation of six instruments (12).

3) *NHS Checklist Continuing Care*. In order to determine whether a patient qualifies for personal care from the NHS, a primary care medical professional or the hospital can make use of the NHS checklist. It is not obligatory.

The NHS Checklist Continuing Care covers 11 domains (Cognition, Behaviour, Psychological Needs, Communication, Mobility, Nutrition – Food and Drink, Continence, Skin (including tissue viability), Breathing, Drug Therapies and Medication, Altered States of Consciousness). Criteria have been formulated for each domain, to make it clear whether a patient should be classified in severity category A, B or C, where A is the most severe. An applicant qualifies for continuing care, when there is a question of 2 or more A's, 1 A and 4 or more B's, 5 B's, or an A in an extremely important domain (for example, an A in Behaviour indicates a risk situation).

4) *NHS Decision Support Tool*. When a patient is referred to the NHS for continuing care, an assessment is carried out using the NHS Decision Support Tool (2). This tool guides the assessment and relates to the same domains as the checklist, but provides more differentiation between domains. Although there is a certain amount of room for free interpretation, the limitations can be charted reasonably unambiguously with the help of this Decision Support Tool. The decision about the ultimate allocation of care is, however, a different matter. Global guidelines do exist, but the discretionary powers of the assessor are of overriding importance in the ultimate allocation of care (for example: people who have a low score on every point do not need assistance, according to the guidelines, but the professional assessor still has the possibility to allocate care).

### *Sources for the United Kingdom*

(1) *FACS stands for Fair Access to Care System*

([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009653](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009653))

(2) [http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH\\_073912](http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH_073912) (see attached *NHS Checklist.pdf* and *NHS Decision Support Tool.pdf*)

(3) *E-mail from the NHS*: Local authorities are responsible for providing social care and the NHS has responsibility for health care. Access to nursing care is via the primary care trust. They have the responsibility to make an assessment of a person's nursing care needs, and to arrange for delivery of the nursing care. In practice nursing care will either be arranged as part of the discharge package following a stay in hospital, or following a request from the individual or from social services. Continuing care is provided because the NHS has a legal duty to provide for those who needs are health related but where it is not appropriate to provide that care in an NHS hospital. In the past such care was provided free of charge in a long stay hospital ward, now this is provided in the person's home or in a nursing home. Continuing care is provided following an assessment by the primary care trust, in the same way as any other NHS service. For those living in their own homes, continuing care will include personal care. For those living in a nursing home, continuing care includes the accommodation costs.

(4) [http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAnd\\_OtherSupport/index.htm](http://www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAnd_OtherSupport/index.htm)

(5) [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4080636.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080636.pdf)

(6) [http://search.cpa.org.uk/sap/documents/SAP041022100\\_DH\\_assessment\\_tools.pdf](http://search.cpa.org.uk/sap/documents/SAP041022100_DH_assessment_tools.pdf)

(7) example: <http://www.face.eu.com/>

(8) [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_093715.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093715.pdf)

(9) see attached Engeland-document1.doc

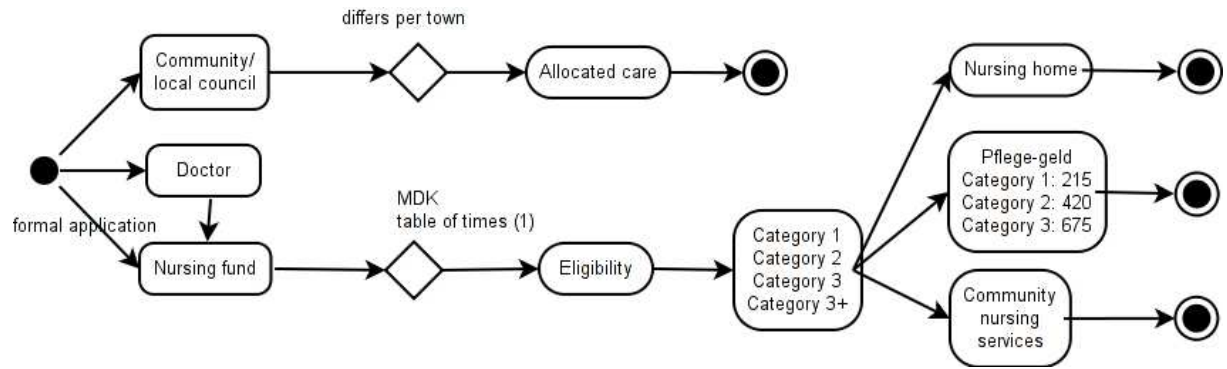
(10) <http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/Finance/Resourceallocationssystem/?parent=2671&child=3191>

(11) <http://www.eastsussex.gov.uk/NR/rdonlyres/A4AF5479-2A33-4E9E-ABBC-88C3B60C8ABC/0/Rapidv23FINALhealth.doc>

(12) [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4080636.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4080636.pdf)



## 2.2. Germany



### *The system in Germany*

In Germany a distinction is made between the branch of the Local Council and the branch of the Pflegekasse (care funds).

The *Local Council (Municipality)*. In Germany, care is provided by the Local Council. Each local council has its own methods for the allocation of care. No documents about these methods could be found.

The *Pflegekasse*. People can apply to the Pflegekasse for the extra costs relating to a long-term handicap. A formal application needs to be submitted to the Pflegekasse, after which an assessment is carried out by the MDK, Medizinischer Dienst der Krankenversicherung (<http://www.mdk.de/>). This assessment is used to first determine if the applicant is eligible for financial allowances and in which category. This is done by making an estimate of the number of minutes of care that the person needs. In order to determine the number of minutes required, there is a tool available for part of the care, the so-called Grundpflege (mainly ADL assistance).

	<b>Stufe I</b>	<b>Stufe II</b>	<b>Stufe III</b>	<b>Stufe III +</b>
Total number of minutes	90	180	300	*
Of which Grundpflege	46	120	240	*

\* Category III+ is for exceptional care needs: a minimum of six hours per day, or the conditions for Stufe III and the need for two carers at night.

After the assessment has been carried out, the applicant is notified of the result. If it is positive (in other words, the applicant requires at least the number of minutes to fall in Stufe I), care can be provided in different ways: in kind (at home or in a nursing home) or in the form of a Personal Health Budget.

In Germany, no distinction is made between older and younger people. Older people are also entitled to an allowance from the Pflegekasse. Local councils support both older people (aged 65 or older) and younger people.

## Measuring instruments in Germany

Decision points and support tools Germany			
Decision point	Carried out by	Support tool	Explanation
Determine eligibility and number of hours	Trained doctor/nurse	Table of times (1) and discretionary powers	
Determine amount of help	Social worker, possibly nurse	-*	Differs per local council

\*- : No tool found or known of, or no tool used

The most important tool is the *Zeittabel*, the *table of times*, which is used to determine the amount of Grundpflege (see below).

Pflegebereich	Pflegetätigkeit	Zeitkorridor
<b>Körperpflege</b>	Ganzkörperwäsche	20-25 Min.
	Teilwäsche Oberkörper	8-10 Min.
	Teilwäsche Unterkörper	12-15 Min.
	Teilwäsche Gesicht/Hände	1-2 Min.
	Duschen	15-20 Min.
	Baden	20-25 Min.
	Zahnpflege	5 Min.
	Rasieren	5-10 Min.
	Kämmen	1-3 Min.
	<b>Toilettengang</b>	Urinieren, Hygiene, Reinigung
Urinieren, Hygiene, Reinigung		3-6 Min.
Windelwechsel nach urinieren		4 Min.
Windelwechsel nach Stuhlgang		7-10 Min.
Richten der Kleidung		2 Min.
<b>Ernährung</b>	Zerkleinerung der Nahrung	2-3 Min.
	Nahrungsaufnahme	15-20 Min.
	Sondenernährung, Reinigung	15-20 Min.
	<b>Mobilität</b>	Aufstehen/ zu Bett gehen
Umlagern		2-3 Min.
Anziehen komplett		8-10 Min.
Anziehen Oberkörper		5-6 Min.
Anziehen Unterkörper		5-6 Min.
Ausziehen komplett		4-6 Min.
Ausziehen Oberkörper		2-3 Min.
Ausziehen Unterkörper		2-3 Min.

The table does not contain strict times; there is a certain amount of flexibility. In the guidelines document (1), there are factors that can make nursing care heavier or lighter (for example, body weight above 80 kg, serious spasticity or stiff joints, limitations in sensory perception). The person who carries out the assessment may deviate from the table, but must give well-grounded arguments.

This table applies only to the determination of the amount of time required for Grundpflege. For other types of care, there is no table available and there are also no explicit guidelines. The criticism that the assessment focuses too much on Grundpflege is common in Germany. There are plans to change the system.

### *Sources for Germany*

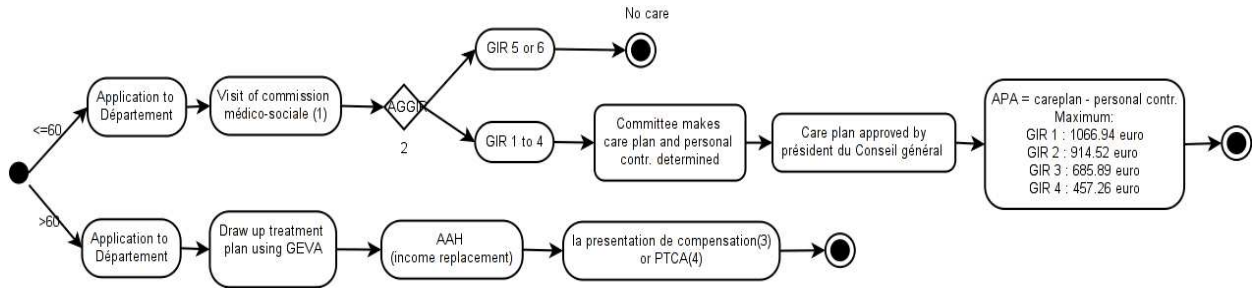
*The flowchart is based on a telephone interview with Klaus Wingefeld, Dr. PH (Bielefeld University, Germany)*

*(1) [Duitsland-Document1.pdf](#)*

*(2) <http://www.pflegestufe.info>*

*(3) <http://www.p-wie-pflegeversicherung.de>*

### 2.3. France



### *The system in France*

In France, a high degree of self-sufficiency is expected of the applicant with regard to the organization of care. However, help is available for making a care plan. Financial support for care is dependent on the applicant's income.

When someone over 60 requires care, he or she is eligible for an 'allocation personnalisée d'autonomie (APA)' from the Département. After the application has been submitted, a socio-medical team ('équipe médico-sociale') makes contact with the applicant's doctor and a member of the team pays a house visit. He or she carries out an assessment with the help of AGGIR, an instrument used to assign an applicant to a care needs category (GIR). There are six categories; the highest four are eligible for a financial allowance. The maximum amount of the allowance is determined by the care needs category to which the applicant is assigned. The actual allowance is dependent on the applicant's personal income, and the approved care plan. The care plan is drawn up by the socio-medical team, in consultation with the applicant and, if relevant, the people in the applicant's surroundings and his or her doctor. This care plan is judged and approved by the president of the General Council (the assembly in a Département). This power is usually delegated to a committee, and once the care plan has been approved, the allowance is paid out.

People with care needs who are younger than 60, apply to the Local Council. In this case, too, there is a committee to estimate what care is needed. This committee draws up a care plan, which is used as the basis for determining which maximum allowances will be granted. No clear decision documents could be found for this process.

In France, there is a different procedure for older people (aged 60 or older) and for younger people. For older people, an allowance is granted simply on the basis of the care needs determined using AGGIR. For younger people (under 60s), there is a much more extensive procedure using GEVA and other decision support tools, where attention is also paid to the determination of the remaining capacity for participation in society (adapted work, training).

## Measuring instruments in France

Decision points and support tools France			
Decision point	Carried out by	Support tool	Explanation
Procedure 60+ Determine category	Multidisciplinary Team	AGGIR	
Procedure 60+ Determine care plan	Multidisciplinary Team	-*	
Procedure <60 Determine care plan	Multidisciplinary Team	GEVA	
Both Procedures Approve care plan	Conseil General	-*	

\* : No tool found/known of, or no tool used

In the table, two measuring instruments are named: the AGGIR and the GEVA. These measuring instruments are very different.

The *AGGIR* is used by the Département to determine the care needs of applicants who are 60 or older. It is a short list used to determine the extent of the limitations with regard to ten different functions:

- coherence (logically consistent speech and behaviour)
- orientation (in time and place)
- washing oneself
- dressing and undressing
- eating independently
- use of the toilet
- mobility (getting up, sitting, lying down)
- moving around indoors (with and without aid)
- moving around outdoors (with and without aid)
- telecommunication (using the telephone, alarm systems and suchlike)

For each function, the assessor determines to what extent the applicant can manage independently. This occurs by assigning a code A, B or C, where A means 'completely independently' and C 'not independently at all'. Subsequently, a computer uses an algorithm (which includes different common combinations) to calculate the category to be assigned; there are 13 in total. These are subsequently converted by a computer programme to a GIR score of 1 to 6. On the basis of this GIR score, the maximum allowance is determined (see flowchart). The GIR score can be calculated online (2), with a computer programme (6) or by using the table below.

A.G.G.I.R		Valeur des codes B et C de chaque Groupe, pour le calcul du rang							
RUBRIQUES	code	Groupe A	Groupe B	Groupe C	Groupe D	Groupe E	Groupe F	Groupe G	Groupe H
		Cohérence	C	2000	1500	0	0	400	200
Cohérence	B	0	320	0	0	0	100	0	0
Orientation	C	1200	1200	0	0	400	200	150	0
Orientation	B	0	120	0	0	0	100	0	0
Toilette	C	40	40	40	0	400	500	300	3000
Toilette	B	16	16	16	0	100	100	200	2000
Habillement	C	40	40	40	0	400	500	300	3000
Habillement	B	16	16	16	0	100	100	200	2000
Alimentation	C	60	60	60	2000	400	500	500	3000
Alimentation	B	20	0	20	200	100	100	200	2000
Élimination	C	100	100	160	400	800	500	500	3000
Élimination	B	16	16	20	200	100	100	200	2000
Transfert	C	800	800	1000	2000	800	500	400	1000
Transfert	B	120	120	200	200	100	100	200	2000
Déplacement Interne	C	200	moins 80	400	200	200	200	200	1000
Déplacement Interne	B	32	moins 40	40	0	0	0	100	1000
Déplacement Externe	C	0	0	0	0	0	0	0	0
Déplacement Externe	B	0	0	0	0	0	0	0	0
Communication	C	0	0	0	0	0	0	0	0
Communication	B	0	0	0	0	0	0	0	0
<b>Ventilation des rangs</b> (dés qu'un rang a été signalé les calculs des groupes suivants sont inopérants)									
Somme si tous C cochés		4440	3660	1700	4600	3800	3100	2500	14000
Rangs	Prévus	1 ou 2 ou 3	4	5 ou 6	7	8	9	10	11 ou 12 ou 13
	Ventilation	≥4380 = 1 ≥4140 = 2 ≥3390 = 3	≥2016 = 4	≥1700 = 5 ≥1432 = 6	≥2400 = 7	≥1200 = 8	≥800 = 9	≥650 = 10	≥4000 = 11 ≥2000 = 12 <2000 = 13
	Groupe suivant si...	<3390 of B	<2016 of C	<1432 of D	<2400 of E	<1200 of F	<800 of G	<650 of H	
<b>Des rangs aux GIR</b>									
	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR
	1 = 1	4 = 2	5 = 2	7 = 2	8 = 3	9 = 3	10 = 4	11 = 4	
	2 = 2		6 = 2					12 = 5	
	3 = 2							13 = 6	
<b>Résumé</b>	• Rang 1 = GIR 1		• Rang 8 ou 9 = GIR 3		• Rang 12 = GIR 5				
	• Rang 2 ou 3 ou 4 ou 5 ou 6 ou 7 = GIR 2			• Rang 10 ou 11 = GIR 4		• Rang 13 = GIR 6			

This table shows how the score is first converted into a grade, and then into a GIR category. The score in 'Groupe A' is calculated first; if it is equal to or higher than 4380 the grade is 1. If the score is lower than grade 1, but equal to or higher than 4140, the grade is 2. If the score is lower than 3390 is, the score in 'Groupe B' is calculated, and if a grade is not found here, the score in 'Groupe C' is calculated; this process continues until a grade is found.

Subsequently, the grade is converted into a GIR category, according to 'des ranges aux GIR'.

A 'Groupe Iso Ressource (GIR)' is an economic concept. It corresponds to a set of profiles that have more or less the same needs, financial or otherwise. This GIR assignment (just like the assignment of grades) was determined by a committee of experts over a long period of time, and with the help of statistical procedures, and ultimately resulted in the algorithm above (13).

The GEVA is used by the Local Council for applicants younger than 60. It is a long list of questions, which serves as a tool to carry out an assessment of the limitations and possibilities for participation (work, training and suchlike). With the GEVA, extensive information is gathered. There are eight main sections: Family, Social and financial circumstances, Habitat and lifestyle, Training and work, Medical aspects, Psychological aspects, Activities and capacities, Help available and Summary (see (5) for the full list of questions). However, the GEVA does not lead directly to a category or a number of points. It provides basic information for drawing up a care and participation plan.

## *Discussion about the measuring instruments in France*

The AGGIR plays an important role in the French system. It has also been researched. Various publications make use of the AGGIR to determine care needs in other contexts. One example is the publication of a study where the AGGIR was used to estimate the level of independence in people suffering from dementia (11).

The AGGIR is easy to use but also gets its fair share of criticism. The results are based on statistics and a small change can lead to a large difference in the result (7). There has also been criticism of the fact that there are only three choices possible per domain (the criticism relates to the uneven number and the limited possibilities for differentiation (8)). In one article, the value of AGGIR was summarized succinctly: the AGGIR is consistent for its purpose, the allocation of resources, and provides consensus about the remaining capacity (in terms of the self-sufficiency of the applicant). However, the limitations of the instrument must be recognized and it should not be used for other purposes than the purpose for which it was intended: the allocation of resources to people who need care.” There is indeed a lot of criticism when the AGGIR is used for another purpose, but that is not the only aspect. The other criticisms of the AGGIR as measuring instrument for care needs are summarized on ‘<http://www.bevernage.com/geronto/aggir.htm>’ .

The GEVA is sometimes criticized for its length, but it has a very different aim from the AGGIR. The GEVA is a checklist that should ensure that the committee that carries out the assessment gathers all the relevant information. (12)

In France, they are hard at work making adaptations to the system, for both the care for older people and the care for people under 60 with a handicap.

## *Sources for France*

(1) <http://documentation.agevillage.com/Article/indexbecf.html>

(2) AGGIR: <http://www.amcehpad.org/IMG/html/girettenouvelle.html>

(3) <http://informations.handicap.fr/art-allocations-aides-17.3.0.0-586.php>

(4) <http://informations.handicap.fr/art-droits-handicap-17.0.0.0-1871.php>

(5) GEVA: [http://www.cnsa.fr/rubrique.php3?id\\_rubrique=131](http://www.cnsa.fr/rubrique.php3?id_rubrique=131)

(6) <http://www.ibou.fr/aggir/>

(7) C. Benaim, J. Froger, B. Compan, J. Pelissier, *Evaluation de l'autonomie de la personne âgée*

(8)

<http://www2.ulg.ac.be/psysante/qualidem/q2%20partie%20B%20pdf%20flamand/Hoofdstuk%2010%20gebruik%20instrumenten.pdf>

(9)

*Elle est cohérente dans son objectif, à savoir l'allocation de ressources pour le sujet dépendant, et elle représente un consensus pour l'évaluation des capacités restantes. Il faut néanmoins connaître ses limites, et ne pas chercher à l'utiliser dans d'autres buts que la détermination des dépenses liées aux aides à fournir au sujet dépendant.*

(10) <http://www.bevernage.com/geronto/aggir.htm>

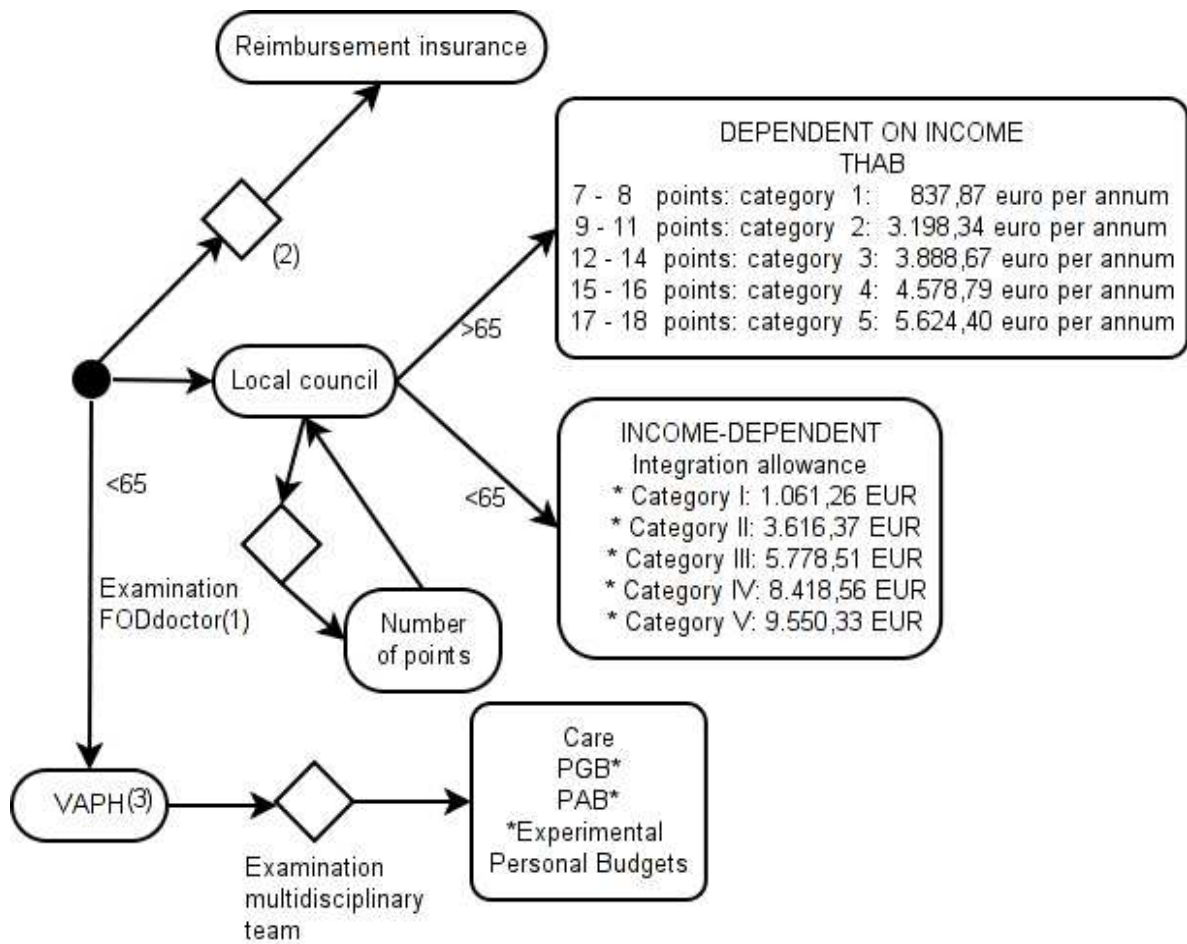
(11) <http://www.ncbi.nlm.nih.gov/pubmed/10214672>

(12) <http://cubitus.senat.fr/rap/r06-359/r06-3599.html>

(13) *Frankrijk-document1.doc*



## 2.4. Belgium



### *The system in Belgium*

Anyone of 65 or older with care needs, or someone younger than 65 with a handicap is entitled to various facilities in Belgium. Certain services provided by the Local Council (such as a discount on heating costs) fall outside the scope of this report.

The local council is where people start with their application. People can apply for an examination here via a FOD (Federal Government Service) doctor. There is a decision support measuring instrument available for this situation. With the help of this measuring instrument, points are assigned and a decision is taken about whether the applicant is eligible for an allowance, on the basis of the total number of points.

The number of points can also form the basis for several other services, of which reimbursement by the insurer is the most significant. In this case, the applicant needs to have at least 15 points, or another certificate.

In addition, disabled people can apply for care and guidance to the VAPH (Flemish Agency for Disabled People). The VAPH carries out its own examination and provides care in kind or a Personal Health Budget on the basis of the results.

For care in kind, it is best for people of 65 or older to approach the local council, or to be more specific, the OCMW (Public Centre for Social Welfare). Medical care is covered by health insurance; for other types of care the applicant has to pay a contribution, usually means-tested.

Older people (65 and over) and younger people (under 65s) go through the same procedure with an examination by the FOD doctor, but they receive different allowances. The allowances for younger people are higher than those for older people.

The biggest difference is the VAPH, the organization that provides care to people with a handicap (care in kind or Personal Health Budget). Only people under 65 are eligible to apply here. Senior citizens (65+) are not entitled to care from the VAPH, unless they were already receiving VAPH care before their 65<sup>th</sup> year.

Decision points and support tools Belgium			
Decision point	Carried out by	Support tool	Explanation
Both procedures Determine number of points	FOD Doctor	Guideline (1)	
Disabled people Determine care/personal health budget	Multidisciplinary Team VAPH	-*	
Both procedures Determine whether reimbursement by insurer	None	Various (2)	Allowance is granted as a result of certain scores on different certificates

\*- : No tool found/known of, or no tool used

Two moments can be seen in the table where measuring instruments are used:

The *THAB Guideline (Contribution towards Help for Senior Citizens)* assesses six capabilities with regard to the following functions:

- .
- mobility
- eating or preparing food
- managing personal hygiene and dressing/undressing
- managing the home and carrying out domestic tasks,
- awareness of dangerous situations and avoiding danger
- communication and social contact

For each function, an assessment is made of whether the applicant has no difficulties (zero points), limited capacities (1 point), good capacities (2 points) or is absolutely not capable of carrying out the tasks without help from others (3 points). The maximum number of points is 18.

The document referred to gives a good idea of the way in which the points are allocated. It also provides insight into the role of discretionary powers exercised by/of the professional who ultimately has to decide where the boundary lies between limited and good capabilities.

2) *Various support tools used to determine whether the applicant is eligible for reimbursement from the insurance*: To be eligible for reimbursement from the insurance, a certain level of limitation has to be demonstrated. Different measuring instruments are available for this purpose and are accepted by the insurers, including the THAB guideline mentioned above and also the KATZ scale, which is very similar to the AGGIR in France (4).

For an overview of recognized certificates for informal or family care and home care, see the table below, taken from the website of the Vlaamse Zorgkas (Flemish Health Insurance) (2).

<b>Certificates informal care and home care</b>		
<b>Certificate</b>	<b>Minimum score required</b>	<b>Available from</b>
Katz scale for home nursing care	score B	health insurance
Socio-medical scale for integration allowance, allowance for help for senior citizens, allowance for help from third persons	score 15	health insurance or FOD Social Affairs
Additional child benefit in the name of the child	66% handicap and 7 points for the level of self-sufficiency	FOD Social Affairs or the organization that pays out child benefit
Additional child benefit in the name of the child	18 points on the socio-medical scale	FOD Social Affairs or the organization that pays out child benefit
BEL profile scale for home help	35 points	home help service
Evaluation scale for verification for the application for an allowance in a care home	score C	health insurance

### *Sources for Belgium*

#### *General:*

*Belgie-algemeen.pdf*

[http://www.vzwcoma.be/index.php?option=com\\_content&task=category&sectionid=15&id=91&Itemid=82](http://www.vzwcoma.be/index.php?option=com_content&task=category&sectionid=15&id=91&Itemid=82)

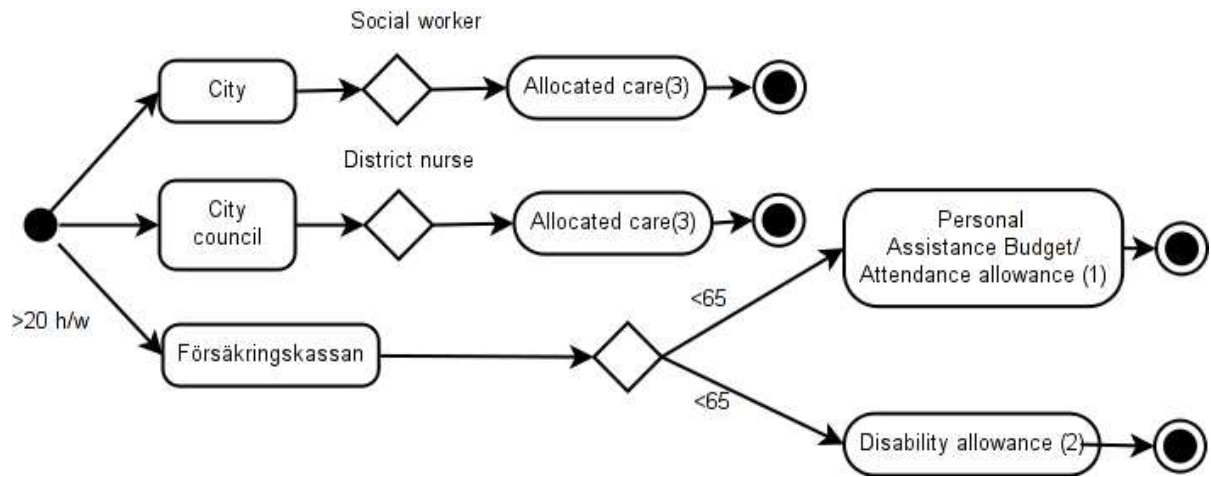
(1) *Belgie-document1.doc*

(2) [http://www.zorg-en-gezondheid.be/aanvragen\\_FAQ.aspx#4](http://www.zorg-en-gezondheid.be/aanvragen_FAQ.aspx#4)

(3) [www.vaph.be](http://www.vaph.be)

(4) *Belgie-document2.doc*

## 2.5. Sweden



## *The system in Sweden*

The system in Sweden is reasonably simple for the applicant. He or she goes to the Local Council and is provided with an assessment and care. If the care needs are high, it is also possible to apply to the 'Försäkringskassan' for additional allowances. The Local Council brings this to the attention of most applicants.

The local council needs assessment is carried out by a nurse and a social worker. This probably takes place on the basis of the discretionary powers of the professionals. No measuring instruments or decision support documents were found.

## *Measuring instruments in Sweden*

<b>Decision points and support tools Sweden</b>			
<b>Decision point</b>	<b>Carried out by</b>	<b>Support tool</b>	<b>Explanation</b>
Determine social care**	Social Worker	-*	
Determine medical care	District nurse	-*	
Determine granting of Försäkringskassan subsidy and the amount of any allowance granted	Unknown. At any rate, a doctor's opinion is always sought	-*	No subsidy if over 65, however, if the supplement had already been granted in the past, it can be "kept"

\* - : No tool found or known of, or no tool used

\*\* : meaning here: care that does not fall under medical care

No measuring instruments or decision support documents were found.

Local councils make no distinction between older people (aged 65 or older) and younger people (under 65s). However, the Försäkringskassan ("social security") do make a distinction between older and younger people. Older people are not entitled to a disability allowance or an attendance allowance. But if these allowances were granted before someone's 65th birthday, people continue to receive them.

## *Sources for Sweden*

(1)

[http://www.forsakringskassan.se/irj/go/km/docs/fk\\_publishing/Dokument/Publikationer/Faktablad/Andra%20spr%C3%A5k/Engelska/assistansersattning\\_eng.pdf](http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Publikationer/Faktablad/Andra%20spr%C3%A5k/Engelska/assistansersattning_eng.pdf)

(2)

[http://www.forsakringskassan.se/irj/go/km/docs/fk\\_publishing/Dokument/Publikationer/Faktablad/Andra%20spr%C3%A5k/Engelska/Handikappers%C3%A4ttning\\_eng.pdf](http://www.forsakringskassan.se/irj/go/km/docs/fk_publishing/Dokument/Publikationer/Faktablad/Andra%20spr%C3%A5k/Engelska/Handikappers%C3%A4ttning_eng.pdf)

(3)

*E-mail from the ombudswoman for older people in Stockholm:*

In the City of Stockholm the Stockholm County Council is responsible for medical services and the City provides the social services.

According to this a social worker (case officer) from the municipality analyses the social situation and it is a civil servant, often a district nurse, from the County Council that assess the medical needs.

The social Eldercare in the City of Stockholm is means-tested and your fee is based on your last income.

You pay to the County Council according to a special table. There is however municipalities in Sweden that has the full responsibility for all care given till elderly persons

(4)

<http://www.vardguiden.se/Tema/Funktionsnedsattning/Personlig-assistans>

### 3. ICF and the measuring instruments

In this paragraph, the measuring instruments found will be compared to each other with respect to the domain being investigated, and related to the International Classification of Functioning, Disability and Health (Netherlands WHO-FIC Collaborating Centre, 2002).

The ICF was developed by the WHO and provides an unambiguous framework that can be used to chart people's functioning and the corresponding problems. Using the ICF, human functioning can be described from three perspectives: the physical body, behaviour and participation in society.

The ICF classification consists of two parts. The first part primarily covers physical functioning and in this area, two components are distinguished: bodily functions and body structures. Both classifications largely follow the organ systems. The second part concerns activities and participation in society. Two components are distinguished here, too: activities and participation (subdivided into nine domains, including communication, self-care, domestic life, interpersonal interactions and relationships), and external factors, concerning an individual's physical and social background, for instance sociodemographic properties (age, gender, education), knowledge and skills, personality and character, lifestyle and habits, past and present experiences.

A list of the components is shown in table 1.

Table 1: ICF classification first level

<b>Functions</b>	<b>Body Structures</b>	<b>Activities and Participation</b>	<b>Environmental Factors</b>
<i>B1 Mental functions</i>	<i>S1 Nervous system</i>	<i>D1 Learning and applying knowledge</i>	<i>E1 Products and technology</i>
<i>B2 Sensory functions and Pain</i>	<i>S2 The eye, ear and related structures</i>	<i>D2 General tasks and demands</i>	<i>E2 Natural environment and human-made changes to environment</i>
<i>B3 Voice and speech functions</i>	<i>S3 Structures involved in voice and speech</i>	<i>D3 Communication</i>	<i>E3 Support and relationships</i>
<i>B4 Functions of the Cardiovascular, Haematological, Immunological and Respiratory systems</i>	<i>S4 Cardiovascular, Immunological and Respiratory systems</i>	<i>D4 Mobility</i>	<i>E4 Attitudes</i>
<i>B5 Functions of the Digestive, Metabolic and Endocrine systems</i>	<i>S5 Structures related to the Digestive, Metabolic and Endocrine systems</i>	<i>D5 Self-care</i>	<i>E5 Services, systems and policies</i>
<i>B6 Genitourinary and Reproductive functions</i>	<i>S6 Structures related to the Genitourinary and Reproductive systems</i>	<i>D6 Domestic life</i>	
<i>B7 Neuromusculoskeletal and movement-related functions</i>	<i>S7 Structures related to movement</i>	<i>D7 Interpersonal interactions and relationships</i>	
<i>B8 Functions of the skin and related structures</i>	<i>S8 Skin and related structures</i>	<i>D8 Major life areas</i>	
		<i>D9 Community, social and civic life</i>	

In the procedure for needs assessment and care allocation, a distinction is made between older and younger people applying for care in several countries (Sweden, France, Belgium and, to an extremely limited extent, the United Kingdom). No standard measuring instrument was found in Sweden. For the older applicant in France (over 60s), determination of the limitations with the help of the standard measuring instrument (AGGIR) is sufficient; in Belgium (over 65s), the THAB guideline is used. In the United Kingdom and Germany, the same measuring instrument is used for older people and younger people (NHS tool and Zeit-tabel (table of times for basic care) respectively).

In this paragraph, we consider to what extent these measuring instruments match the ICF domains. The measuring instruments relate mainly to the D component of the ICF: Activities and Participation. Table 2 shows which D domains of the ICF are assessed in the different standard measuring instruments.

Limitations in mobility, self-care and communication seem to form the core elements for care needs assessment. In all four measuring instruments, the Mobility and Self-care domains are assessed, and in three of the four measuring instruments, the Communication domain is assessed; the Zeit-tabel used in Germany is an exception.

Another conspicuous aspect is that only the THAB used in Belgium explicitly covers managing the household, including meal preparation, in the needs assessment. In addition, in the THAB questions are explicitly asked about communication possibilities and social behaviour. This item is covered in the other instruments under the Communication domain, in the conversation component.

The other domains relating to behaviour and participation are not explicitly covered in the different measuring instruments.

However, some measuring instruments do cover other aspects of functioning.

For instance, there are separate questions in the NHS tool about the ICF Mental functions 'consciousness functions (B110)', 'behavioural problems' and 'psychological needs'. The ICF function 'Respiratory functions (B440)' the treatment-oriented aspects 'medication' and 'skin and wound care' are also covered.

Aspects of Mental functions are also covered in the AGGIR: 'orientation in time and place (B114)' and 'coherence (in speech and behaviour)'.

Finally, in the THAB there are specific questions about the ability to assess risks and therefore avoid dangerous situations.

Table 2: ICF components and the categories of the measuring instruments used

<b>Domains, sorted in ICF sequence</b>	<b>ICF</b>	<b>UK NHS tool</b>	<b>D Zeit-tabel</b>	<b>F AGGIR</b>	<b>B THAB</b>
<b>D1. Learning and applying knowledge</b>	+				
<b>D2. General tasks and demands</b>	+				
<b>D3. Communication</b>	+	+		+	+
Receiving	+	+			
Producing	+	+			
Conversation and use of communication devices	+	+		+	+
<b>D4. Mobility</b>	+	+	+	+	+
Changing and maintaining body position		+	+	+	
Carrying, moving and handling objects		+			
Walking and moving			+	+	+
Moving around using transportation					
<b>D5. Self-care</b>	+	+	+	+	+
D510. Washing oneself		+ <sup>1</sup>	+	+	+ <sup>2</sup>
D520. Caring for body parts		+ <sup>1</sup>			+ <sup>2</sup>
D530. Toileting		+	+	+	+ <sup>2</sup>
D540. Dressing			+	+	+
D550. Eating		+	+	+	+
D560. Drinking		+	+	+	+
D570. Looking after one's health					
<b>D6. Domestic life</b>	+				+
Acquisition of necessities					
Household tasks					
D630. Preparing meals					+
D640. Doing housework					+
Others					
<b>D7. Interpersonal interactions and relationships</b>	+				+
General					+
<b>D8. Major life areas</b>	+				
Education					
Work and employment					
Economic life					
<b>D9. Community, social and civic life</b>	+				
<b>NON ICF D CATEGORIES</b>					
Breathing		+			
Medication		+			
Variable state of consciousness		+			
Behavioural problems		+			
Psychological needs		+			
Skin and wound care		+			
Coherence (speech and behaviour)				+	
Orientation (in time and place)				+	
Assess and avoid dangerous situations					+

<sup>1</sup> The items 'Washing oneself' and 'Caring for body parts' are not explicit questions in the NHS tool. However, the NHS tool does ask about 'Skin and wound care': 'Skin (including tissue viability)'.  
<sup>2</sup> The items 'Washing oneself', 'Caring for body parts' and 'Toileting' are not explicit questions in the THAB. The THAB does enquire about 'personal hygiene'

In France, the GEVA is used to assess applicants for care who are younger than 60. The GEVA is based on the ICF. It is a long list of questions that serves as a tool to assess the limitations and possibilities for participation (work, training and suchlike). With the GEVA, extensive information is gathered in eight main sections: Family, Social and Financial circumstances, Habitat and Lifestyle, Training and Work, Medical aspects, Psychological aspects, Activities and Capacities, Help Available and Summary. However, the GEVA does not lead directly to a category or a number of points. It provides basic information for drawing up a care and participation plan.

## *4. Consideration of the measuring instruments: what stands out?*

The measuring instruments for needs assessment and care allocation in five European countries were studied. Similarities and differences were observed. To some extent, the differences are accounted for by the differences in the way in which needs assessment and care allocation is organized. In this section, we will elucidate the points that stand out. The following themes will be dealt with below:

- several organizations involved
- standards and arbitrariness in the process of determining limitations
- transparency in the allocation of care
- difference between older people (over 65s) and younger people (under 65s)
- assessment in several stages
- future developments

### *Several organizations*

In all five countries, several organizations are involved in needs assessment and care allocation. Government authorities (national authorities, province, municipality), health insurers and professionals all play a role, sometimes with a lot of room for their own policy. This is often at the expense of unambiguity and transparency.

### *Standards and arbitrariness in the process of determining limitations*

The measuring instruments, or parts of them, differ widely with regard to unambiguity and arbitrariness.

It was established that in four of the five countries, simple measuring instruments are available to determine ADL limitations: Germany (Zeit-tabel, table of times for 'Grundpflege': personal hygiene, use of the toilet, eating, mobility), France (AGGIR: washing, dressing and undressing, eating, use of the toilet, mobility), United Kingdom (NHS tools: eating, mobility, use of the toilet) and Belgium (THAB guideline: personal hygiene, eating, mobility). These measuring instruments are used in the United Kingdom and Germany for all applicants, and in France and Belgium for all older people (over 60s and over 65s, respectively). Another conspicuous aspect is that these measuring instruments are used by health-related bodies (NHS, MDK, FOD doctor); only in France is the AGGIR used by the Département, but there, too, a socio-medical team gets involved. In Sweden, no measuring instruments were found.

For the determination of limitations other than ADL, the measuring instruments are less transparent. In the United Kingdom, the NHS tools are used for all applicants to determine care needs in the areas of cognition, behavioural disorders, emotions and mood, communication, status of the skin, breathing, compliance and variable state of consciousness. In France, the AGGIR is used for older applicants (over 60s) to determine limitations relating to coherence in speech and behaviour, orientation in time and space, communication and telecommunication. In Belgium, the THAB guideline is used for older applicants (over 65s) to chart limitations relating to managing the household, recognizing dangerous situations, communication and social contact. The themes are different in these three countries; in Germany and Sweden, no measuring instruments were found that are used routinely.

The instruments mentioned here all produce a differentiated score as result (in points or minutes of care) that provides an indication of care needs. This differentiated score is subsequently graded into a limited number of care needs categories, aided by relatively simple algorithms (Zeit-tabel, THAB

guideline) or relatively complex algorithms (AGGIR, NHS-tools). In the case of the AGGIR, the algorithm is also available digitally.

Local councils also play a role. Local councils in the United Kingdom and Germany are allowed a great deal of policy freedom in the area of needs assessment and care allocation. That is also true for whether or not they use measuring instruments. This results in significant differences between municipalities; this ‘arbitrariness’ between local councils is sometimes called the ‘postal code problem’ (Eijlders et al, 2009).

In France, the local council is responsible for needs assessment and care allocation for younger applicants (under 60s), where they often make use of the GEVA set of instruments. In Belgium, the application for care is handled by the local council, and the THAB guideline is used there.

### *Transparency in the allocation of care*

Determining limitations with the help of the Zeit-tabel, NHS tools, AGGIR and the THAB guideline is reasonably transparent, although there is a certain amount of room for the discretionary powers of the assessor (after all, the distinction between somewhat limited and seriously limited is not always completely obvious).

On the basis of the determination of the care needs, care in kind can be granted or an allowance in the form of a budget. When care is provided in kind, it is not always visible how the care needs and the care allocation are connected to each other. The relationship seems to depend heavily on the discretionary powers of the assessor.

In France, Germany and Belgium, a budget for care is allocated. This budget is calculated on the basis of the care needs category to which the applicant is assigned. This direct link between the category of care needs and the allocation of care seems, on the face of it, extremely transparent. But in practice, there is room for nuance. For instance, in France the available budget is a maximum allowance; the actual size of the budget depends on the applicant's own income and also on the care plan drawn up for the applicant.

### *Older and younger applicants*

In the procedure for needs assessment and care allocation, a distinction is made between older and younger applicants in several countries (Sweden, France, Belgium and, to an extremely limited extent, the United Kingdom). For the older applicant (over 65s, in France over 60s), determination of the limitations with the help of the standard measuring instrument (AGGIR, THAB guideline) is sufficient for care to be allocated.

For the younger applicant (under 65s, in France over 60s), more complex measuring instruments are used to determine care needs (GEVA in France, VAPH examination in Belgium). In addition, close attention is paid to the determination of remaining capacity and the capability for participation in work and training. There are no algorithms available for these measuring instruments; the approach used for this group of younger applicants is tailor-made and aimed at integration or at least partial integration in society. This has consequences for the themes covered. For example, subjects are inquired about in the GEVA that are included in the protocols for medical advisers at insurance companies in the Netherlands. The budgets available for younger applicants are generally somewhat larger than those for older applicants.

### *ICF and the measuring instruments*

We have investigated the extent to which the measuring instruments assess the ICF components. It emerges that the measuring instruments are mainly limited to four domains of the ICF D component - Activities and Participation: limitations in mobility, self-care and communication. The domains

relating to behaviour and participation (learning and applying knowledge, general tasks and demands, domestic life (apart from Belgium), interpersonal interactions and relationships, major life areas (education, work, income), and community, social and civic life are not covered in the different measuring instruments.

However, some measuring instruments do cover other aspects of functioning. For instance, in the UK there are separate questions about the Mental functions 'consciousness functions (B110)', 'behavioural problems' and 'psychological needs', as well as the treatment-oriented aspects 'medication' and 'skin and wound care'. In France, the Mental functions 'orientation in time and place' and 'coherence (in speech and behaviour)' are covered and in Belgium attention is paid to the ability to assess risks and therefore avoid dangerous situations.

### *Assessment in several stages*

In the United Kingdom and France, needs assessment is carried out in two stages.

In order to be eligible for personal care provided by the NHS in the United Kingdom, one has to be referred by a medical professional. The NHS Checklist Continuing Care is available for this medical professional, and is used to determine whether an applicant is eligible for NHS care. The definitive assessment and care allocation is carried out by an NHS professional, with the help of the NHS Decision Tool. This prevents applicants erroneously applying for care from the NHS. In France, an estimate is first made using AGGIR to see whether an applicant is eligible for a budget; the definitive allocation happens in the second stage, on the basis of the care plan and the applicant's personal income.

In France and Germany, chronic care is initially seen as the responsibility of the applicant himself or herself. That means that, in France, no budget is allocated if the applicant's personal income or the direct family's income is too high. In Germany, people are only entitled to care, if they can demonstrate that they have arranged personal care and domestic help themselves for a period of at least six months.

### *Future developments*

Measuring instruments for needs assessment and care allocation are in a state of flux.

First of all, there is a development happening, especially in the United Kingdom, and that is a move towards 'self-testing'. People are busy developing measuring instruments that are available via internet and can be filled in by the applicant personally.

There is a trend in Europe to allocate care increasingly in the form of budgets. This makes the link between the determination of care needs and the actual allocation of care less dependent on the discretionary powers of the assessor.

On the other hand, there is rather a lot of discussion about the measuring instruments in use. To begin with, it has to be stated that very little research has been carried out into the validity and reliability of the measuring instruments available. But there are other criticisms. Instruments such as AGGIR are admittedly simple to use, but the domains that are tested and the possibilities for giving alternative answers are limited. As a result, good differentiation that does justice to the complexity of the actual situation is scarcely possible. Furthermore, the ultimate result with regard to assessment and the consequences for the care to be provided is based on statistics from the past. Research is required into whether the assessed and allocated care received actually helps the applicant to manage his or her limitations. Finally, it is clear that ADL limitations are well charted with the instruments available, but there is still much room for improvement in determining more complex limitations relating to cognitive, emotional and social aspects and how a person functions in society.



# *Appendices*

*Appendix 1: FACS (VK)*

*Appendix 2: NHS Decision support tool (VK)*

*Appendix 3: Pflegezeitbemessung (Duitsland)*

*Appendix 4: AGGIR (Frankrijk)*

*Appendix 5: THAB Richtlijn (België)*



# *Appendix 1:* *FACS (VK)*

## **FAIR ACCESS TO CARE SERVICES GUIDANCE ON ELIGIBILITY CRITERIA FOR ADULT SOCIAL CARE**

*[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009653](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009653)*

## **FAIR ACCESS TO CARE SERVICES GUIDANCE ON ELIGIBILITY CRITERIA FOR ADULT SOCIAL CARE**

The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows :

### *Critical – when*

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

### *Substantial - when*

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

### *Moderate - when*

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

### *Low – when*

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

*Appendix 2:*  
*NHS Decision support tool (VK)*

**NHS Decision Support Tool (DST)**

Source:

[http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH\\_073912](http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH_073912)

# NHS DECISION SUPPORT TOOL

Source: [http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH\\_073912](http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Continuingcare/DH_073912)

We have developed the Decision Support Tool (DST) to support practitioners in the application of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care.

**Note: We have tried to make this document as clear and accessible as possible for people having assessments for NHS continuing healthcare, and their families and carers. Because of the nature of NHS continuing healthcare and this document, some words are used that may not be immediately understandable to someone who is not professionally trained. The person using the DST should make sure that individuals, and carers or representatives (where consent is given), understand and agree to what has been written. If necessary, advocacy support may be needed.**

**All these tools are available electronically (as Word documents) and pages or boxes can be expanded as necessary.**

## Summary (July 2009)

- (i) The purpose of the Decision Support Tool (DST) is to support the application of the National Framework and inform consistent decision making.
- (ii) The DST should be used in conjunction with the guidance on the National Framework for NHS Continuing Healthcare.
- (iii) The DST should be completed by a multidisciplinary team, following a comprehensive multidisciplinary assessment of an individual's health and social care needs and their desired outcomes. The DST is not an assessment in itself.
- (iv) The consent of the individual who is the subject of the DST must be obtained before the assessment is carried out and they should be given a full opportunity to participate in the completion of the DST. The individual should be given the opportunity to be supported or represented by a carer or advocate if they so wish.
- (v) The DST asks multidisciplinary teams (MDTs) to set out the individual's needs in relation to 12 care domains. Each domain is broken down into a number of levels, each of which is carefully described. For each domain MDTs are asked to identify which level description mostly closely matches the individual's needs.
- (vi) MDTs are then asked to make a recommendation as to whether the individual should be entitled to NHS continuing healthcare. This should take into account the range and levels of need recorded in the DST and what this tells them about whether the individual has a primary health need. This should include consideration of the nature, intensity, complexity or unpredictability of the individual's needs. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.
- (vii) All sections of the DST must be completed.
- (viii) This is a summary. It is very important that the guidance notes are read in full and that those completing DSTs have an understanding of the National Framework for continuing healthcare.

## User Notes

### Key principles

1. This Decision Support Tool (DST) should support the application of the National Framework and inform consistent decision making in line with the primary health need approach. The DST should be used in conjunction with the guidance on the National Framework. Practitioners should ensure they are familiar with the guidance before beginning to use the DST. An individual will be eligible for NHS continuing healthcare where it can be said that their *'primary need is a health need'*. The decision as to whether a person has a primary health need takes into account the legal limits of Local Authority (LA) provision. Using the Decision Support Tool correctly should ensure that all needs and circumstances that might affect an individual's eligibility are taken into account in making this decision.
2. The Decision Support Tool should be used following a comprehensive multidisciplinary assessment of an individual's health and social care needs and their desired outcomes. Where a multidisciplinary assessment has been recently completed, this may be used, but care should be taken to ensure that this remains an accurate reflection of current need. The tool is not an assessment in itself. Rather it is a way of bringing together and applying evidence in a single practical format to facilitate consistent evidence-based decision making on NHS continuing healthcare eligibility.
3. The multidisciplinary assessment of needs should be in a format such that it can also be used to assist Primary Care Trusts (PCTs) and LAs to meet care needs regardless of the outcome of the assessment for NHS continuing healthcare. The assessment of needs process should be carried out in accordance with other relevant existing guidance, including those on the Single Assessment Process, the Common Assessment Framework and the Care Programme Approach. It should include referral for specialist assessments and also make use of existing such assessments wherever it is appropriate in the light of the individual's care needs.
4. The multidisciplinary assessment that informs completion of the DST should be carried out with the knowledge and consent of the individual, and the individual should be given a full opportunity to participate in the assessment. The individual should be given the opportunity to be supported or represented by a carer or advocate if they so wish. The assessment process should draw on those who have direct knowledge of the individual and their needs.
5. Completion of the tool should be carried out in a manner that is compatible with wider legislation and national policies where appropriate, including the End of Life Care Strategy, long-term conditions policy and the Mental Capacity Act 2005.
6. Although the tool supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual's needs, it cannot directly determine eligibility. Professional judgement will be necessary in all cases to ensure that the individual's overall level of need is correctly determined and the appropriate decision made.

### Process

7. Once an individual has been referred for a full assessment for NHS continuing healthcare (by use of the Checklist or, if this is not used in an individual case, by direct referral for a full assessment for NHS continuing healthcare) then, irrespective of the individual's setting, the PCT has responsibility for coordinating the whole process until the decision about funding has been made and a care plan has been agreed. The PCT should identify an individual, or individuals, to carry out this coordination role. The coordinator may be a PCT member of staff or may be from an external organisation by mutual agreement.
8. The coordinator should identify the appropriate individuals to comprise the multidisciplinary team (MDT) and liaise with them to complete the DST. This involves matching, as far as possible, the extent and type of the individual's specific needs with the descriptions in the DST that most closely relate to them. This approach should build up a detailed analysis of needs and provide the evidence to inform the decision regarding eligibility.

9. As with any examination or treatment, the individual's consent should be obtained before the process of completing the DST commences. The individual should be made aware that the DST is to be completed, have the process explained to them, and be supported to play a full role in contributing their views on their needs. It should be made explicit to the individual whether their consent is being sought to a specific aspect of the assessment for NHS continuing healthcare (i.e. completion of the DST) or to the full process. It should also be noted that individuals can withdraw their consent at any time in the process.

10. The individual should be invited to be present or represented wherever possible. The individual and their representatives should be given sufficient notice of completion of the DST to enable them to arrange for a family member or other advocate to be present. Where the individual would find it practically difficult to make such arrangements (such as when they are in hospital or their health needs make it difficult for them to contact relevant representatives), the PCT should offer to make the arrangements for them, in accordance with their wishes.

11. Even where specific circumstances mean that, in a limited range of situations, it is not practicable for the individual to be present or represented, the views of the individual and/or their representative should be obtained and actively considered in the completion of the DST. Those completing the DST are asked to note within it whether the individual was present and/or represented and, if not, the reasons for this.

12. Even where an individual has not elected for a family member to advocate for them, the views and knowledge of family members may be taken into account, where consent has been given to seek these views.

13. Completion of the DST should be organised so that the person understands the process, and receives advice and information to enable them to participate in informed decisions about their future care. Decisions and rationales should be transparent from the outset.

14. If there is a concern that the individual may not have capacity to give their consent, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. Those completing assessments or the DST should particularly be aware of the five principles of the Act:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests.
- Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

It must also be borne in mind that consideration of capacity is specific to both the decision to be made and the time that it is made, i.e. the fact that a person may be considered to lack capacity to make a particular decision should not be used as a reason to consider that they cannot make any decisions. Equally, the fact that a person was considered to lack capacity to make a specific decision on a given date should not be a reason to assume that they lack capacity to make a similar decision on another date.

15. If the person lacks the mental capacity to either to refuse or to consent, a 'best interests' decision should be taken (and recorded) as to whether or not to proceed with assessment of eligibility for NHS continuing healthcare. Those making this decision should bear in mind the expectation that all who are potentially eligible for NHS continuing healthcare should have the opportunity to be considered for

eligibility. A third party cannot give or refuse consent for an assessment for NHS continuing healthcare on behalf of a person who lacks capacity unless they have a valid and applicable Lasting Power of Attorney (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection. In confirming decisions on whether to proceed with considering an individual for potential eligibility for NHS continuing healthcare, the PCT should consult with any relevant third party who has a genuine interest in the person's welfare. This will normally include family and friends.

16. If there is no one available and appropriate to consult with, the PCT should consider appointing an Independent Mental Capacity Advocate (IMCA). The purpose of IMCAs is to help vulnerable people who lack capacity who are facing important decisions made by the NHS and Local Authorities about serious medical treatment and changes of residence – for example, moving to a hospital or care home. NHS bodies and LAs have a duty, under the Act, to instruct and consult the IMCA where these decisions involve people who lack capacity in relation to the relevant decision and who have no family or friends who are available or appropriate to consult with.

17. It is important to be aware that the fact that an individual may have significant difficulties in expressing their views does not of itself mean that they lack capacity. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act and with disability discrimination legislation.

18. Robust data-sharing protocols, both within an organisation and between organisations, will help to ensure that confidentiality is respected but that all necessary information is available to complete the DST.

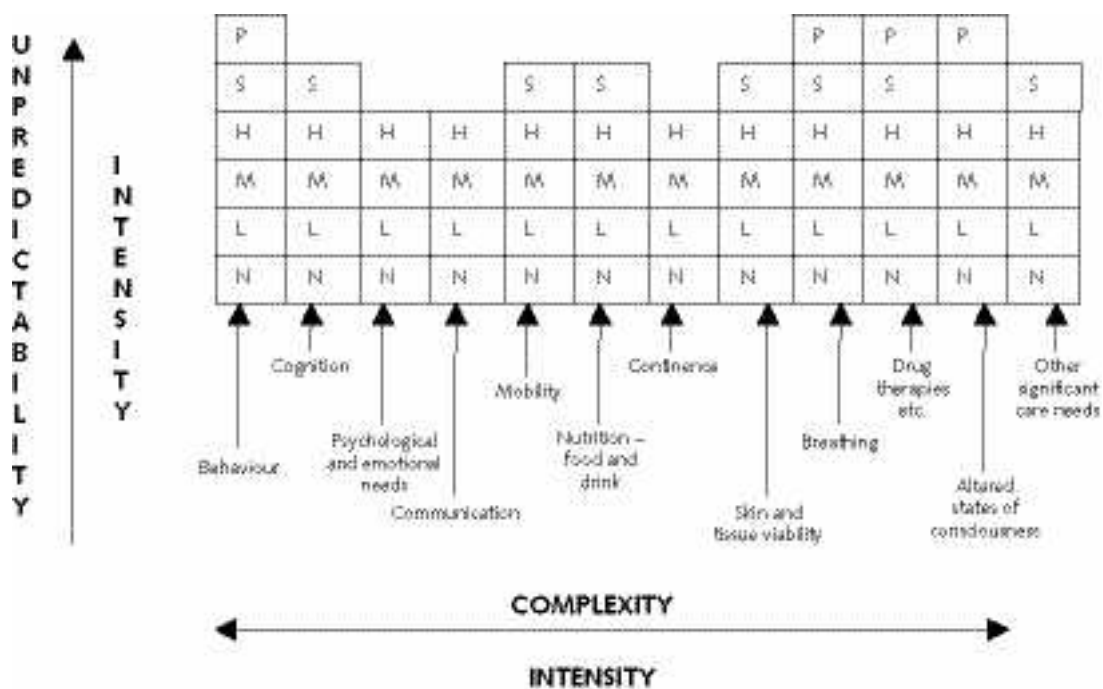
19. A copy of the completed DST should be made available to the individual together with an explanation as to the process for final decision making by the PCT.

20. The DST provides practitioners with a needs-led approach by portraying need based on 12 'care domains' (including an open domain for needs that do not readily fit into the other 11). The tool is in three sections:

- Section 1 – Personal information.
- Section 2 – Care domains.
- Section 3 – Recommendations.

All sections need to be filled in. The care domains should also all be completed, but in the order most appropriate to the individual's needs. It is best practice to complete the DST on a single date but if this is not practicable each section should state the date of completion.

21. Each domain is subdivided into statements of need representing no needs ('N' in the table below), low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain (see Figure 1). The table below sets out the full range of the domains. The detailed descriptors of them are set out in the 12 domain tables for completion later in this document.



**Figure 1: How the different care domains are divided into levels of need.**

22. The descriptions in the DST are examples of the types of need that may be observed. They should be carefully considered but may not always adequately describe every individual's circumstances. The MDT should first determine and record the extent and type of need in the space provided. The descriptions may not always exactly describe the individual's needs so if there is difficulty in placing their needs in one or other of the levels, the MDT should use professional judgement based on consideration of all the evidence to decide the most appropriate level. If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion. Please do not score an individual as being between levels. It is important that differences of opinion on the appropriate level are based on the evidence available and not on presuppositions about a person's need or generalised assumptions about the effects of a particular condition.

23. It is important that the wording of domain levels is carefully considered and assumptions are not made. The fact that an individual has a condition that is described as 'severe' does not necessarily mean that they should be placed on the 'severe' level of the relevant domain. It is the domain level whose description most closely fits their needs that should be selected (for example, the fact that a person is described as having 'severe' learning disabilities does not automatically mean that they should be placed on the 'severe' level of the Cognition domain).

24. Assessors need to consider how different but interrelated needs across more than one domain can complicate the individual's overall care needs. Examples of different needs that should be considered separately in different domains but which may interact across domains are those in the skin and continence domains.

25. The fast-track process should always be considered for any individual with a rapidly deteriorating condition that may be entering a terminal phase. For other individuals who have a more slowly deteriorating condition and for whom it can reasonably be anticipated that their needs are therefore likely to increase in the near future, the domain levels selected should be based on current needs but the likely change in needs should be recorded in the evidence box for that domain and taken into account in the recommendation made. This could mean that a decision is made that they should be eligible for NHS continuing healthcare immediately (i.e. before the deterioration has actually taken place) or, if not, that a date is given for an early review of their needs and possible eligibility.

Professional judgement based on knowledge of the likely progression of the condition should determine which option is followed.

26. Where a particular effect of a condition could be reflected in more than one domain it can be recorded in both domains where appropriate. The fact that it is the same need being acknowledged in two or more domains should be recorded both in the space given in that domain and in the recommendation at the end of the DST. Care should be taken in reaching conclusions on eligibility. The question is whether the needs are such that the primary need is a health need, not the number of domains that a single need can be recorded in.

27. The levels are relative to each other and to the other domains: some domains include needs that are so great that they could reach the 'priority' level, but others do not. This is because the needs in some care domains are considered never to reach a level at which they on their own should trigger eligibility; rather they would form part of a range of needs which together could define a primary health need.

28. Within each domain there is space to justify why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant. We know that, around the country, particular types of needs are assessed using different tools: in order to avoid practitioners having to change from tools they know well, we do not prescribe the best assessments to use. However, regard should be given to other existing and emerging policies in each area, for example guidance from the National Institute for Clinical Excellence

29. Needs should not be marginalised because they are successfully managed. Well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need will this have a bearing on NHS continuing healthcare eligibility. However, there are different ways of reflecting this principle when completing the DST. For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should be given as to the present-day need if that support were withdrawn or no longer available and this should be reflected in the Behaviour domain.

30. It is not intended that this principle should be applied in such a way that well-controlled physical health conditions should be recorded as if the medication support was not present. Where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain.

31. here may be circumstances, on a case-by-case basis, where an individual may have particular needs that are not covered by the 11 defined care domains within the DST. In this situation, it is the responsibility of the assessors to determine and record the extent and type of the needs in the "additional" domain provided entitled 'Other Significant Care Needs' and take this into account when deciding whether a person has a primary health need. The severity of the need should be weighted in a similar way (i.e. from 'Low' to 'Severe') to the other domains using professional judgement and then taken into account when deciding whether a person has a primary health need. It is very important that the agreed level is compatible with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

### **Establishing a Primary Health Need**

32. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the person's needs, along with the MDT's recommendation about eligibility or ineligibility. A clear recommendation of eligibility to NHS continuing healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains.

If there is:

- one domain recorded as severe, together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs,

**this may well also indicate a primary health need.** In these cases, the overall need, the interactions

between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for NHS continuing healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equals one high'. The judgement whether someone has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs. MDTs are reminded of the need to consider the limits of local authority responsibility when making a Primary Health Need recommendation (see paragraph 26 of the National Framework for Continuing Healthcare).

33. If needs in all domains are recorded as '**no need**', this would indicate ineligibility. Where all domains are recorded as '**low need**', this would be unlikely to indicate eligibility. However, because low needs can add to the overall picture, influence the continuity of care necessary, and alter the impact that other needs have on the individual, all domains should be completed.

34. The coordinator should ensure that all parts of the DST have been completed, including the MDT's recommendation on eligibility, and forward it to the PCT for decision making. The coordinator should also advise the individual of the timescales for decision making. In doing this, they should also check whether there is a need for urgent and/or interim support and liaise with the PCT and local authority to ensure that this is put in place where appropriate. The National Framework guidance gives further details on the actions to be taken.

35. The equality monitoring data form should be completed by the patient who is the subject of the DST. Where the patient needs support to complete the form, this should be arranged by the PCT co-ordinator. The co-ordinator should forward the data form to the appropriate location, in accordance with the relevant PCT's processes for processing equality data.

## Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

### 1. Behaviour:

Human behaviour is complex, hard to categorise, and may be difficult to manage. Challenging behaviour in this domain includes but is not limited to:

- aggression, violence or passive non-aggressive behaviour
- severe disinhibition
- intractable noisiness or restlessness
- resistance to necessary care and treatment (this may therefore include non-concordance and non-compliance, but see note below)
- severe fluctuations in mental state
- extreme frustration associated with communication difficulties
- inappropriate interference with others
- identified high risk of suicide

The assessment of needs of an individual with serious behavioural issues will usually have included a specialist assessment which includes an overall consideration of the risk(s) **to themselves, others or property** with specific attention to aggression, self-harm and self-neglect and any other behaviour(s).

1. Describe the actual needs of the individual, including any episodic needs. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour is likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour.
2. Note any overlap with other domains.
3. Circle the assessed level overleaf.

Description	Level of need
No evidence of 'challenging' behaviour.	No needs
Some incidents of 'challenging' behaviour. A risk assessment indicates that the behaviour does not pose a risk to self or others or a barrier to intervention. The person is compliant with all aspects of their care.	Low
'Challenging' behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self or others. The person is nearly always compliant with care.	Moderate
'Challenging' behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self and/or others. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe

<p>'Challenging' behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self and/or others. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.</p>	<p>Priority</p>
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## 2. Cognition:

This may apply to, but is not limited to, individuals with learning disability and/or acquired and degenerative disorders. Where cognitive impairment is identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved. **Please refer to the National Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about a person's capacity. The principles of the Act should also be applied to all considerations of the individual's ability to make decisions and choices.**

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment (for example difficulties in retrieving short-term memory) which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. <b>OR</b> Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Low
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Moderate
Cognitive impairment that could include marked short-term memory issues and maybe disorientation in time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make choices appropriate to need on a limited range of issues they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	High
Cognitive impairment that may include, in addition to any short-term memory issues, problems with long-term memory or severe disorientation. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate even basic needs and to protect them from harm, neglect or health deterioration.	Severe

### 3. Psychological and Emotional Needs:

There should be evidence of considering psychological needs and their impact on the individual's health and well-being. Use this domain to record the individual's psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs, this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts and reassurance. <b>OR</b> Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Low
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or well-being. <b>OR</b> Withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. <b>OR</b> Withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

## 4. Communication

If individuals have communication needs these should be reflected in the MDT assessment. This section relates to difficulties with expression and understanding, not with the interpretation of language.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Low
Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.	High

## 5. Mobility:

This section considers individuals with impaired mobility. Please take other mobility issues such as wandering into account in the behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken as part of the assessment process (in line with section 6.14 of the National Service Framework for Older People, 2001), and the impact and likelihood of any risk factors considered.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, with reference to movement and handling and falls risk assessments where relevant. Describe the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
Not able to consistently weight bear. <b>OR</b> Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. <b>OR</b> In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.	Moderate
Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. <b>OR</b> Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. <b>OR</b> At a high risk of falls (as evidenced in a falls risk assessment). <b>OR</b> Involuntary spasms or contractures placing themselves and carers or care workers at risk.	High
Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

## 6. Nutrition – Food and Drink:

Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet. <b>OR</b> Able to take food and drink by mouth but requires additional/supplementary feeding.	Low
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. <b>OR</b> Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Moderate
Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. <b>OR</b> Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. <b>OR</b> Nutritional status “at risk” and may be associated with unintended, significant weight loss. <b>OR</b> Significant weight loss or gain due to identified eating disorder. <b>OR</b> Problems relating to a feeding device (for example PEG.) that require skilled assessment and review.	High
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids. <b>OR</b> Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

## 7. Continence:

Where continence problems are identified, a full continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Take into account any aspect of continence care associated with behaviour in the Behaviour domain.
3. Circle the assessed level overleaf.

Description	Level of need
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. <b>AND</b> is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care.	High

## 8. Skin (including tissue viability):

Evidence of wounds should derive from a wound assessment chart or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
No risk of pressure damage or skin condition.	No needs
Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. <b>OR</b> Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. <b>OR</b> A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. <b>OR</b> Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. <b>OR</b> A skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Moderate
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment <b>OR</b> Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. <b>OR</b> Specialist dressing regime in place; responding to treatment.	High
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require a minimum of daily monitoring/reassessment. <b>OR</b> Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule' or above <b>OR</b> Multiple wounds which are not responding to treatment.	Severe

## 9. Breathing

1. Describe below the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath which may require the use of inhalers or a nebuliser and has no impact on daily living activities. <b>OR</b> Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Low
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities. <b>OR</b> Episodes of breathlessness that do not respond to management and limit some daily living activities. <b>OR</b> Requires any of the following: low level oxygen therapy (24%). room air ventilators via a facial or nasal mask. other therapeutic appliances to maintain airflow. <b>OR</b> CPAP (Continuous Positive Airways Pressure).	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. <b>OR</b> Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. <b>OR</b> Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy.	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

## 10. Drug Therapies and Medication: Symptom Control:

The individual's experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication. In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill. References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

1. Describe below the actual needs of the individual and provide the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
Requires supervision/administration of and/or prompting with medication or may have a physical, mental state or cognitive impairment requiring support to take medication, but shows compliance with medication regime. <b>OR</b> Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Low
Requires the administration of medication due to: non-concordance or non-compliance, type of medication (for example insulin), or route of medication (for example PEG, liquid medication). <b>OR</b> Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. <b>OR</b> Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	High
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. <b>OR</b> Severe recurrent or constant pain which is not responding to treatment. <b>OR</b> Risk of non-concordance with medication, placing them at risk of relapse.	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating	Priority

condition. <b>OR</b> Unremitting and overwhelming pain despite all efforts to control pain effectively.	
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## 11. Altered States of Consciousness (ASC):

ASCs can include a range of conditions that affect consciousness including Transient Ischemic Attacks (TIAs), Epilepsy and Vasovagal Syncope

1. Describe below the actual needs of the individual providing the evidence that informs the decision overleaf on which level is appropriate (referring to appropriate risk assessments), including the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	Low
Occasional episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. <b>OR</b> Occasional ASCs that require skilled intervention to reduce the risk of harm.	High
Coma. <b>OR</b> ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

## 12. Other significant care needs to be taken into consideration:

There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision.

1. Enter below a brief description of the actual needs of the individual, including providing the evidence why the level in the table overleaf has been chosen (referring to appropriate risk assessments), and referring to the frequency and intensity of need, unpredictability, deterioration and any instability.
2. Circle the assessed level overleaf.

Description	Level of need
	Low
	Moderate
	High
	Severe

### Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Behaviour						
Cognition						
Psychological Needs						
Communication						
Mobility						
Nutrition – Food and Drink						
Continence						
Skin (including tissue viability)						
Breathing						
Drug Therapies and Medication						
Altered States of Consciousness						
Other significant care needs						
<b>Totals</b>						

Please note below any views of the individual on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement. Where the individual is represented or supported by a carer or advocate, their understanding of the individual's views should be recorded.

## Decision Support Tool for NHS Continuing Healthcare

### Section 3 – Recommendations

#### Recommendation of the multidisciplinary team filling in the DST

Please give a recommendation on the next page as to whether or not the individual is eligible for NHS continuing healthcare. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether the individual's primary need is for healthcare. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual's primary needs are health needs should include consideration of:

**Nature:** This describes the particular characteristics of an individual's needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

**Intensity:** This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').

**Complexity:** This is concerned with how the needs present and interact to increase the skill needed to monitor the symptoms, treat the condition(s) and/or manage the care. This can arise with a single condition or can also include the presence of multiple conditions or the interactions between two or more conditions.

**Unpredictability:** This describes the degree to which needs fluctuate, creating challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, or unstable or rapidly deteriorating condition.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.

Also please indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set.

Where there is no eligibility for NHS continuing healthcare and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.

*Recommendation on eligibility for NHS continuing healthcare detailing the conclusions on the issues outlined on the previous page:*

**Names and signature of the team**

**Date**

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# *Appendix 3:*

## *Pflegezeitbemessung (Duitsland)*

### **Pflegezeitbemessung**

<http://www.p-wie-pflegeversicherung.de/pflegeversicherung/zeitkorridore/index.html>

### **Orientierungswerte zur Pflegezeitbemessung**

<http://www.pflegestufe.info/pflege/pflegeversicherung.html>

## Pflegezeitbemessung

Quelle: <http://www.p-wie-pflegeversicherung.de/pflegeversicherung/zeitkorridore/index.html>

<b>Pflegebereich</b>	<b>Pflegetätigkeit</b>	<b>Zeitkorridor</b>
<b>Körperpflege</b>	Ganzkörperwäsche	20-25 Min.
	Teilwäsche Oberkörper	8-10 Min.
	Teilwäsche Unterkörper	12-15 Min.
	Teilwäsche Gesicht/Hände	1-2 Min.
	Duschen	15-20 Min.
	Baden	20-25 Min.
	Zahnpflege	5 Min.
	Rasieren	5-10 Min.
	Kämmen	1-3 Min.
<b>Toilettengang</b>	Urinieren, Hygiene, Reinigung	2 bis 3 Min.
	Stuhlgang, Hygiene, Reinigung	3-6 Min.
	Windelwechsel nach urinieren	4 Min.
	Windelwechsel nach Stuhlgang	7-10 Min.
	Richten der Kleidung	2 Min.
<b>Ernährung</b>	Zerkleinerung der Nahrung	2-3 Min.
	Nahrungsaufnahme	15-20 Min.
	Sondenernährung, Reinigung	15-20 Min.
<b>Mobilität</b>	Aufstehen/ zu Bett gehen	1-2 Min.
	Umlagern	2-3 Min.
	Anziehen komplett	8-10 Min.
	Anziehen Oberkörper	5-6 Min.
	Anziehen Unterkörper	5-6 Min.
	Ausziehen komplett	4-6 Min.
	Ausziehen Oberkörper	2-3 Min.
Ausziehen Unterkörper	2-3 Min.	

## Orientierungswerte zur Pflegezeitbemessung

<http://www.pflegestufe.info/pflege/pflegeversicherung.html>

Der erste Schritt bei der Begutachtung ist die Prüfung, ob die Voraussetzungen erfüllt sind, die im §14 SGB XI genannt werden.

Um über die Pflegestufe der Antragstellenden zu entscheiden, wurde der Zeitaufwand für die nötigen Hilfen als eines der wichtigsten Kriterien bestimmt. In der Anfangsphase der Pflegeversicherung wurde festgestellt, dass unterschiedliche GutachterInnen zu manchmal sehr unterschiedlichen Einstufungen kamen. Jemandem morgens zu helfen sich von Kopf bis Fuß zu waschen kann 15 oder 45 min dauern, auch wenn die gleiche Grunderkrankung (z.B. M. Parkinson) vorliegt. Es soll aber nicht Grundlage staatlichen Handelns sein, dass Pflegebedürftige allein von der Qualifikation oder dem guten Willen eines Gutachters abhängen. Für die 13 häufigsten Verrichtungen der **Grundpflege** wurden deshalb Zeitkorridore entwickelt. Für das Baden werden zum Beispiel 20-25 Min als angemessen erachtet, für die Zahnpflege 5 Min. Im Rahmen dieser Zeiten sollen Laienpflegekräfte in der Lage sein, die vollständige Übernahme einer pflegerischen Handlung durchzuführen (BRi, S. 113). Wird die Hilfe in Form der "teilweise Übernahme" oder als "Beaufsichtigung" geleistet, können die Zeitvorgaben nur teilweise angerechnet werden. [... mehr über die Formen der Hilfeleistung]. Diese Zeitkorridore wurden in die "Richtlinien zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches" (BRi) aufgenommen und sind damit für alle an der Pflegeversicherung beteiligten verbindlich.

Die GutachterInnen sollen sich an diese Vorgaben halten und müssen Abweichungen begründen. Ein Beispiel sind die pfleegerschwerenden und pflegeerleichternden Faktoren. Trotz dieser Zeitkorridore gilt:

**"Für die Feststellung der Pflegebedürftigkeit und die Zuordnung zu einer Pflegestufe ist allein der im Einzelfall bestehende individuelle Hilfebedarf des Antragstellers maßgeblich. In so fern können und sollen die Zeitorientierungswerte für die Begutachtung nach dem SGB XI nur Anhaltsgrößen im Sinne eines Orientierungsrahmens liefern. Sie sind damit für den Gutachter ein Instrument zur Feststellung des individuellen Hilfebedarfs."** (BRi, S. 113)

Diese Zeitkorridore haben pflegerische Arbeiten die alltäglich als Einheit empfunden werden penibel unterteilt, um zu einigermaßen angemessenen Zeitvorgaben kommen zu können.

Beispiel: Die pflegende Schwiegertochter spricht von "morgens waschen und anziehen". Diese Beschreibung ist recht oberflächlich und wird einem Vorgang der leicht 45 min dauern kann nicht gerecht. Das SGB XI erkennt nur einen Teil der Hilfen an, die zum Tagesbeginn geleistet werden. Hier ist eine Aufzählung dazu: Getränk anreichen, aufstehen, ins Bad begleiten, Zahnpflege, entkleiden, Ganzkörperwäsche, Einlagen anlegen, ankleiden, kämmen, rasieren, in die Küche begleiten, wo es Frühstück gibt. Sie sehen, die Begutachtungsrichtlinien (BRi) haben ihre eigene Logik.

Es ist selten, dass jemand auf die vollständige Übernahme aller dieser Tätigkeiten angewiesen ist. Häufig können Oberkörper und Intimbereich selbst gewaschen werden und bei der Zahnpflege genügt es, Zahnbürste und Becher anzureichen. Diese unterschiedlichen Formen der Hilfeleistung werden bei der Pflegezeitbemessung berücksichtigt. Außerdem muss berücksichtigt werden, wenn Menschen, z.B. aufgrund von Übergewicht für einzelne Verrichtungen länger brauchen oder wenn die Pflege durch das Untergewicht der Pflegebedürftigen "erleichtert" wird. [zu den Erschwernisfaktoren] Hier finden sie Erklärungen zu den einzelnen Verrichtungen. Die Zeitangaben aus den BRi beziehen sich immer auf die Hilfeform der vollständigen Übernahme.

## Körperpflege

Quelle: "Richtlinien des GKV Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches", veröffentlicht im August 2009 vom MDS, Essen, Seiten 117-9

"Die Hautpflege (einschließlich Gesichtspflege) ist als Bestandteil der Körperpflege bei den jeweiligen Zeitorientierungswerten berücksichtigt. Das Schminken kann nicht als Gesichtspflege gewertet werden. Zur Körperpflege zählt auch das Haarewaschen. Es ist Bestandteil der Verrichtung Waschen/Duschen/Baden. Erfolgt das Haarewaschen im Rahmen einer dieser Verrichtungen ist dies dort zu dokumentieren. Alleiniges Haarewaschen ist der Verrichtung "Waschen" zuzuordnen und unter "Teilwäsche Oberkörper" zu dokumentieren. Der notwendige zeitliche Hilfebedarf ist jeweils gesondert zu dokumentieren. Ein ein- bis zweimaliges Haarewaschen pro Woche entspricht dem

heutigen Hygienestandard. Maßgebend ist die medizinische bzw. pflegerische Notwendigkeit. Der Hilfebedarf beim Haarewaschen umfasst auch die Haartrocknung.

### **1. Waschen**

- Ganzkörperwäsche: (GK): 20 bis 25 Min.
- Teilwäsche Oberkörper: (OK): 8 bis 10 Min.
- Teilwäsche Unterkörper: (UK): 12 bis 15 Min.
- Teilwäsche Hände/Gesicht: (H/G): 1 bis 2 Min.

Während die Intimwaschungen hier zu berücksichtigen sind, ist die Durchführung einer Intimhygiene z. B. nach dem Toilettengang der Verrichtung "Darm- und Blasenentleerung" zuzuordnen.

### **2. Duschen**

- Duschen: 15 bis 20 Min.

Hilfestellung beim Betreten der Duschtasse, bzw. beim Umsetzen des An-tragstellers z. B. auf einen Duschstuhl, ist im Bereich der Mobilität "Stehen" zu berücksichtigen.

Wenn bei dieser Verrichtung nur Teilhilfen (Abtrocknen/Teilwaschungen) anfallen, kann der Zeitorientierungswert nur anteilig berücksichtigt werden.

### **3. Baden**

- Baden: 20 bis 25 Min.

Eine Hilfestellung beim Einsteigen in die Badewanne ist im Bereich der Mobilität "Stehen" zu berücksichtigen.

Wenn bei dieser Verrichtung nur Teilhilfen (Abtrocknen/Teilwaschungen) anfallen, kann der Zeitorientierungswert nur anteilig berücksichtigt werden.

### **4. Zahnpflege**

- Zahnpflege: 5 Min.

So weit nur Mundpflege erforderlich ist, kann der Zeitorientierungswert nur anteilig berücksichtigt werden.

### **5. Kämmen**

- Kämmen: 1 bis 3 Min.

### **6. Rasieren**

- Rasieren: 5 bis 10 Min.

### **7. Darm- und Blasenentleerung**

Nicht zu berücksichtigen ist unter diesen Verrichtungen die eventuell eingeschränkte Gehfähigkeit beim Aufsuchen und Verlassen der Toilette. Kann der Antragsteller die Toilette nur deshalb nicht alleine aufsuchen, ist dies unter "Gehen" im Bereich der Mobilität festzustellen und zeitlich zu bewerten.

- Wasserlassen (Intimhygiene, Toilettenspülung ): 2 bis 3 Min.
- Stuhlgang (Intimhygiene, Toilettenspülung ): 3 bis 6 Min.
- Richten der Bekleidung: insgesamt 2 Min.
- Wechseln von Inkontinenzprodukten (Intimhygiene, Entsorgung)
  - o nach Wasserlassen: 4 bis 6 Min.
  - o nach Stuhlgang: 7 bis 10 Min.
- Wechsel kleiner Vorlagen: 1 bis 2 Min.

Beachte: Der im Rahmen eines Toilettentrainings erforderliche Wechsel von Inkontinenzprodukten ist von seinem zeitlichen Aufwand her in der Regel sehr viel geringer ausgeprägt als ein üblicher Windelwechsel, dem eine unkontrollierte und unregelmäßige Harnblasen- und Darmentleerung zugrunde liegt.

- Wechseln/Entleeren des Urinbeutels: 2 bis 3 Min.
- Wechseln/Entleeren des Stomabeutels: 3 bis 4 Min.

Beachte: Für den notwendigen Wechsel des Systems (Basisplatte) ist aufgrund der unterschiedlichen individuellen Gegebenheiten die Vorgabe eines Zeitorientierungswertes nicht möglich."

## Ernährung

Quelle: "Richtlinien des GKV Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches", veröffentlicht im August 2009 vom MDS, Essen, Seiten 69-70

### 8. Mundgerechtes Zubereiten der Nahrung

"Zur "mundgerechten" Zubereitung der Nahrung gehört allein die letzte Maßnahme vor der Nahrungsaufnahme, z. B. das Zerkleinern in mundgerechte Bissen, das Heraustrennen von Knochen und Gräten, das Einweichen harter Nahrung bei Kau- und Schluckbeschwerden und das Einfüllen von Getränken in Trinkgefäße. Erfasst werden nur solche Maßnahmen, die dazu dienen, die bereits zubereitete Nahrung so aufzubereiten, dass eine abschließende Aufnahme durch den Antragsteller erfolgen kann. Hierzu zählen nicht das Kochen oder das Eindecken des Tisches. Die Zubereitung von Diäten, einschließlich des anhand der Diätvorschriften vorzunehmenden Bemessens und Zuteilens der zubereiteten Nahrung bzw. einzelner Nahrungsbestandteile ist nicht hier, sondern unter der lfd. Nr. 17 "Kochen" zu berücksichtigen. Die regelmäßige Insulingabe, die Blutzuckermessungen sowie grundsätzlich auch die Gabe von Medikamenten sind keine verrichtungsbezogenen krankheitsspezifischen Pflegemaßnahmen, da sie aus medizinisch-pflegerischen Gründen nicht objektiv notwendig in einem unmittelbaren zeitlichen und sachlichen Zusammenhang mit dieser Verrichtung vorgenommen werden müssen."

### 9. Aufnahme der Nahrung

"Dazu gehören die Nahrungsaufnahme in jeder Form (fest, breiig, flüssig) wie auch die Verabreichung von Sondennahrung mittels Ernährungssonde einschließlich der Pflege der Sonde und die Verwendung von Besteck oder anderer geeigneter Geräte (z. B. behindertengerechtes Geschirr oder Essbesteck), um Nahrung zum Mund zu führen. Notwendige Aufforderungen zur bedarfsgerechten Aufnahme der Nahrung in fester, breiiger und flüssiger Form (Essen und Trinken), die eine Überwachung und/oder Erledigungskontrolle erfordern, sind beim Hilfebedarf zu berücksichtigen, wenn der Antragsteller aufgrund fehlender Einsichtsfähigkeit dazu nicht in der Lage ist (z. B. bei mukoviszidosekranken Kindern abhängig vom Lebensalter oder bei geronto-psychiatrisch veränderten Menschen). Wenn im unmittelbaren zeitlichen und sachlichen Zusammenhang mit der Aufnahme der Nahrung z. B. das Wechseln der Sprechkanüle gegen eine Dauerkanüle bei einem Tracheostomapatienten zur Ermöglichung des Schluckens oder vor oder während dieser Verrichtung eine oro/tracheale Sekretabsaugung notwendig ist, handelt es sich um eine verrichtungsbezogene krankheitsspezifische Pflegemaßnahme. Diese ist zusätzlich zu dem bei der Aufnahme der Nahrung bestehenden Hilfebedarf zu berücksichtigen. Die Angaben zu Punkt D 4.0/ III. / 4. "Ermittlung des zeitlichen Umfangs des regelmäßigen Hilfebedarfs" sind zu berücksichtigen. Im Gegensatz dazu ist das Legen einer Dauerernährungssonde keine solche Maßnahme, weil sie aus medizinisch-pflegerischen Gründen nicht objektiv notwendig in einem unmittelbaren zeitlichen und sachlichen Zusammenhang mit dieser Verrichtung vorgenommen werden muss."

## Mobilität

Quelle: "Richtlinien des GKV Spitzenverbandes zur Begutachtung von Pflegebedürftigkeit nach dem XI. Buch des Sozialgesetzbuches", veröffentlicht im August 2009 vom MDS, Essen, Seite 120-1

### 10. Selbständiges Aufstehen und Zubettgehen

#### Umlagern

"Der durch das Umlagern tagsüber und/oder nachts anfallende Pflegeaufwand nach Häufigkeit und Zeit wird als Bestandteil der Körperpflege, Ernährung oder Mobilität betrachtet und entsprechend berücksichtigt. Dabei wird so verfahren, dass der notwendige Hilfebedarf unabhängig davon, ob das Umlagern solitär oder im Zusammenhang mit den Verrichtungen der Körperpflege, Ernährung oder Mobilität durchgeführt wird, hier zu dokumentieren ist.

- einfache Hilfe zum Aufstehen/zum Bett gehen: je 1 bis 2 Min.
- Umlagern: 2 bis 3 Min."

### 11. An- und Auskleiden

"Bei der Feststellung des Zeitaufwandes für das An- und Ablegen von Prothesen, Orthesen, Korsetts und Stützstrümpfen hat der Gutachter aufgrund einer eigenen Inaugenscheinnahme den Zeitaufwand individuell zu messen.

Das komplette An- und Auskleiden betrifft sowohl den Ober- als auch den Unterkörper. Daneben kommen aber auch Teilbekleidungen und Teilkleidungen sowohl des Ober- als auch des

Unterkörpers vor und müssen gesondert berücksichtigt werden. Bei der Verrichtung Ankleiden ist das Ausziehen von Nachtwäsche und das Anziehen von Tagesbekleidung als ein Vorgang zu werten. Bei der Verrichtung Auskleiden ist das Ausziehen von Tagesbekleidung und das Anziehen von Nachtwäsche als ein Vorgang zu werten.

- Ankleiden gesamt: (GK): 8 bis 10 Min.
- Ankleiden Oberkörper/Unterkörper: (TK): 5 bis 6 Min.
- Entkleiden gesamt: (GE): 4 bis 6 Min.
- Entkleiden Oberkörper/Unterkörper: (TE): 2 bis 3 Min."

## **12. Gehen**

"Die Vorgabe von orientierenden Zeitwerten ist aufgrund der unterschiedlichen Wegstrecken, die seitens des Antragstellers im Rahmen der gesetzlich definierten Verrichtungen zu bewältigen sind, nicht möglich."

## **13. Stehen (Transfer)**

"Notwendige Hilfestellungen beim Stehen sind im Hinblick auf die Durchführung der gesetzlich vorgegebenen Verrichtungen im Rahmen aller anfallenden notwendigen Handlungen zeitlich berücksichtigt.

Als Hilfebedarf ist ausschließlich der Transfer zu berücksichtigen. Hierzu zählt z. B. das Umsetzen von einem Rollstuhl/Sessel auf einen Toilettenstuhl oder der Transfer in eine Badewanne oder Duschtasse.

Jeder Transfer ist einzeln zu berücksichtigen (Hin- und Rücktransfer = 2 x Transfer).

- Transfer auf den bzw. vom Rollstuhl/Toilettenstuhl/Toilette in die bzw. aus der Badewanne/Duschtasse: je 1 Min."

## **14. Treppensteigen**

"Keine andere Verrichtung im Bereich der Grundpflege ist so abhängig vom individuellen Wohnbereich des Antragstellers wie das Treppensteigen. Aus diesem Grund ist die Vorgabe eines Zeitorientierungswerts nicht möglich ...

Bei Begutachtungen in stationären Einrichtungen kann ein Hilfebedarf beim Treppensteigen wegen der Vorgabe der "durchschnittlichen häuslichen Wohnsituation" nicht gewertet werden."

## **15. Verlassen und Wiederaufsuchen der Wohnung**

"Die Vorgabe von Zeitorientierungswerten ist nicht möglich. Die Zeiten sind individuell zu erheben. Bei Wartezeiten im Zusammenhang mit dem Aufsuchen von Ärzten und Therapeuten können bis zu 45 Minuten angesetzt werden."

# *Appendix 4:*

## *AGGIR (Frankrijk)*

### **AGGIR**

<http://www.agevillage.com/article-1030-1-Comment-fonctionne-la-grille-AGGIR.html>

## La grille AGGIR

A.G.G.I.R		Valeur des codes B et C de chaque Groupe, pour le calcul du rang							
RUBRIQUES	code	Groupe A	Groupe B	Groupe C	Groupe D	Groupe E	Groupe F	Groupe G	Groupe H
	Cohérence	C	2000	1500	0	0	400	200	150
Cohérence	B	0	320	0	0	0	100	0	0
Orientation	C	1200	1200	0	0	400	200	150	0
Orientation	B	0	120	0	0	0	100	0	0
Toilette	C	40	40	40	0	400	500	300	3000
Toilette	B	16	16	16	0	100	100	200	2000
Habillemt	C	40	40	40	0	400	500	300	3000
Habillemt	B	16	16	16	0	100	100	200	2000
Alimentation	C	60	60	60	2000	400	500	500	3000
Alimentation	B	20	0	20	200	100	100	200	2000
Élimination	C	100	100	160	400	800	500	500	3000
Élimination	B	16	16	20	200	100	100	200	2000
Transfert	C	800	800	1000	2000	800	500	400	1000
Transfert	B	120	120	200	200	100	100	200	2000
Déplacement Interne	C	200	moins 80	400	200	200	200	200	1000
Déplacement Interne	B	32	moins 40	40	0	0	0	100	1000
Déplacement Externe	C	0	0	0	0	0	0	0	0
Déplacement Externe	B	0	0	0	0	0	0	0	0
Communication	C	0	0	0	0	0	0	0	0
Communication	B	0	0	0	0	0	0	0	0
<b>Ventilation des rangs</b>		(dés qu'un rang a été signalé les calculs des groupes suivants sont inopérants)							
Somme si tous C cochés		4440	3660	1700	4600	3800	3100	2500	14000
Rangs	Prévus	1 ou 2 ou 3	4	5 ou 6	7	8	9	10	11 ou 12 ou 13
	Ventilation	≥4380 = 1	≥2016 = 4	≥1700 = 5	≥2400 = 7	≥1200 = 8	≥800 = 9	≥650 = 10	≥4000 = 11
		≥4140 = 2		≥1432 = 6					≥2000 = 12
		≥3390 = 3							<2000 = 13
	Groupe suivant si...	< 3390 et B	< 2016 et C	< 1432 et D	< 2400 et E	< 1200 et F	< 800 et G	< 650 et H	
<b>Des rangs aux GIR</b>		Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR	Rang = GIR
		1 = 1	4 = 2	5 = 2	7 = 2	8 = 3	9 = 3	10 = 4	11 = 4
		2 = 2		6 = 2					12 = 5
		3 = 2							13 = 6
<b>Résumé</b>		• Rang 1 = GIR 1		• Rang 8 ou 9 = GIR 3		• Rang 12 = GIR 5			
		• Rang 2 ou 3 ou 4 ou 5 ou 6 ou 7 = GIR 2			• Rang 10 ou 11 = GIR 4		• Rang 13 = GIR 6		

## Comment fonctionne la grille AGGIR

L'outil AGGIR, Autonomie gérontologique groupes iso ressources, permet d'évaluer la perte d'autonomie à partir du constat des activités effectuées ou non par la personne seule. Son remplissage exclut tout ce que font les aidants et/ou les soignants, afin de mesurer seulement ce que fait la personne âgée. En revanche, les aides matérielles et techniques sont considérées comme faisant partie de la personne : lunettes, prothèses auditives, fauteuil roulant, poche de colostomie.

### 10 variables

La grille AGGIR comporte donc 10 variables dites discriminantes, se rapportant à la perte d'autonomie physique et psychique, et 7 variables dites illustratives, se rapportant à la perte d'autonomie domestique et sociale.

### Chaque variable possède trois modalités :

A : fait seul, totalement, habituellement et correctement ;  
B : fait partiellement, ou non habituellement ou non correctement ;  
C : ne fait pas.

*Habituellement* est la référence au temps.

*Correctement* est la référence à l'environnement conforme aux usages.

La notion "*seul*" correspond à "fait spontanément seul". Elle suppose qu'il n'est besoin ni d'incitation ni de stimulation de la part d'un tiers.

Une stimulation ponctuelle est à différencier d'une stimulation totale, nécessitant une présence permanente de l'aidant pour la réalisation de l'acte considéré. Dans ce dernier cas, la personne "ne fait pas".

Ces variables permettent une différenciation très nette des individus selon trois modalités : forte perte d'autonomie, perte d'autonomie partielle et pas de perte d'autonomie.

### ATTENTION à la modalité B.

La modalité B, en aucun cas, n'est à utiliser lorsque l'évaluateur ne sait pas. Elle correspond à une définition précise. Dans le doute, il convient d'observer à nouveau ce que fait la personne et de se demander si elle peut faire seule, de façon partielle, correcte, habituelle.

## 1. Cohérence

**Converser et/ou se comporter de façon logique et sensée par rapport aux normes admises par la société dans laquelle on vit.**

### Précisions :

- logique : de raison, raisonnable ;
- sensée : qui a du bon sens, le sens commun ;
- correcte : conforme aux convenances et usages admis et acceptés en référence aux normes sociales.

### Observation :

Dans le cas où la personne est cohérente et logique mais dans son propre système de pensée, il convient d'évaluer en tenant compte des écarts par rapport à ce qui est considéré comme logique et correct par la société.

### Exemples :

La modalité est C :

- si une personne se promène toute nue hors de chez elle ;
- si une personne fait ses besoins dans des réceptacles non prévus à cet effet.

La modalité est B :

- si une personne a, par moment, une conduite et un raisonnement logiques et, par moment, illogiques
  - si une personne prétend à tort, de façon répétée, qu'elle a été volée et que, par ailleurs, elle ne pose pas de problème;
  - si elle a des comportements déplacés.
- On retrouvera des troubles de la cohérence dans d'autres variables, par exemple "habillage", si la personne met sa chemise par dessus sa veste, ce qui n'est pas correct.

## 2. Orientation

**Se repérer dans le temps, les moments de la journée, dans les lieux.**

**Précisions :**

Il ne faut pas demander à la personne âgée "quel jour est-on ?" car peu d'entre nous sauraient répondre le 23 ou le 24 juin durant une période de vacances .

**Questions à se poser :**

Est-ce que la personne sait se situer par rapport aux saisons (été, hiver ), par rapport aux moments de la journée (matin, soir), dans des lieux de vie habituels (maison, appartement, quartier, unité de vie ) ? Connaît-elle l'année, le mois ?

**Exemples :**

*La modalité est C :*

- si une personne se trompe pratiquement toujours de logement, de chambre ;
- si une personne ne différencie pas le jour et la nuit ;
- si l'heure des repas est à rappeler quotidiennement.

*La modalité est B :*

- si une personne se trompe rarement de logement.

**ATTENTION** : vérifier la cohérence des variables.

Ainsi, si cohérence et orientation ne sont pas "A", il est très improbable d'avoir "A" sur l'ensemble des autres variables discriminantes ; ce n'est pas le logiciel qui corrigera les erreurs de codification !

## 3. Toilette

**Elle concerne l'hygiène corporelle.**

**Précisions :**

Pour "seul", il est indispensable que l'acte soit spontané, sans incitation.

A domicile, les installations - la salle de bains, la baignoire ou douche - ne doivent pas influencer l'évaluation de cette variable. On peut être propre sans posséder de telles installations.

**Questions à se poser :**

Il est essentiel de demander à l'entourage si l'on est obligé de dire toujours à la personne âgée d'aller faire sa toilette pour qu'elle l'effectue.

Il importe aussi de ne pas imposer ses propres règles d'hygiène à une personne qui est propre mais avec d'autres règles culturelles.

**Exemples :**

*La modalité est C*

- si la toilette n'est jamais effectuée.

*La modalité est B*

- si la toilette est effectuée correctement, mais s'il est nécessaire d'inciter régulièrement la personne ou de préparer les affaires de toilettes ou le bain, sans pour autant laver la personne.

La variable Toilette comprend toilette du haut et toilette du bas. Pour renseigner la variable Toilette, il convient d'abord de codifier l'autonomie pour la toilette des parties hautes puis des parties basses du corps qui font l'objet de précisions dans les deux points suivants.

Pour passer de ces deux variables à une seule variable Toilette, on utilisera le raisonnement suivant :

- si les modalités de Toilette haut et bas sont A, celle de Toilette est A ;
- si elles sont C, celle de Toilette est C ;
- dans tous les autres cas, elle est B : soit CC = C ; AA = A ; autres = B.

#### **Toilette du haut**

**Visage, tronc, membres supérieurs, mains, rasage, coiffage.**

##### **Précisions :**

- Le dos n'a volontairement pas été pris en compte, car, après 80 ans, il est difficile pour la majorité des personnes de se laver le dos seules, totalement, habituellement et correctement.
- Pour le coiffage, c'est le coup de peigne ou de brosse qui est retenu. Le travail de la coiffeuse professionnelle n'est évidemment pas évalué ici.
- Le nettoyage de la denture a été supprimé car il s'avère qu'il fait perdre toute sensibilité à l'évaluation sur une variable très importante.

#### **Toilette du bas**

**Régions intimes, membres inférieurs, pieds.**

##### **Précisions :**

Ne sont pas pris en compte les ongles des orteils.

## **4. Habillage**

### **Généralités**

**Il comporte l'habillage, le déshabillage et la présentation.**

#### **Questions à se poser :**

Faut-il préparer les vêtements pour que la personne soit vêtue correctement ?

La tenue des vêtements, leur lavage, leur repassage, les travaux de couture ne sont pas évalués ici mais dans la variable Ménage.

#### **Exemples :**

*La modalité est C :*

- si l'habillage est totalement incorrect : non conforme aux usages, incompatible avec la météo.
- si la personne ne s'habille pas seule.

*La modalité est B :*

- si la personne ne s'habille que lorsqu'elle y est invitée et/ou que ses vêtements ont été préparés ;
- si elle utilise souvent des vêtements sales ;
- si elle assure l'essentiel de l'habillage, mais pas la totalité. Habillage à partir de "habillage haut, moyen et bas"

**On cotera la variable après avoir évalué les 3 variables décrites ci-dessous :** Habillage du haut, Habillage moyen et Habillage du bas.

On utilisera alors le raisonnement suivant :

- si les trois modalités de Habillage du haut, moyen et du bas sont A, habillage est A ;
- si elles sont C, habillage est C ;
- dans tous les autres cas, la modalité d'habillage est B : soit CCC = C ; AAA = A ; autres = B.

#### **Habillage du haut**

**Vêtements passés par les bras et/ou la tête**

##### **Précisions :**

- on ne tient pas compte des chapeaux éventuels qui ne sont pas indispensables sous nos climats.

### **Habillage moyen**

**Fermeture sur le corps, c'est-à-dire boutonnage des vêtements, fermetures éclairs, ceintures, bretelles, pressions.**

### **Habillage du bas**

**Vêtements passés par le bas du corps, y compris les chaussettes, les bas, les chaussures.**

#### **Précisions :**

- suivant la saison été/hiver, on peut être A, B ou C.

## **5. Alimentation**

### **Généralités**

**Les deux variables qui permettent de codifier l'alimentation sont : se servir et manger.**

Elles évaluent une double activité partant du fait que les aliments sont préparés en cuisine. "Se servir" : couper la viande, ouvrir un pot de yaourt, peler un fruit, remplir son verre. "Manger" : porter les aliments à sa bouche et avaler.

**Alimentation à partir de se servir et manger.** Pour passer des deux variables précisées plus loin, "se servir" et "manger", à la variable Alimentation simplifiée, on utilise le raisonnement suivant :

- si les modalités de "se servir" et de "manger" sont A : Alimentation est A ;
- si les modalités de "se servir" et de "manger" sont C : Alimentation est C ;
- si la modalité de "se servir" est B et celle de "manger" est C : Alimentation est C ;
- si la modalité de "se servir" est C et celle de "manger" est B : Alimentation est C ;
- dans tous les autres cas : Alimentation est B. soit : CC = C ; BC = C ; CB = C ; AA = A ; autres = B.

### **Se servir**

#### **Précisions :**

- si une personne bénéficie d'un portage de repas, est servie à table ou dans son lit à l'aide d'un plateau, se servir commence au moment où elle prépare les aliments avant de les mettre à sa bouche et de les avaler (couper la viande, peler un fruit) ; - mettre le couvert, préparer la table, se retrouve dans les activités de ménage. Il convient d'observer que l'utilisation d'aliments prêts à être consommés (une salade de fruits au lieu d'un fruit à peler, par exemple) rend beaucoup plus autonome.

#### **Exemples :**

*La modalité est C*

- si une personne ne coupe pas sa viande, n'ouvre pas un pot de yaourt, ne pèle pas un fruit, ne remplit pas son verre.

*La modalité est B*

- si une partie de ces actes ne sont pas effectués, par exemple, si elle ne coupe pas seule sa viande.

### **Manger**

**Porter les aliments et boissons à la bouche et les avaler.**

#### **Précisions :**

- si une personne âgée a une sonde gastrique qu'elle gère elle-même, elle doit être cotée A.

#### **Exemples :**

*La modalité est C :*

- si la personne ne met pas seule les aliments à sa bouche quelle que soit la cause somatique ou psychique ;
- si la personne n'avale pas, si la personne ne boit pas seule ;
- si la personne ne gère pas sa sonde de gavage.

*La modalité est B :*

- si la personne doit être incitée à se nourrir et/ou à boire,
- si elle renverse sur la table ou sur elle des aliments car le repas n'est pas correct à son goût.

## 6. Elimination urinaire et anale

Il ne s'agit pas de maîtriser l'élimination (l'incontinence est un diagnostic médical), mais d'assurer l'hygiène de l'élimination. Les problèmes d'hygiène des sanitaires (chasse d'eau et autres) font partie des activités ménagères.

### - Elimination urinaire

*La modalité est A*

- si la personne âgée assure seule correctement son hygiène de l'élimination.

### - Elimination anale

**Assurer l'hygiène de l'élimination anale.**

*La modalité est A*

- si une personne ayant une poche de colostomie assure seule et correctement, son changement.

### **Question à se poser :**

Est-il nécessaire d'inciter la personne à aller aux toilettes ?

### **Exemples :**

*La modalité est C :*

- si la personne renverse régulièrement le contenu de l'urinal ;
- si la personne est toujours incitée à se rendre aux toilettes pour qu'elle n'urine pas n'importe où ;
- si la personne ne place pas elle-même et n'enlève pas les protections à usage unique. Il faut se méfier des couches utilisées abusivement par les soignants (" couches d'accueil ").

*La modalité est B :*

- si l'incitation pour aller aux toilettes est intermittente avec des actes spontanés ;
- si le changement d'usage unique s'effectue parfois correctement, parfois incorrectement ou s'il n'est utile qu'à certains moments sur les 24 heures (nuit par exemple) et nécessite alors une aide. Le bassin est peu significatif, car d'utilisation périlleuse, même par un adulte en pleine forme

### **Elimination à partir d'élimination urinaire et élimination anale**

**Pour passer des deux variables " élimination urinaire " et "élimination anale ", à la variable élimination, on utilise le raisonnement suivant :**

- si la modalité de l'élimination urinaire ou de l'élimination anale est C, la modalité élimination est C ;
- si les deux modalités sont A, la modalité élimination est A.

Dans tous les autres cas, la modalité est B, soit : CC = C ; CB = C ; CA = C ; BC = C ; AC = C ; AA = A ; autres = B.

## 7. Transferts: se lever, se coucher, s'asseoir

### **Généralités**

**Assurer ses transferts : passer d'une des trois positions à une autre, dans les deux sens.**

### **Précisions :**

Cette variable n'inclut que les changements de position et n'inclut pas la marche et les déplacements évalués dans les variables : déplacement à l'intérieur et déplacement à l'extérieur. Un matériel adapté permet des activités impossibles sans lui : lit à hauteur variable, potences, sièges adaptés et peut donc conduire à un classement " A ".

### **Exemples:**

*La modalité est C*

- si les changements de position lever/coucher dans les deux sens ne sont pas effectués.

*La modalité est B :*

- si la personne se couche seule, mais ne se lève pas seule ou inversement ;
- si le transfert lit/fauteuil est effectué, mais pas le transfert assis/debout.

## 8. Déplacements à l'intérieur de la maison

### Dans le lieu de vie

**Au domicile, le lieu de vie comporte les pièces habituelles ainsi que les locaux de service (local poubelles, hall où se trouvent les boîtes aux lettres...).**

L'utilisation par la personne seule de cannes, déambulateur ou d'un fauteuil roulant peut lui permettre d'être B voire A.

### Questions à se poser :

Le déplacement est-il effectif dans toutes les pièces de la maison ?

Dans le cas d'une personne en fauteuil roulant, le manipule-t-elle seule ? La maison comporte-t-elle un escalier ?

### Exemples :

*La modalité est C*

- si la personne n'effectue pas seule ses déplacements.

*La modalité est B :*

- si la personne manipule seule son fauteuil roulant mais n'accède pas à toutes les pièces ;
- si le déplacement n'a lieu que dans certaines pièces de la maison, par exemple lorsque la personne se déplace dans sa chambre mais ne descend pas l'escalier qui dessert la cuisine.

## 9. Déplacements à l'extérieur

### Précisions

On est dehors ou en plein air lorsque l'on a franchi la porte extérieure de la maison ou du bâtiment.

Il existe essentiellement **deux notions** à prendre en compte :

- le fait que la personne sorte spontanément ou pas à l'extérieur ;
- l'importance de la distance parcourue à partir de la porte extérieure.

### Questions à se poser :

Le bâtiment est-il à étages ou de plain-pied ?

### Exemples :

*La modalité est C*

- si l'on ne sort pas seul spontanément.

*La modalité est B*

- si l'on ne sort que rarement à l'extérieur ou si l'on ne sort pas sur tous les types de sol, ou
- si l'on ne sort que de quelques mètres seulement autour de la maison.

## 10. Communication à distance

### Rapport à la technologie

**Utiliser les moyens de communication à distance : téléphone, alarme, sonnette, téléalarme, dans un but d'alerter.**

### Précisions :

La notion d'appel en cas d'urgence est celle qu'il est indispensable de prendre en compte dans cette variable.

### Questions à se poser :

Au domicile, la personne a-t-elle les moyens à la fois psychiques et matériels d'utiliser un moyen de

communication pour alerter son entourage ou un service spécialisé, en cas de problème ? Si la personne émet un appel d'urgence, existera-t-il avec certitude une personne pour le recevoir ?

**Exemples :**

*La modalité est C :*

- a domicile: si la personne n'a ni téléphone, ni téléalarme, ni voisin proche à alerter par cris ou coups aux murs.

*La modalité est B:*

- si une personne utilise fréquemment la téléalarme ou la sonnette sans raison valable.

# *Appendix 5:*

## *THAB-richtlijn (België)*

### **THAB-Richtlijn formulier 3-4. Vragen over beperkingen over zelfredzaamheid**

*Bron: FOD SOCIALE ZEKERHEID, Directie-generaal, Personen met een handicap, pag. 9-12 (vormgeving bewerkt). [www.handicap.fgov.be](http://www.handicap.fgov.be)*

## **THAB-richtlijn formulier 3-4: Vragen over beperkingen over zelfredzaamheid**

Bron: FOD SOCIALE ZEKERHEID, Directie-generaal, Personen met een handicap, pag. 9-12 (vormgeving bewerkt). [www.handicap.fgov.be](http://www.handicap.fgov.be)

*Dit formulier moet worden ingevuld door uw behandelend geneesheer en/of door een geneesheer van uw keuze.*

### **BESCHRIJVING VAN DE ZELFREDZAAMHEID**

Het is in het algemeen de bedoeling dat men vergelijkt met de maatman, maatvrouw van dezelfde leeftijd dan die van de aanvrager/aanvraagster.

- Ga na welke de invloed is van de volgende factoren :  
Beweeglijkheid als zodanig, zintuiglijke problemen, de gevolgen van organiciteit, energetische aspecten, cognitieve aspecten, psychische aspecten.
- Houd rekening met dagdagelijkse activiteiten en niet met uitzonderlijke activiteiten.
- Concentreer u niet enkel op wat allemaal niet meer kan, maar ga ook na wat nog wel mogelijk is.
- Let op gewoontepatronen (man-vrouw rol, ...). Het is niet omdat men iets gewoonlijk niet doet dat men het ook niet kan doen.
- Meldt de aangewende hulp: prothesen, orthesen, hulppapparaten, aanpassingen van de woning, hulp van familie, ...

**De behandelende arts dient gevraagd de zelfredzaamheidsproblemen te BESCHRIJVEN en onder elke rubriek één van de vier mogelijkheden aan te kruisen.**

**HIJ KAN HIERAAN DIVERSE VERSLAGEN TOEVOEGEN zoals een sociaal verslag, een verslag van een psycholoog, ... ten einde het multidisciplinaire karakter van het dossier te vrijwaren.**

**DEZE BEOORDELING is ENKEL INDICATIEF en MAAKT GEEN DEEL UIT van de wettelijke beslissing.**

**DE ARTS VAN DE MEDISCHE DIENST BEPAALT HET AANTAL PUNTEN NADAT BETROKKENE WERD ONDERZOCHT en het DOSSIER VOLLEDIG WERD SAMENGESTELD.**

## 1. VERPLAATSMOGELIJKHEDEN

Ga na wat mogelijk is binnenshuis, buitenshuis in de onmiddellijke omgeving – voor een verdere afstand – vertrouwde en niet vertrouwde omgeving, welk voertuig nog kan bestuurd worden, welke de mogelijkheden zijn bij het nemen van het openbaar vervoer. Welke zijn de problemen in geval van zintuigelijke beperkingen?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

Zijn er beperkingen ?

Ja  Neen

**Zo Ja, beschrijving:** .....

**AANGEWENDE HULP :** .....

- geen moeilijkheden, geen bijzondere inspanning en geen bijzondere hulpmiddelen
- beperkte moeilijkheden of beperkte bijkomende inspanningen of beperkt beroep op bijzondere hulpmiddelen
- grote moeilijkheden of grote bijkomende inspanningen of uitgebreid beroep op bijzondere hulpmiddelen
- onmogelijk zonder hulp van derden, zonder opvang in een aangepaste voorziening of zonder volledig aangepaste omgeving

## 2. MOGELIJKHEDEN OM ZIJN VOEDSEL TE NUTTIGEN OF TE BEREIDEN

Ga na welke de mogelijkheden zijn bij het inkopen van voedingswaren, welke de mogelijkheden zijn bij het bereiden van broodmaaltijden en warme maaltijden (alledaagse bereidingen). Zijn er problemen bij het nuttigen van voeding en dranken, zijn er slikproblemen, zijn er aanpassingen aan de keuken, welke zijn de mogelijkheden wat de vaat betreft en het opbergen ervan ? Welke zijn de problemen in geval van zintuigelijke beperkingen ?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

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### 3. MOGELIJKHEID OM VOOR ZIJN PERSOONLIJKE HYGIËNE IN TE STAAN EN ZICH TE KLEDEN

Ga na of dagelijks toilet mogelijk is, zich volledig wassen – aan de lavabo, in de douche of in een ligbad. Ga na welke de mogelijkheden zijn bij het zich aan- en uitkleden. Ga na welke de mogelijkheden zijn bij de aankoop en keuze van kledij.

Welke zijn de mogelijkheden bij het gebruik van het toilet ? Zijn er sanitaire aanpassingen ?

Zijn er specifieke verzorgingsmaatregelen (stoma, canule, sonde, ...) ?

Welke zijn de problemen in geval van zintuigelijke beperkingen ?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

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### 4. MOGELIJKHEDEN OM ZIJN WONING TE ONDERHOUDEN EN HUISHOUDELIJK WERK TE VERRICHTEN

Welke zijn de mogelijkheden op het vlak van dagdagelijks onderhoud, welke zijn de mogelijkheden op het vlak van opruimen, stofzuigen, dweilen, ramen poetsen, bed opmaken, ... Welke zijn de mogelijkheden op het vlak van onderhoud van de kledij en het strijken, het gebruik van een wasmachine, het gebruik van de waslijn of een droogkast, het opbergen van de kledij. Welke zijn de mogelijkheden wat het kleine herstel van kledij betreft ? Wat zijn de mogelijkheden bij het uitvoeren van kleine herstellingen in de woning (een lamp vervangen, een nagel inkloppen,...) ? Welke zijn de problemen in geval van zintuigelijke beperkingen ?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

Zijn er beperkingen ?

Ja  Neen

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## 5. MOGELIJKHEDEN OM TE LEVEN ZONDER TOEZICHT, BEWUST ZIJN VAN GEVAAR EN GEVAAR KUNNEN VERMIJDEN

Welke zijn de mogelijkheden op het vlak van het herkennen van gevaar, het kunnen reageren op gevaar en het gevaar kunnen vermijden ? Vormt de persoon een gevaar voor zichzelf of voor de omgeving ? Kan de persoon zijn/haar medicatie correct innemen ? Staat de persoon onder bescherming (juridisch, financieel,...) ? Is er punctueel of permanent toezicht nodig ? Welke zijn de problemen in geval van zintuigelijke beperkingen ?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

**Let op :** in de overige rubrieken moet het gevaar inherent aan allerlei handelingen binnen die rubrieken beoordeeld worden.

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## 6. MOGELIJKHEDEN TOT COMMUNICATIE EN SOCIAAL CONTACT

Welke zijn de mogelijkheden op het vlak van communicatie (visueel, verbaal, schriftelijk,...) ? Welke zijn de mogelijkheden op het vlak van het gebruik van diverse technische communicatiemiddelen : telefoon, gsm, computer, ...? Welke zijn de mogelijkheden op het vlak van het leggen en onderhouden van contacten binnen het gezin, de familiekring en daarbuiten ? Welke zijn de problemen in geval van zintuigelijke beperkingen ?

Zijn er hulpmiddelen nodig, is er begeleiding nodig, enz. ?

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OPGEMAAKT OP: ...../...../20..... DOOR :

NAAM: .....(dokter in de geneeskunde) (arts)

WONENDE TE (adres) : .....

Tel. : .....

**STEMPEL van de Arts**

**HANDTEKENING**

**UMC Utrecht**  
**Location Stratenum**

Julius Center for Health Sciences and  
Primary Care

Dr. Wynand J.G. Ros

PO Box 85500  
HP STR 6.131  
3508 GA Utrecht

Tel 088 75 686 16

E-mail [w.j.g.ros@umcutrecht.nl](mailto:w.j.g.ros@umcutrecht.nl)

[www.umcutrecht.nl](http://www.umcutrecht.nl)



University Medical Center  
*Utrecht*