10 JUL 2014

GUIDELINES FOR DISABILITY ASSESSMENT USING THE FUNCTIONAL ASSESSMENT REPORT

(Adapted from article by A/Prof Ng Yee Sien. Adults and Elderly with Multiple Disabilities. The Singapore Family Physicians Volume 40(2) Apr-Jun 2014; 43-55)

AUTHOR'S DISCLAIMER IN ORIGINAL ARTICLE

This guideline provides a general overview of disability assessment and a possible schema of assessment based on published literature and the author's experiences in this field. The text will not be applicable to all schemes and policies and the views and opinions expressed are of the author only.

The ADL definitions and the method in which the severity of disability is categorized vary considerably between the disability-related national schemes and third-party insurers. Similarly the thresholds and disability category whereby the claimant is successful in obtaining claims also vary significantly between the disability-related national schemes and insurers. The author will not be held responsible for any disputes that arise in the claims process and the assessor is advised to check with the particular scheme and insurer for details and updates on the assessment process regularly. The author is currently not affiliated to any disability-related national scheme or third-party insurer.

INTRODUCTION

There are various Government schemes such as the Pioneer Generation – Disability Assistance Scheme (PioneerDAS), Foreign Domestic Worker (FDW) Grant, FDW Levy Concession for Persons with Disabilities (PWDs), Public Transport Concession for PWDs, Special Needs Savings Scheme (SNSS) and Enhancement for Active Seniors (EASE). These schemes use the disability assessment outcomes from the Functional Assessment Report (FAR) to determine the applicants' scheme eligibility of the disability criterion (which varies across schemes), amongst others. (Please see Annex A for the FAR). The FAR can be completed by any of the approved assessors including Singapore Medical Council (SMC) fully registered doctors, Singapore Nursing Board (SNB) registered Nurses, and fully registered Physiotherapists or Occupational Therapists under the Allied Health Professions Council (AHPC).

[Note: The FAR does not apply to the ElderShield (ESH) and Interim Disability Assistance Programme for the Elderly (IDAPE).]

2. The FAR ascertains if the applicant (i) requires assistance in the six Activities of Daily Living (ADLs) – feeding, dressing, bathing, toileting, transfers and mobility, which have the most direct and significant impact on caregiver burden; as well as the (ii) time of onset of their need for assistance. As a proxy, the requirement for assistance in ADLs for more than 6 months would be taken as permanent disability. However, there could be exception cases which will require a case-by-case

assessment by the SMC fully registered doctors only (Please see Para 9 for more details).

3. The assessment of disability involves *strictly* the assessment of the severity of activity limitation including ADLs, and *not* the assessment of the severity of loss of body structure or function[1]. This is important conceptually because the loss of body structure/function or impairment may *not* correlate to disability and activity limitation. Instead, there is a direct correlation between the severity of activity limitation and ADL performed and the amount of care required.

GENERAL PRINCIPLES OF DISABILITY ASSESSMENT

4. For the purpose of the Government schemes stated in Para 1, each ADL is dichotomised into independent and dependent, as two distinct groups in the FAR. ***Independence*** is the performance of an ADL *without* the need for a helper *regardless* of whether aids (such as modified eating utensils or walking frames) are used. ***Dependency*** is defined as the need for assistance from a helper and so indicates presence of caregiver burden.

5. The FAR is meant for those who already have reached their developmental milestones and established their ADLs (as a practical guide we will use age threshold of 8 years old as a reference to apply the assessment to. For children below that age, they would require a certification from the paediatrician to ascertain if they require permanent assistance with their ADLs.)

6. Apart from the disability assessment done with the FAR, the disability-related Government schemes mentioned in Para 1 accept a few other documents, in lieu of the FAR assessment. These documents include:

a) Approval Letter for ESH or IDAPE

b) Approval Letter for PioneerDAS (applicable for all other disability-related Government schemes except PioneerDAS)

c) A doctor's memo or note certifying that the subject is bedridden permanently.

7. ***General principles*** of disability assessment with FAR follow:

a) Assess what the subject actually does and *not* what the subject can do. It is important to differentiate between *capacity* (what the subject can do) and *performance* (what the subject actually does). This is because performance and *not* capacity determines caregiver burden.

[1] For example, for a subject who has a left middle cerebral artery stroke resulting in a right hemiparesis, it is not an assessment of degree of loss of strength of the right arm (loss of body structure/function), but an assessment of the amount of assistance a subject requires to dress himself or groom himself *because* of the loss of strength in the right arm (activity limitation).

For example*, both* cognitive/mental and physical impairments should be taken in consideration for each ADL. In subjects with dementia, they may be able to wear a shirt independently in front of an assessor (capacity), but are fully unable to do so at home because of memory impairment, severe apraxia or significant depression (performance). The subject should be assessed as requiring assistance (performance).

b) Assess the particular ADL as requiring assistance if the performance on that ADL fluctuates. This is to ensure a fair appraisal of the subject's performance and to reflect caregiver burden.

   For example, if a subject has moderately impaired vision due to advanced diabetic retinopathy or cataracts, he may be able to transfer from bed to chair without assistance in the daytime but requires assistance at night because of the high risk of falls. He should be assessed as requiring assistance for transfers.

c) If an ADL has more than one component, assistance required for any one component is considered as requiring assistance for the ADL.

   For example, if a subject with a severe rheumatoid arthritis of hands requires assistance in cutting up food but is able to bring the food to his mouth by himself, chew and swallow safely, he should be assessed as requiring assistance for feeding.

d) Supervision (no contact required) is considered requiring assistance.

e) If there is doubt in the assessment of a particular ADL, it is helpful to rephrase the question from 'how much can the subject perform' in that ADL to 'how much assistance from the caregiver' is required, as the major goal of the disability assessment is to determine caregiver burden.

PRACTICAL ADMINISTRATION OF DISABILITY ASSESSMENT: ASSESSMENT OF THE SIX ACTIVITIES OF DAILY LIVING IN DETAIL

8. For the purpose of the FAR assessment, the assessor should decide whether the subject can perform each ADL independently or is dependent. Assessors are to conduct the assessment in the presence of the applicant through interview and/or observation. There is no need for detailed physical examination or tests, unless there are areas of ambiguity. The assessor is also encouraged to state the subject's diagnosis under the *Comments Section* of the FAR.

9. There are two scenarios which require a case-by-case assessment by the SMC fully registered doctors to assess the permanence of the disability. Such cases should be clearly stated under the *Comments Section* of the FAR.

a) The subject is assessed to have permanent disability since the onset of the condition, with no chance of recovery.

b) The subject is assessed to have recovery potential and is unlikely to be permanently disabled after a period of six months.

10. The following assessment administration guidelines may be useful in these situations.

FEEDING

11. ***Definition:*** Ability to feed oneself food after it has been prepared and made available. The assessment begins when someone places the food within the reach of the subject. It involves the following sub-components: cutting up the food into bite-size portions, bringing food to the mouth with the use of utensils, chewing and swallowing it safely. If a subject relies on other means of feeding, usually a nasogastric tube, then the assessment is how the subject administers the feeding himself.

12. ***Practical Points:*** First decide whether a helper needs to be present at all during the actual eating process to decide between independence and dependence. Amongst the 6 ADLs discussed, the amount of assistance is probably the most subjective for feeding.

13. ***Independence*** is the ability to cut food, bring food to mouth, chew and swallow without a helper needing to be present. This is regardless if adaptive cutlery (for example long handled or built up forks and spoons) is used. If a subject feeds via a nasogastric tube, he must be able to pour the enteral feed down the tube independently. This usually requires an additional funnel to guide the feed down to the tube and he should hold the funnel independently together with the nasogastric tube.

14. ***Dependence*** means a helper needs to be present during the feeding process. The assistance can range from setting up of the eating process including having the helper open containers, cut meat, pour liquids or help the subject wear a cuff to hold utensils, or the need for preparation of modified food consistencies such as a pureed or thickened diet, or the need for the helper to scoop food onto a spoon repeatedly before the subject brings the spoon to his mouth, or the need for the helper to manually feed every mouthful or the need to check the mouth for residual food with each mouthful *or* the need to prompt safe swallowing with each swallow to prevent choking (for example the need to remind the subject to chin tuck and do a double swallow with each swallow).

DRESSING

15. ***Definition:*** Ability to put on, take off, secure and unfasten upper *and* lower body garments. Garments will include prostheses (artificial limbs), orthoses (braces such as a thoracolumbar corset), and specialized garments which are deemed necessary for the subject such as compression stockings for lower limb oedema. The subject should be assessed on clothing that he wears on a regular basis *and* of appropriate decency if he appears in public. We do not recommend that the wearing of undergarments and of footwear be considered as this complicates the assessment.

16. ***Practical Points****:* Divide the task first into upper and lower body dressing and assess whether assistance is required for each. Lower body dressing is usually more difficult.

17. ***Independence*** is the ability to dress the upper and lower body completely without the need for a helper. The subject may use aids such as a long-handled reacher to pull up his trousers if he is unable to bend his trunk.

18. ***Dependence*** means that a helper is required and the assistance may range from a helper providing verbal instructions on the steps required to put on clothes or that a helper needs to assist the subject in putting on, taking off, securing and unfastening the garments for the upper and/or lower body.

19. ***Other points:*** Garments, which are deemed necessary for the subject's condition, are best assessed as an able or not able situation. For example, a subject has been prescribed a rigid thoraco-lumbar orthosis for severe osteoporosis of the spine with compression fractures for prevention of further deterioration and is instructed to wear it. If he is unable to put it on himself, then this should be assessed as requiring assistance. Garments that are not absolutely necessary for the subject's condition, for example a sports-type knee brace that the subject wears for warmth and comfort for osteoarthritis of the knee should *not* then be taken into consideration in the assessment for dressing.

<u>BATHING</u>

20. ***Definition*****:** Ability to wash or bathe in a bathtub, shower or sponge/bed bath. This has the 3 sub-components of washing, rinsing and drying.

21. ***Practical Points*****:** For practical purposes, it is reasonable to assess bathing below the neck only.

22. ***Independence*** is the ability to *wash, rinse and dry* the body without the need for a helper. This is regardless of whether the subject bathes himself in a tub, showers or does a bed-bath.

23. ***Dependence*** indicates the need for a helper to *wash, rinse and dry* the body. The 10 body parts are the left arm, the right arm, the chest, the abdomen, the front perineal area including the genitalia, the back perineal area including the buttocks, the left upper leg, the right upper leg, the left lower leg/foot and the right lower leg/foot. Note that portions of a body part will be considered as unable, so the ability to wash only half the chest is considered as the chest is not washed.

24. ***Other Points:*** The back is excluded from bathing because healthy non-disabled people may otherwise be assessed to be disabled. Many people do not wash their back every day or use an assistive device like a long-handled sponge. A clearer picture of disability will result if the back is not included.

25. The face and neck is excluded because of two reasons. Firstly, washing the face and neck is a separate ADL assessment in *grooming*, and grooming may further

include brushing the teeth, shaving and washing the hair. Secondly, washing the neck and the face has a fairly strong functional overlap with eating and the functional scores generally correlate. The aim of this particular ADL assessment is to assess the disability in bathing in isolation.

26. Note that the definition of bathing includes *wash, rinse and dry.* The amount of assistance is often under-estimated because a subject may be able to wash, but has difficulty manipulating a towel to dry. This should be assessed as requiring assistance to bathe in accordance to the general principles described above.

TOILETING

27. ***Definition*****:** Ability to use the lavatory and manage bowel and bladder hygiene. It consists of 4 steps: (1) maintenance of balance, (2) adjusting clothing before using a toilet, (3) maintaining perineal hygiene and flushing the toilet and subsequently (4) adjusting clothing after using the toilet. The definition remains the same if a bedpan or commode is used. If a bedpan or commode is used, then step (3) would be the need to clear the bedpan and commode as well.

28. By strict definition, this does *not* take into account other aspects of toileting. This includes:

- Transferring from a bed or chair onto the toilet seat. This would be assessed under Transfers.

- The actual bladder or bowel function including whether the subject is continent, leaks, soils the bed or uses a catheter. This is considered as bladder and bowel continence.

29. By definition, it *includes* however:

- Maintaining the balance during clothing adjustment and the actual act of urination and defaecation.

- Perineal hygiene issues including using toilet paper to clean the perineum and the ability to flush the toilet or clear the bedpan.

30. If a subject uses a diaper, then the assessment includes the entire process of removing the diapers, perineal hygiene, putting on a new diaper and discarding the old diapers.

31. If a subject is on a long-term indwelling catheter, do not assess the component of changing the catheter under toileting, as there is usually no caregiver burden involved. If a subject is on self-intermittent catheterization, then he should be assessed as per the definition of toileting given above.

32. ***Practical Points:*** To determine whether assistance required, it is often useful to divide the ADL into 4 steps listed above. For ease of assessment, a part of a component that is not performed should be assessed as not performed and therefore requiring assistance.

33. ***Independence:*** No helper required to perform all 4 steps.

34. ***Dependence:*** A helper is required to help the subject to perform in 1 or more of the 4 steps.

TRANSFERS

35. ***Definition:*** All aspects of transferring from bed to a chair or wheelchair and back to a bed. This tests several skills including doing first a sit-up from a lying position, a sit to standing position, a weight or pivot shift and a controlled descent to a sitting position in another location.

36. ***Practical Points:*** The heights of the bed and chair are often different and the assessment should assess the direction of transfer that comprises the most difficulty. In a hospital, the bed is often higher than the chair and it is more difficult to get back to the bed from a chair. In homes where mattresses are often placed directly on the ground (futon-styled beds) the opposite occurs.

37. ***Independence:*** To transfer from bed to chair and vice versa without the need of a helper. If in a wheelchair, then approaches, locks brakes, removes foot and arm rests and does a transfer often with a sliding board. Regardless, all these are done independently.

38. ***Dependence:*** Assistance to the subject ranges from requiring only coaxing, cuing or at most steadying assistance to guide the subject to transfer, to subject's body requiring light or heavy support during transfer, to having more than one helper to do the transfer or the subject is unable to transfer regardless of assistance.

39. ***Other Points:*** The act of transferring is basic and critical in ADL. Many of the other basic ADLs such as eating, bathing, toileting require an initial act of transfer to a sitting position prior to ADL performance. Transfer from bed to chair or wheelchair is often the most important, common and difficult, and hence this particular transfer forms the definition for this ADL.

MOBILITY

40. ***Definition****:* The act of walking, once in a standing position. If a wheelchair is used for locomotion, assessment commences only from a seated position on a level surface. The distance that is considered significant is controversial (see *other points* below). For this guideline, we use a distance of 8 metres as significant. This would be approximately the end-to-end distance between 2 HBD apartment rooms, or twice the length of an average size GP clinic.

41. ***Practical Points:*** Record the assessment with the mode of locomotion that the subject uses most often, either walking or wheelchair. The distance that is considered significant is the same for walking or wheelchair mobility. The discussion that follows applies for both forms of locomotion.

42. ***Independence:*** The ability to walk independently for a distance of 8 metres. This is regardless of walking aid used and the speed of walking. Common walking aids are a cane (single-point stick), quad (4-point) stick, forearm or elbow crutches, axillary crutches and a walking frame (with or without wheels, the latter termed a rollator frame).

43. ***Dependence:*** Requires a helper to assist the subject to walk 8 metres. Assistance could range from contact guarding and gentle guidance to prevent falls, helper supporting the weight of the subject or to the extent that (1) the subject is unable to walk, (2) the subject cannot cover 8 metres regardless of the amount of assistance or (3) two helpers are required. Points (1) to (3) indicate a very large burden of care.

44. ***Other Points:*** The assessment of walking does not usually include the sub-component of standing up initially from a seated position. This is more accurately assessed under Transfers.

45. The main issue of debate lies in the distance that needs to be covered to be considered significant. Most authorities divide threshold distances into household ambulation and community ambulation. Household ambulation is the distance required generally to move within the home environment and would plausibly cover the distance between a room and a toilet. The average 3-room HDB flat (two bedrooms, a kitchen/dining room and a living room) measures about 64 square metres. A reasonable distance for significant household ambulation would then be 8 metres.

46. Community ambulation is the distance required to move for Instrumental ADL purposes such as grocery shopping or to the nearest bus-stop. 50 metres seems a reasonable distance in the local context: this is the minimum distance between a pedestrian crossing (for example, traffic lights, overhead bridge or zebra crossing) and a point where we can cross the road without using the pedestrian crossing. However we use a household ambulation of 8 metres as our threshold significant distance because we feel that a large majority of disabled subjects are home-bound in Singapore and this more accurately reflects burden of care.

47. Some subjects with significant paralysis of the all limbs including subjects with high cervical spinal cord injury or multiple sclerosis use a powered or electric wheelchair for mobility. The threshold distances do not change because again, we are measuring the amount of assistance required and not the subject's ability to propel a wheelchair primarily.

ANNEX A

Functional Assessment Report
功能评估报告

IMPORTANT NOTE: This report assesses the need for assistance in Activities of Daily Living and is only for the purpose of application of specific government schemes administered by AIC, SG Enable, SNTC and HDB. It is NOT valid for ElderShield or the Interim Disability Assistance Programme for the Elderly (IDAPE). If you are applying for ElderShield/IDAPE, please use the ElderShield/IDAPE claim form instead. More information is available from the websites of Aviva, Great Eastern and NTUC Income. Please contact the individual agencies if there are further queries on the other government schemes.

Any Singapore-registered doctor's memo or document certifying that person needing assessment is bedridden may be accepted in lieu of the functional assessment report.

要注：这份报告旨在评估一个人在日常生活中是否需要帮助，唯一目的是用来申请护联中心、新加坡协助残疾人自立局、特需信托机构及建屋局等机构管理的特定政府计划。它不适用于乐龄健保计划(ElderShield)或乐龄中期残障援助计划(IDAPE)。若是您想申请乐龄健保计划 / 乐龄中期残障援助计划，请使用乐龄健保计划 / 乐龄中期残障援助计划表格。详细资料请参阅 Aviva、大东方及职总英康保险公司网站。关于其他政府计划的询问，请联系个别的相关机构。

如需要评估者拥有任何新加坡注册医生的备忘录或文件证明长期卧床，需要评估者将无需进行功能评估。

SECTION A: TO BE COMPLETED BY PERSON NEEDING ASSESSMENT / CAREGIVER **A组：由需要评估／看护人者填写**	
Name of Person Assessed **受评估者姓名**	: _____
NRIC/BC **身份证／出生证号码**	: _____
Important: Please proceed to complete this form, only if the person has required assistance in Section A Part 1 (iii) to (viii) for more than 6 months and/or if the person will require assistance in Section A Part 1 (iii) to (viii) on a permanent basis. **注意：唯有在受评估者已在A组第1部分（iii）至（viii）项中需要超过6个月的援助及／或将在A组第1部分（iii）至（viii）项中需要永久性帮助的情况下才填写这份表格。**	
1 INFORMATION ON FUNCTIONAL STATUS (TO BE COMPLETED BY PERSON NEEDING ASSESSMENT / CAREGIVER) **关于功能状况的资料（由需要评估／看护人者填写）** *Please provide additional information to aid the assessment.* *请提供额外资料以助评估。*	

Please circle the answers that apply for the person needing assessment: 请圈出适用于需要评估者的答案：		
i	Does the person assessed need a mobility aid when indoors? 受评估者在户内时是否需要助行器？	Yes / No 需要 / 不需要
ii	If "Yes", please indicate the mobility aids used: 若是"需要"，请注明所使用的助行器： ☐ Wheelchair (Powered / Manual) 轮椅（电动／人工） ☐ Artificial Limbs / Devices 义肢／器具 ☐ Crutches 拐杖	

	☐ Walking Cane / Quad Stick 助行藤杖 / 四脚拐杖 ☐ Walking Frame (with / without wheels) 助行框（有轮／无轮） ☐ Others (please specify) 其他（请注明） _____	
iii	Does the person need help to move (with or without walking aids or wheelchair) between his or her room to the toilet in his or her home? 受评估者在家里是否需要帮助才能从房间去厕所（有或无助行器或轮椅）？	Yes / No 需要 / 不需要
iv	Does the person need help to bathe and dry himself or herself (excluding the back)? 受评估者洗澡或擦干身体（背部除外）时是否需要帮助？	Yes / No 需要 / 不需要
v	Does the person need help to wear and take off both upper and lower body clothing? 受评估者穿衣穿裤及脱衣脱裤时是否需要帮助？	Yes / No 需要 / 不需要
vi	Does the person need help to cut up food, bring the food to the mouth, chew and swallow? 受评估者割切食物、把食物放进嘴巴、咀嚼及吞咽时是否需要帮助？	Yes / No 需要 / 不需要
vii	Does the person need help to use the toilet and to clean himself or herself after passing motion or urination? 受评估者如厕时及大小便后清理自己是否需要帮助？	Yes / No 需要 / 不需要
viii	Does the person need help to transfer from bed to chair (or bed to wheelchair) and vice versa? 受评估者从下床到椅子（或轮椅）上或从椅子（或轮椅）到上床时是否需要帮助？	Yes / No 需要 / 不需要
ix	Approximately, when did the person first require assistance with (iii) to (viii), where applicable? 受评估者首次需要（iii）至（viii）项援助时（适用之处）大概是在什么时候?	_____/_____ (MM/YYYY) _____/_____（月份/年份）

2 Declaration by Person Needing Assessment / Caregiver
需要评估／看护人者宣誓

I declare that the above information has been provided to the best of my knowledge, true and correct. I give consent to the assessor to use the above information for the functional assessment. I also declare that I have not withheld any relevant information or made any misleading statement. I give my consent to the assessor to communicate with any physician who has attended to me.

我宣誓，以上资料是根据我所知提供的，并且属实和正确。我同意让评估者使用以上资料为参考。我也宣誓，我没有隐瞒任何相关资料或作出任何误导性声明。我同意让评估者与任何曾治疗我的医生沟通。

_____	_____	_____
Name and Signature of Person Needing Assessment / Caregiver 需要评估／看护人者姓名及签名	I/C Number 身份证号码	Date 日期

SECTION B: TO BE COMPLETED BY ASSESSOR (i.e. SMC FULLY REGISTERED DOCTOR, SNB-REGISTERED NURSE OR FULLY REGISTERED PHYSIOTHERAPIST / OCCUPATIONAL THERAPIST UNDER AHPC)

FUNCTIONAL ASSESSMENT

Patient's Sticky Label (where applicable)

(if no patient's sticky label)

Name of Person Assessed : _____

NRIC/BC : _____

1 Activities of Daily Living (ADLs)*

		Requires help/supervision from an assistant.	Independent – No help is required.
i	Mobility	☐	☐
ii	Washing or Bathing	☐	☐
iii	Dressing	☐	☐
iv	Feeding	☐	☐
v	Toileting	☐	☐
vi	Transferring	☐	☐

2 Comments

Please estimate when the assistance with the ADLs first started.	_____/_____ (MM/YYYY)

Additional Comments (e.g. whether the need for assistance is of permanent nature, or unlikely to require permanent assistance due to recovery potential): _____

_____

I confirm that the assessment done for the above applicant is true and correct to my best knowledge, and with reference to the declaration made by the applicant in Section A. I am aware that the assessment for this application will serve as reference only. The Scheme Administrator reserves the right to make the final decision on the application outcome and reject any application if the information is found to be inaccurate, or if any relevant information has been withheld by the applicant.

Name, Registration No. &Signature of Assessor	Stamp of Organisation/ Clinic / Hospital	Date	Tel / Fax Nos.
_____	_____	_____	_____

***Important Note:** Assessor must sign against any amendment made and affix the official stamp of the organisation / clinic / hospital. If not, the report will be deemed to be incomplete.*

**** Notes for Assessor***

a. *Washing or Bathing* — *Needs help to wash body (excluding back) in the bath, shower or sponge/bed bath. Includes subcomponents of washing, rinsing and drying.*

b. *Dressing* — *Needs help to put on, take off, secure and unfasten garments (upper and lower) and any braces, artificial limbs or other surgical appliances.*

c. *Feeding* — *Needs help to feed oneself after food has been prepared and made available.*

d. *Toileting* — *Needs help to use the toilet and manage bowel and bladder hygiene. Consists of (i) maintenance of balance during the act of urination or defecation and clothing adjustment, and (ii) maintaining perineal hygiene such as using toilet paper to clean the perineum. Independent of actual bowel or bowel functions e.g. incontinence. Does not include changing of long-term indwelling catheter under toileting.*

e. *Transferring* — *Needs help to transfer from bed to an upright chair or wheelchair, and vice versa. Includes sit-up from a lying position, a sit to standing position, a weight or pivot shift and a controlled descent to a sitting position in another location.*

f. *Mobility* — *Needs help to walk indoors or move in a wheelchair from room to room on level surface for about 8 meters (about twice the length of a clinic). This is regardless of the use of walking aid and the speed of walking.*