Adult Social Care and Health
OP/PD

Enablement operational protocols for Kent Enablement at Home (KEaH)

Issue Date:	**February 2020**
Review Date:	**February 2022**
Owner:	**Policy and Quality Assurance** **Business Delivery Unit** **Invicta House** **Maidstone** **Kent ME14 1XX**
Version:	**V10**

Summary of Changes V10
Change of client record system from AIS/SWIFT to Mosaic and resulting related changes throughout protocol document to system process requirements
Sections 21, 23, and 26 KEaH to complete Care and Support Planning

Contents

References within the Document:

1. Adult Case Recording with Care Practice Guidance*
2. ASCH Care and Support Planning Policy and Practice Guidance*.
3. Carers Policy and Practice Guidance *
4. National Eligibility Criteria
5. Eligibility Determination form
6. Eligibility Decision form
7. Care and Support Statutory Guidance Issued under the Care Act 2014
8. Charging Booklet
9. Charging Policy for Home Care and Other Non-Residential Services
10. Domiciliary Charge Advice Letter (KEaH)
11. KEaH Client Letter no ongoing needs
12. GP Letter –Health needs no Social Care Need*
13. CHC eligible- Letter re transfer of responsibility

* **found on Knet Policy and Templates pages**

1. Introduction

Enablement is a service for adults provided through Adult Social Care and Health (ASCH) delivered primarily in-house known as Kent Enablement at Home (KEaH) but can be delivered by the private and voluntary sector. It forms part of the assessment process, is a preventative activity, non-chargeable and is not a 'time and task' service.

Enablement is a support service designed to be implemented quickly and flexible in nature. It is an intensive, short term, targeted intervention that assists people to regain, maintain or develop daily living skills and the confidence to carry these out to the best of their ability. Enablement supports people to maintain their independence and continue living in their communities promoting wellbeing and improving quality of life.

Enablement takes place in a person's home over a time limited period usually of up to 3 weeks but can be a maximum of 6 weeks according to individual need.

The Enablement provider and individual will agree a programme of support setting out the individual's goals and the pathway to achieving them.

Enablement does not provide therapy or medical intervention.

2. Definitions

ASCH	Adult Social Care Health
Care Act	The Care Act 2014
ESW	Enablement Support Worker
KCC	Kent County Council
KEaH	Kent Enablement at Home
Mosaic	Client Record System
National Eligibility Criteria	See Appendix 1
OP/PD	Older People/Physical Disabilities
SPOT	Senior Practitioner Occupational Therapist

3. Enabling

3.1 The Enabling approach promotes independence by giving adults the opportunity and confidence to learn and regain some of the skills they may have lost due to poor health, disability or after a stay in hospital. Support or activities that promote independence and can form part of enabling include:

- rehabilitative programmes of care
- information and advice
- community equipment,
- minor adaptations,
- major adaptations
- support for carers
- Technology Enabled Care Service (TECS) (e.g. telecare, GPS devices) and telehealth

3.2 Other enabling support:

(i) **Intermediate Care**

Intermediate care is the provision of integrated services (e.g. nursing, physiotherapy or occupational therapy) that promotes faster recovery from illness, prevents unnecessary acute hospital admission and premature admission to long-term residential care, supports timely discharge from hospital and maximises independent living. An individual may be provided with Enablement following a period of Intermediate Care.

(ii) **Crisis Resolution & Home Treatment Team**

The Crisis Resolution Home Treatment Team (CRHTT) is a 24-hour service that supports, through assessment and treatment at home, adults who are experiencing a severe mental health problem which could otherwise lead to an inpatient admission to a psychiatric hospital. They also support people being discharged from psychiatric hospital, enabling them to continue recovery at home. Where appropriate, practitioners should consider referring individuals to the Crisis Resolution & Home Treatment Team within KMPT. This does not rule out Enablement at a later date.

(iii) **Enablement Recovery Service (Mental Health)**

Kent Enablement Recovery Service (KERS) provides county wide Social Care recovery services to people experiencing Mental Health problems and who live in the Kent County Council area. It is for people with mental health problems at a point in their recovery journey where they are able to engage with the service. The aim of the service is to help people live as independently as possible by learning or relearning the skills necessary for daily living. The service is free and lasts for up to 12 calendar weeks and is open to those within primary and secondary care who have eligible social care needs.

(iv) **Rehabilitation Services (Visual Impairment)**

Kent Association for the Blind provides rehabilitation services for visually impaired and deafblind people, on behalf of ASCH. These services include skills training using non sighted and low vision methods in:

- daily living activities e.g. personal care and cooking
- communication e.g. Braille, use of IT technology
- mobility e.g. long cane techniques and route familiarisation

Rehabilitation programmes can be of varying lengths depending on the needs and outcomes agreed between the practitioner and the individual. Programmes are regularly monitored through case supervision

(v) **Kent Pathway Service**

Kent Pathway Service provides short term intensive support for individuals with a learning disability who wish to learn or develop a skill which will either reduce their dependence on others or avoid an increase in support such as:

- travel training
- budget planning
- daily living activities
- preparation for work

4. Enablement as part of Assessment, Review and Re-assessment

Enablement is part of the processes of assessment, review and re-assessment and helps inform decisions taken regarding a person's need for on-going care and support.

5. Duration of Enablement

5.1 Enablement is a programme of care and support, consisting of goals agreed with the individual, for a specified period of time.

5.2 Enablement is a time limited assessment service which is provided free for up to 6 weeks; the duration being determined according to individual need. The service aims to support individuals to reach agreed goals. Individuals are likely to achieve their agreed goals within 3 weeks although some may require the full 6 weeks free service.

5.3 Enablement should last no longer than 6 weeks. In exceptional circumstances, this may be extended with Operational Manager approval where there is evidence that the additional investment will enable the individual to achieve their goals relative to their assessed needs.

5.4 There is no minimum period of Enablement and, within the 6-week period, Enablement will end when the individual's goals have been achieved, irrespective of its duration.

5.5 Any unmet goals at the end of the period of enablement will be recorded.

5.6 An individual can have more than one period of Enablement where a review or re-assessment has identified potential for the person to be more independent. This must be approved by an Operational Manager.

6. Non-Chargeable Service

6.1 Enablement is a service provided free of charge in accordance with the provisions of the Care Act and its Regulations.

6.2 Costs of Enablement services must be excluded from an individual's personal budget.

7. Service referrals

7.1 Enablement should be the first consideration for **all new adult referrals**, irrespective of an individual's financial means.

7.2 **Individuals currently receiving ongoing services** will be considered for Enablement during review or re-assessment. Practitioners must base their decision to refer individuals for Enablement on the potential to reduce the level of support currently being provided, or to prevent an increase in the level of support. (please see 5.6 above)

8. Exclusions

8.1 There may be reasons why, when applying professional judgement, the assessment evidences that an alternative service response will be more effective. In these circumstances, the assessor must record the reason for this decision.

8.2 The following are reasons why it **may** not be valid to refer someone for Enablement:

- The individual only requires Universal Preventative Services - Information, Advice and/or equipment /minor adaptation,
- the individual requires a major adaptation and no other ongoing services,
- the individual requires end of life or palliative care,
- the individual requires specialist support from a physiotherapist, nurse, occupational therapist, community psychiatric nurse, speech and language therapist, etc. i.e. intermediate care,
- there are safeguarding concerns which prevent Enablement from being provided. This decision should be informed by the Adult Protection protocols and risk assessment,
- the individual requires specialist dementia care which makes Enablement inappropriate,
- the individual requires specialist assessment and support for needs resulting from deafness, sight impairment and deaf blindness and the expertise is not available via Enablement,
- where there is evidence, supported by a risk assessment, that the level of risk in an individual's home cannot be satisfactorily addressed to carry out Enablement safely,
- the individual is in receipt of services funded by NHS Continuing Health Care.
- The individual is non weight bearing and use of mobility aids and equipment is contra indicated.

8.3 There may be situations where someone who fits one of the above exclusions may yet benefit from Enablement. The professional judgement of the practitioner will therefore be key in determining whether an individual is referred for Enablement.

Practice Guidance

9. Individuals not currently in receipt of a service from ASCH

9.1 Enablement must be the first option to be considered by staff following completion of a Contact Assessment.

9.2 Decisions not to refer someone for Enablement must be based on evidence obtained during the assessment process, including received occupational therapist advice.

9.3 Where the decision has been made that Enablement is not appropriate, this should be recorded on the client record system Mosaic as an Assessment Outcome citing one or more of the exclusion reasons**.**

9.4 At final review of their period of Enablement the individual will have their eligible needs determined by the Supervisor using the national eligibility criteria pursuant to the Care Act. The individual must be provided with a copy of the Eligibility Decision form.

10. Individuals currently in receipt of a service from ASCH

10.1 Enablement must be **considered** by all practitioners when carrying out reviews or re-assessments.

10.2 Any decision to refer an individual for Enablement must be based on evidence obtained during the review or re-assessment process and recorded on the client system Mosaic, as a review or re- assessment outcome.

10.3 Where an individual is about to start a period of Enablement, the practitioner should, where appropriate, review and suspend or alter the Personal Budget for the initial and any subsequent weeks the person will be receiving Enablement.

10.4 Where the individual continues to receive an existing package of support and Enablement runs alongside, charges for the existing support package will continue unchanged where this service remains unchanged, and there will be no changes to the person's financial contribution.

10.5 Day care activities or meals may continue as long as they do not conflict with the goals the individual is pursuing. Any decision to provide other services alongside Enablement will depend on the particular circumstances of the case and must be agreed by the Team Manager.

10.6 Following Enablement, if there are changes in the individual's needs a proportionate re-assessment should take place and a re-application of the eligibility criteria as well as a financial re-assessment may be required.

11. Enablement and Carers

11.1 When referring an individual for Enablement, practitioners must consider the wellbeing and needs of any carers (relatives, friends) who may be providing support to the individual. (Where an adult provides the care under contract or as part of voluntary work they should not normally be regarded as a carer.)

11.2 Where it appears that the carer may have any level of needs for support, referral for an assessment of their needs must be made to the appropriate agency; unless the carer chooses to refuse to have an assessment. Practitioners who are uncertain about their obligations toward identified carers must refer to Carers Policy and Practice Guidance (see link page 2)

11.3 Practitioners with the agreement of the individual must involve carers in the discussion about Enablement, explain the goals and outcomes that are being sought for the individual and seek their support in helping to achieve them.

11.4 On request carers must be given a copy of the review paperwork, subject to the individual's agreement, when the individual has completed their period of Enablement. This is to share information about what the individual has been able to achieve and do for themselves no longer requiring the carer to do for them.

11.5 Any care a Carer is willing and able to do will be recorded and taken into account following an eligibility determination of any identified ongoing needs and during the care and support planning stage for any eligible needs the individual has.

12. Refusal to Participate

12.1 Whilst an individual can refuse Enablement at any point, the practitioner is responsible for explaining that Enablement is part of the assessment, review and re-assessment processes. They should highlight any risks to the individual's safety or independence that may follow if the service is not accepted or completed in line with the agreed goals. The

practitioner must ensure that the individual and/or carer understand the risks and that these have been explained to the individual in their preferred communication format.

12.2 If the individual still refuses Enablement the practitioner must consider other means by which their needs can be assessed e.g. Risk Assessment, Best Interest Assessment where someone lacks Mental Capacity. These assessments may be necessary to support the decisions of practitioners.

12.3 In situations where an individual has refused Enablement the details of the case must be clearly recorded in the person's case file on Mosaic and formally communicated to them in their preferred communication format. (Template provided on KNET and in due course on Mosaic)

13. Accessing Enablement (post decision to refer)

13.1 Practitioners must use the Appropriate Contact Assessment or Ready to Transfer Form within Mosaic to record the outcomes the individual wishes to achieve.

13.2 Practitioners will refer an individual to KEaH via Mosaic using the Appropriate Form and may include other supporting documentation. If the referral to KEaH is following a review they will complete the review on Mosaic and assign the next step to the appropriate KEaH Team.

13.3 On receipt of the referral and supporting documentation via MOSAIC a decision will be made as to whether the referral to KEaH is appropriate and if so whether KEaH has capacity to provide the required service. Where the referral is not appropriate for KEAH this will be discussed with the SPOT and the referrer and recorded (see Section15).

13.4 Where KEAH accepts the referral, this shall be recorded on Mosaic by KEaH staff and the referrer is notified via Mosaic. Case responsibility for individuals will be held within KEaH during the period of enablement.

13.5 The start date will be recorded on Mosaic. A Supervisor will be assigned via Mosaic. The service will commence based on the assessment and goals setting step within Mosaic.

13.6 The Supervisor will, as soon as practicable and within 72 hours of the commencement of the service, conduct an assessment of the individual in their own home, identifying any safeguarding issues, confirming the appropriateness of the service, setting goals with the individual and agreeing the programme of Enablement.

13.7 The weekly hours of care required, **as identified in the Assessment and Goal Setting**, will be recorded by KEaH on Mosaic under Initial Level of Need. The Supervisor will also identify and KEaH staff will record on Mosaic the Target Domiciliary Requirement (defined as the weekly hours of domiciliary care proposed at the end of Enablement).

13.8 The service will be delivered by an Enablement Support Worker (ESW) according to the agreed programme of Enablement. On each visit the ESW will record the nature of the contact and the individual's progress as against their agreed set goals.

13.9 The Supervisor will, at the first assessment visit, provide the individual with an information pack explaining the service, the complaint procedure and a copy of the agreed Programme of Enablement.

13.10 Where a Personal Assistant (PA) is employed to support the individual, the ESW will not provide any training or similar support to them as this is not a function of the ESW contract.
However, KEaH will work alongside a PA where it has been formally requested by the referrer, the PA has been trained to the appropriate level as mandated by KCC and it has been signed off by the KEaH OT/SPOT.

14. KEaH Lack of Service Capacity

Where KEaH is unable to provide the service for lack of capacity, the referral will be recorded on Mosaic as rejected, a rejection reason recorded within the Mosaic form of 'KEaH does not have any capacity' and sent to the PI Team or appropriate Hospital Team for redirection to Purchasing to arrange the required service via a commissioned agency. KEaH's involvement is then ended.

15. Rejecting a referral into KEaH as Inappropriate

15.1 All referrals deemed inappropriate for KEaH will be discussed with the LO and SPOT prior to rejection.

15.2 Where KEaH is unable to accept a referral into the service, a rejection and its reason must be recorded on Mosaic

15.3 Recordable reasons for rejecting a referral include:

- Needs can only be addressed by Occupational Therapy
- The person has been recently assessed by KEaH and is being referred with the same needs
- KEaH does not have any capacity
- KEaH does not have capacity to meet specific times as requested
- KEaH has offered part package and the user has declined
- Late stage Palliative
- Late stage Dementia
- Late stage Degenerative illness (not dementia)
- Continuing Health Care
- Mental Health
- Unsuitable; Day Care is required
- Unsuitable; Residential Care is required
- Unsuitable; Respite Care is required
- The person is independent and requires only non- personal care (e.g. weekly clean)

16. Resuming or repeating a Programme of Enablement

Where an individual receiving Enablement is taken to hospital, KEaH will liaise with hospital staff to determine if the person is to be admitted. If the person is returning home without being admitted the service will resume on return.

If an individual is admitted to hospital and there is no known discharge date, the enablement package will end and a new referral to the service will be made as appropriate. Where there is no open PISI involvement KEaH will close the case. If there is open PISI involvement KEaH will close only their involvement NFA (no further action)

17. Enablement and Kent Sensory Services (KSS)

17.1 Specialist workers from Sensory Services, Kent Association for the Blind or Hi Kent need to contribute, where appropriate, to the Programme of Enablement agreed by the individual and the Enablement Supervisor. An assessment by Sensory Services or KAB is needed before the Programme of Enablement can be completed.

17.2 A specialist from one or more of these agencies may lead in developing the Programme and/or continue to provide support throughout the period of Enablement.

17.3 If KSS identifies an individual for Enablement or an ongoing support package they must refer the case to the relevant PISI Team, with the consent of the individual. The primary need of the individual will dictate the primary worker in line with KSS protocols.

18. Review and Extension

18.1 The Supervisor will conduct a final review nearing the end of the period of Enablement, or sooner if requested by the ESW, to identify goals met and any ongoing care needs.

18.2 The outcome of each individual's final review, i.e. the weekly hours of domiciliary care proposed at the end of Enablement, even if it is zero hours, will be recorded by KEaH on Mosaic under Final Domiciliary Need.

18.3 Where the Final Domiciliary Need is different to the recorded Target Domiciliary Requirement the reason for the difference must be recorded on Mosaic by selecting from a dropdown list.

18.3 Where the individual has ongoing care needs and there is evidence that the additional investment will enable the individual to achieve their goals relative to their assessed needs, an extended period of enablement should be considered. In such cases approval by an Operational Manager must be sought.

19 Provision of Equipment only

19.1 Where the provision of equipment wholly meets the individual's identified need and the individual has no other ongoing care needs, the equipment is provided as a preventative measure aimed at reducing and delaying needs from developing. As such the equipment is provided without need to apply the national eligibility criteria and determine eligibility.

19.2 The provision of equipment shall be recorded on Mosaic by KEaH staff. This should be recorded in the final review and as a Case Note.

20 No Ongoing Care Need

20.1 Where on final review it is identified all set goals have been met by the individual and it has been determined they have no eligible needs for ongoing social care, the enablement service will end and the individual's case will be closed. The individual will be provided with a copy of the Eligibility Decision form and a letter explaining the case will be closed Case closure will be recorded on Mosaic by KEaH staff. (Letter template on Mosaic, Enablement: 'KEaH Client Letter no ongoing needs'). If the individual is an existing client with PISI, KEaH will close their involvement NFA (no further action)

Health Needs

20.2 Where on final review it is identified the individual has no eligible needs for ongoing social care but has a health need associated with administering of medication, TED stockings or other, the individual will be provided with a copy of the Eligibility Decision form and the individual's GP will be sent a letter notifying of this outcome. (Until such time as the template is available on Mosaic, See Knet templates, Enablement: GP Letter –Health needs no Social Care Need)

20.3 Where it becomes known that the individual has been assessed as eligible for Continuing HealthCare, responsibility for arranging and monitoring services for the individual must pass to the NHS. Kent County Council can only provide support while NHS arranges transfer of services, The KEaH Locality Organiser will write to the NHS advising of the KEaH service end date and requesting details of the new provider to expedite case handover. (letter template on Mosaic, Enablement: CHC eligible- Letter re transfer of responsibility)

21. Ongoing Care needs identified at Final Review

21.1 At the end of their period of Enablement**, individuals, known and current** to ASCH and with ongoing care needs that remain unchanged and that will not benefit from an extended period of Enablement, will have their cases forwarded via Mosaic by KEaH staff to the PISI team
Where there is a change of need following the period of enablement KEaH will reapply the Eligibility Criteria, amend the existing Care and Support Plan accordingly, forward via Mosaic to the Purchasing Team and notify the PISI Team

21.2 **Individuals new** to ASCH services, with ongoing care needs following a period of Enablement, whether or not these needs will be wholly met by a carer thus not requiring an ongoing package of care, will have their eligible needs determined by KEaH Supervisors, SPOT and Locality Organisers.

22. Determining Eligibility

22.1 KEaH Supervisors, SPOTs and Locality Organisers will determine the eligibility of a person's needs using the national eligibility criteria, once the final review has occurred and before any financial considerations.

22.2 Eligibility determinations shall be recorded in MOSAIC under the Care Needs Assessment. The person must be provided with a copy of the completed Eligibility Decision form.

22.3 The completed Eligibility Determination form, the signed Eligibility Decision form and the final review will be completed on Mosaic by KEaH staff.

23. Individuals with Eligible Needs

Above threshold

23.1 Where a person has eligible needs, the person will be asked whether they have resources above the financial limits and, if so, KEaH will provide information and advice for the person to find and arrange their own care and support provision. The KEaH supervisor will also provide the individual with the Domiciliary Charge Advice Letter (KEaH only) and a copy of the letter is signed electronically by the individual and held on Mosaic. If the client requests a Care and Support plan at this stage, this will be provided by KEaH. After confirming with the person that they have found their own provision, KEaH involvement ends. Should the person be unable to arrange their own care provision within 5 working days of the completion of their period of enablement, KEaH becomes a chargeable service and the final review form will be forwarded via Mosaic to the Purchasing Team who will make efforts to arrange the care and support provision. In such cases the person may be charged an arrangement fee. (See Arrangement Fee below).

23.2 In the case of a person with eligible needs and resources above the financial limits who has **asked KCC to arrange** their care and support on their behalf, KEaH will complete a Care and Support plan for the person and refer to the Purchasing team to secure the required package of care and support with a provider agency. The person may be charged an arrangement fee for this. (See Arrangement Fee below).
Upon receipt of confirmation from Purchasing of the agreed provision and start date, KEaH involvement ends as of the start date. KEaH is responsible for closing their involvement on and for managing the client e-file pursuant to Adult Case Recording with Care Practice Guidance.

Below threshold

23.3 Where a person has eligible needs that are not being fully met informally and where, upon being asked, the person indicates they do not have resources above the financial limits, KEaH will complete a Care and Support plan and forward via Mosaic to the SPOT for sign off by Registered Practitioner who will forward via Mosaic to the Purchasing Team to secure the required package of care and support with a commissioned agency. Upon receipt of notification via Mosaic from Purchasing of the agreed provision and start date, KEaH involvement ends as of the start date. KEaH is responsible for closing their involvement on Mosaic.

23.4 It is the responsibility of the KEaH Supervisor to provide the individual with a copy of the charging booklet (the ‘blue book’): ‘Charging for care in your own home and support in the community’ together with the Domiciliary Charge Advice Letter (KEaH only). The individual should be asked to sign an electronic copy of the letter and the signed letter is attached to the Mosaic form and forwarded via Mosaic to the Purchasing Team.

Arrangement Fee

23.5 A person with eligible needs and resources above the financial limits who access their care through KCC either because they have asked to have their care arranged or because they have been unable to arrange their own care provision within 5 working days following completion of their period of enablement, may be subject to an annual arrangement fee.
The KEaH Supervisor must inform the person that if they access their care through KCC they may be charged an arrangement fee.

(The Arrangement Fee is an annual flat fee in order to pay for the administration associated with accessing care through KCC. This will be paid in weekly instalments and added to the invoice for the care and support. The annual fee includes the cost of raising an invoice, paying a provider invoice and negotiating and arranging a care package. A person who lacks the capacity to arrange their own care and who has no-one authorised to do so on their behalf will not be charged an arrangement fee. *Refer to* Charging Policy for Home Care and Other Non-Residential Services)

24. Financial Assessment

24.1 A person, who has been in receipt of Enablement from KEaH, has ongoing eligible needs as determined at final review and so appropriate for moving to a chargeable service, is subject to a financial assessment and to paying a contribution to the cost of their care from the date the chargeable service starts.

24.2 Where there is any doubt or dispute, a person with eligible needs is entitled to request a financial assessment to determine whether they have resources above the financial limits.

24.3 Referral for financial assessment shall be made by the Purchasing Team.

25. KEaH as a Chargeable Service

25.1 A person, including those self- funding, who continues to receive a home care service from KEaH following the end of their period of Enablement because there is no alternative ongoing service available is subject to the Charging Policy for Home Care and Other Non-Residential Services as they would be if they moved to another provider.

25.2 The unit costs (service cost) will be calculated using the blended average cost contained within the cost setting guidance.

25.3 Charging will commence 5 working days from the date the person is assessed as completing their Enablement provision (final review) and forwarded to Purchasing via Mosaic. (refer to link Charging Policy For Home Care and other Non-Residential Services)

25.4 On the start of the chargeable service, Case responsibility remains with KEaH.
Upon being notified via Mosaic by the Purchasing Team of the commencement of the new ongoing service, KEaH completes a NFA (no further action) case closure and

assigns the individual to the PISI Team. It is for Purchasing to add a final assessment and first review of the Care and Support plan and forward to PISI.

26. Care and Support Planning

At the end of their period of Enablement, where an individual is assessed to have ongoing needs for care and support and these needs have been determined to be eligible and are unmet, KEaH will undertake Care and Support planning pursuant to S.23 of these operational protocols and in accordance with the ASCH Care and Support Planning Policy and Practice Guidance.

Where an individual has ongoing eligible needs for care and support which are being fully met by equipment and/or informal carers KEaH may upon request from the individual complete a Care and Support plan for the individual.

Appendix 1 National Eligibility Criteria Summary

(refer for further guidance to The Care Act and Statutory Guidance)

Adult's needs are **only eligible** if they **meet all 3** conditions, namely:

1. Their needs are due to a **physical or mental impairment or illness**
2. The effect of these needs means that they **are unable to achieve 2 or more specified outcomes** (see below)
3. as a consequence of being unable to achieve **2** or more outcomes, **there is, or is likely to be, a significant impact on their wellbeing**

Terms Defined in the regulation

1. **Physical or mental impairment or illness:**
    - Includes physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury.

2. **Unable to achieve**:
    - the person is **unable** to achieve the outcome **without assistance**; or
    - the person is **able** to achieve the outcome **without assistance but** doing so:
        - causes them significant pain, distress or anxiety;
        - endangers or is likely to endanger health or safety;
        - takes significantly longer than would normally be expected.

3. **Specified Outcomes**:
    1. Managing and maintaining nutrition
    2. Maintaining personal hygiene
    3. Managing toilet needs
    4. Being appropriately clothed
    5. Being able to make use of the adult's home safely
    6. Maintaining a habitable home environment
    7. Developing and maintaining family or other personal relationships
    8. Accessing and engaging in work, training, education or volunteering
    9. Making use of necessary facilities or services in the local community including public transport and recreational facilities or services
    10. Carrying out any caring responsibilities the adult has for a child

4. **Significant Impact**

The term is undefined in the legislation and has its ordinary meaning