Australasian Rehabilitation Outcomes Centre

AROC Tips for using the FIM in a Community Setting

This resource is designed to be used by clinicians performing FIM assessments in a community setting.

The FIM is primarily used in an inpatient clinical setting however, it is also a valid tool to use in a community setting. Within the community, direct observation of FIM items can be difficult and therefore the FIM assessor will need to communicate with clients, carers, and/or family members to complete the assessment. However, there needs to be a degree of skill on the part of the assessor when interviewing to sift out the facts of what the client can actually do.

General principles for using FIM in the community

- Timeframes for admission and discharge data collection are generally not relevant when community clinicians are scoring FIM. Frequently, community clinicians are using FIM to capture a 'snapshot' of function – and this may be repeated on a periodic basis (e.g. annually, as dictated by funding bodies).
- Many community clinicians are required/funded to complete the FIM within a one-hour assessment session. It is unlikely that the assessor would be able to observe all of the FIM items within one hour. Therefore, gathering information from a reliable historian (or range of sources) may give further information to support scoring of the FIM.
- Often these assessments are utilised by funding bodies to determine the number of hours required for attendant care assistance. In the community, more significant activity limitation often equates to a greater level of assistance & therefore increased funds to support care requirements.
- It is likely that much of the information required to score FIM in a community setting, will be reliant on an interview, rather than direct observation of a client's completion of their daily activities.
- FIM can be administered by a phone call. AROC would recommend that assessors combine a phone call with a period of observation/conversation to maximise accuracy of FIM scores.
- Information must be gathered about performance throughout the day, evening and overnight as a client's performance may fluctuate over a 24 hour period.
- Clinicians should use the "lowest score" rule to determine the need for assistance throughout the week, as a client may be having a 'good' day when they are being assessed, however their performance may fluctuate during the week. It is necessary to capture this within community assessments particularly for those that inform funding levels.
- For some FIM items it may be necessary to include narrative documentation to explain aspects of the recorded score. For example:
  - When scoring an item as 6 – community clinicians are encouraged to note whether the modified independence score has been selected due to extra time, use of an assistive device or concerns about the client's safety.
  - When scoring an item as 1 – community clinicians are encouraged to note whether this score has been selected due to presence of two helpers; the activity not being completed; or the client being at risk of injury if tested.

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General tips for obtaining the history/current performance level

- In an inpatient setting, FIM is designed to be scored by a team across a variety of environments and disciplines – in a community setting, the 'team' may include informal and formal carers as well as clinicians and community support people (for example staff at a day centre).
- Remember to enquire about the amount of assistance provided by a helper across all environments.
  (For example: home, supported day program, work, leisure activity group).
- Consider who might be the best historian to provide the most accurate information – this may be a combination of the patient, informal carers and paid carers.
- Some FIM items will be observable during a short assessment such as locomotion around the environment; transfers – bed/chair/wheelchair.
- Community clinicians will be able to observe some FIM items during conversation (for example: expression; comprehension; other cognitive items).
- Gather information through informal conversation and curious exploration with the patient/carers instead of working through a formal set of questions.
- Sometimes it is easier to gather information about a client's cognitive performance in the community as you can 'set up' a scenario (for example over the phone when arranging an appointment you can ask a patient to have their medication ready when you arrive, ask them to give directions to their home, etc.). This may assist the assessor to differentiate between a client's capacity for basic and complex/abstract cognition (memory & problem solving).
- Use open-ended questions to investigate a client's ability to complete their daily activities – this allows you to get information that is more expansive (for example, rather than asking *"When he gets out of bed, what does he do?", "How does he manage to put his T-shirt on?"* ask "S*o when he wakes up in the morning, tell me everything he does until after breakfast"*). You may then need to go back and ask more specific questions to clarify the details of functional performance.
- Remember that some patients, upon questioning, may be likely to inflate their capacity; this can be related to their lack of insight or some people are embarrassed to ask for assistance. This is where it can be useful to compare the client's perspective with the report from another historian.

FIM Items	Tips for Community Clinicians Assessing Specific FIM Items
Eating	▪ Remember meal preparation is not included in the FIM however it is included in the FAM if community clinicians want to follow this up in another way. ▪ Opportunity to observe the patient drinking a hot or cold drink might occur during a home-based assessment. ▪ Observe/ask the patient to show you any adaptive equipment they might use when eating/where they eat. ▪ Community clinicians may have opportunity to observe a patient opening food containers (for example: taking the lid off milk, opening the butter container) during an assessment.
Grooming	▪ Community clinicians may not be able to observe grooming tasks during a short home-based assessment; patients may be asked to demonstrate a specific grooming task/s.

	▪ Remember a patient may be able to comb their hair if you request them to demonstrate, but in usual daily life they may not comb their hair spontaneously due to a range of issues (for example: memory or mood).
Bathing	▪ It is unlikely that community clinicians will observe bathing during a community assessment – refer to general principles regarding gathering information (above). ▪ Community clinicians may ask a patient: *"Tell me about how you usually shower and dry yourself?"* They may then gather further information through asking more specific questions.
Dressing: **Upper Body &** **Lower Body**	▪ Clinicians may be able to observe aspects of this item if you make a specific request however you will need to gather collateral information about usual daily practice. ▪ Remember to ask about orthoses/prostheses that the patient might use and incorporate this into your scoring. ▪ Remember to gather information about how a client chooses, and obtains their own clothes from their usual storage places.
Toileting	▪ It can be difficult to gather information about toileting during conversation as clients might find it embarrassing/confronting to discuss their ability to manage the three aspects of toileting (particularly perineal hygiene). ▪ Use a sensitive approach when gathering this information. ▪ Remember to sensitively explore any differences between assistance required following voiding or bowel movements; also assistance required when cleaning an ostomy device if applicable.
Bladder/Bowel Management	▪ It can be difficult to gather information about Bladder/Bowel management during conversation as clients might find it embarrassing/confronting to discuss their ability to manage bladder & bowel requirements. Use a sensitive approach when gathering this information. ▪ If clinicians are unsure of the purpose of medications used/prescribed they can check this with a local pharmacist (e.g. Frusemide – commonly thought to be used to support bladder management is actually a diuretic). ▪ When scoring Bowel management include medication prescribed by a medical practitioner, and medication recommended by a clinician (such as a district nurse or pharmacist) that has an immediate physiological response if it is ceased. ▪ Types of equipment can vary in the community, for example a client might use a bucket or a juice bottle rather than a urinal for bladder management. This is still considered equipment and should be captured in FIM scoring. Do not forget to explore the use of continence products such as pads during the assessment. ▪ Community clinicians may need to gather collateral information about frequency of accidents. Reinforce the definition of accidents – wetting or soiling linen, clothing or bedclothes, as appropriate. ▪ Gather information about any accidents that have occurred within the past three days prior to the assessment. These should be included when assigning a score for Bladder or Bowel Management Part 2.
Transfers	▪ Community clinicians may be able to observe some of these during an assessment session. ▪ Some of the equipment might be multi-purpose (for example a mobile commode may also be used as a stationary over-toilet frame or bedside commode). ▪ Community clinicians should enquire about the 'usual' armchairs that clients use as there may be a few of these located in different rooms, and different degrees of assistance may be required for each.

	▪ Explore the client's use of ceiling track hoists within the context of their specific daily routines. In the community, sometimes the use of a hoist may score higher than a '1'. Often there may be only one helper involved, and the client may also contribute some of the effort towards completion of the transfer. Community clinicians should assign a score based on the amount of help that is provided. Other clients may manage the entire task independently (therefore the score would be 6). ▪ Toilet transfer: remember this is scored in relation to a "standard" toilet and therefore any assistive devices must be accounted for in the score.
Locomotion	▪ Community clinicians may have opportunity to observe some aspects of locomotion during a standard home-based assessment. ▪ It can be challenging sometimes to determine the usual distance travelled by a client. Clinicians should ask clients and helpers about the most frequent destinations. ▪ It is important to capture the most frequent mode of locomotion. For example: Barry is able to self-propel a manual wheel chair 20 metres without a helper. He is predominantly housebound. To access the community a helper pushes his chair. Barry's FIM score is 5 – Household Ambulation, his usual locomotion is 20 metres independently. ▪ If different levels of assistance are required for indoor locomotion vs. community-based locomotion, this may need to be captured in the narrative notes that accompany a FIM assessment.
Comprehension / Expression	▪ These items can usually be observed during conversation. Clinicians need to gather a collateral history to determine the level of prompting received over an entire 24 hour period, not just during the assessment session. ▪ Interpreters may be required for the assessment, but this does not contribute to the item score. ▪ Community clinicians should observe the types and amounts of prompts that the client's informal or formal carers provide during the assessment period.
Social Interaction	▪ Community clinicians should gather information from a range of sources – as the client may be on their 'best behaviour' while an assessment is being undertaken. ▪ Example: Some clients with TBI find others in the house difficult to cope with (eg. children, dogs, additional noise, visitors to the house).
Problem Solving	▪ Community clinicians might ask a question such as: *"What would you have done if I hadn't turned up on time today?"*; *"What would you have done if your partner was sick and couldn't bring you to the appointment today?"* ▪ Clinicians should ask informal or formal carers about problems that the client might encounter during a usual week which may require support/assistance to solve. ▪ Ask: *"Is the client able to manage their own finances?"; "Can the client look after their own medication independently?"*
Memory	▪ Community clinicians might explore whether the client remembers that you phoned and arranged the appointment, or whether the client remembered the appointment. ▪ Community clinicians may set a task in advance of the appointment, for example: *"Can you please have your medication out and ready when I arrive?"* ▪ Observation can provide some further clues regarding memory. For example, some clients may not think they have a memory problem however, community clinicians may observe disorganisation in the house, this might be because the client can't find things and therefore 'turns the house upside down' looking for items.