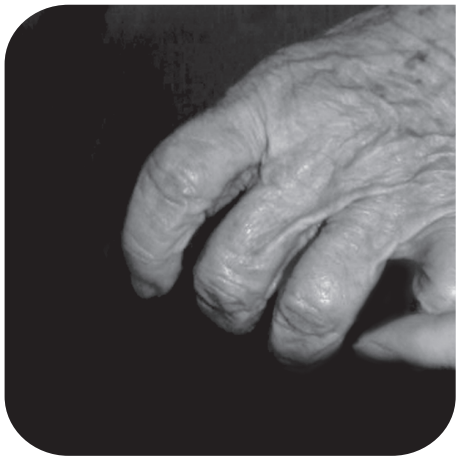
Australian Government
Department of Health and Ageing

Aged Care Funding Instrument (ACFI)

Assessment Pack



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ACFI 7–9	Behaviour record(s)	These are the required ACFI assessments if claiming above a rating A in these questions.
ACFI 10	Cornell Scale for Depression	This is the required ACFI assessment if claiming above a rating A in this question.

Assessors must be competent and experienced to achieve accurate outcomes with the assessment tools. Guidelines are provided for published tools.

Photocopy the assessments from this pack as required when completing the ACFI appraisal. Include the completed copy in the ACFI Appraisal Pack.

Publication Date: 2 July 2007

Part 1: Guidelines for assessments

ACFI 5 Continence

The required ACFI assessment is the Continence Record.

A urine assessment (i.e. the 3 day urinary record section of the Continence Record) is not required if the resident is continent of urine (including persons with a urinary catheter) or self–manages continence devices. A bowel assessment (i.e. the 7 day bowel record section of the Continence Record) is not required if the resident is continent of faeces (including persons with an ostomy) or self-manages continence devices.

Continence Record

Note: The appropriate section of the Continence Record from the ACFI Assessment Pack must be completed when claiming above a rating A in this question.

Note: In counting frequency of incontinence the following are included:

- episodes of incontinence
- changing of wet or soiled pads
- increase in pad wetness
- passing urine/ bowels open during scheduled toileting (as this is an avoided incontinence episode).

Complete the urinary record for three consecutive days and bowel record for seven consecutive days (if exceptional circumstances prevent a continuous record, additional days may be permitted–refer following note). Use the codes provided and complete the record. Codes 1 to 4 relate to episodes of urinary incontinence. Codes 5 to 7 relate to episodes of bowel incontinence.

Code 1:	Incontinent of bladder
Code 2:	Pad change for incontinence of bladder
Code 3:	Pad has increased wetness
Code 4:	Passed urine during scheduled toileting
Code 5:	Incontinent of faeces
Code 6:	Pad change for incontinence of faeces
Code 7:	Bowel open during scheduled toileting.

The required assessment (if claiming above a rating A) is the Continence Record. The Continence Record includes a '3 day Urinary Record' and a '7 day Bowel Record'. Continence logs or diaries that were completed within the six months prior to the appraisal may be used to complete the ACFI Continence Record if the log or diary accurately informs on the Continence Record and it continues to reflect the resident's continence status at the time of the appraisal.

If claiming for scheduled toileting* (as documented by a code 4 or code 7), you must provide documentary evidence of incontinence prior to implementing scheduled toileting e.g. ACCR or flowchart completed prior to scheduled toileting being implemented.

*Scheduled toileting for the purposes of ACFI 5 (Continence) is:
staff accompanying a resident to the toilet (or commode) or providing a urinal or bedpan or other materials for planned voiding/ evacuation according to a daily schedule designed to reduce incontinence.

ACFI appraiser identification details

Although the data to complete the Continence Record may have been collected by a number of different care staff, only one appraiser should complete the ACFI Appraiser Identification Details Box. The box must be completed and the person doing so is signifying that he/ she is responsible for the validity and accuracy of the record.

Note
If the resident is unavailable for 24 hours (e.g. illness or outing) when completing the record over consecutive days, an extra 24 hours can be added at the end of the recording period and the reason for the absence or unavailability on the missed day is to be noted on the record.

If you need to add an additional 24 hours to the record, photocopy a blank Continence Record, complete it for the additional day and include this in the ACFI Appraisal Pack.

ACFI 6 Cognitive Skills

The required assessment is the Psychogeriatric Assessment Scales–Cognitive Impairment Scale (PAS).

Follow general instructions for completing an assessment. Please ensure the setting is appropriate and engage in a conversation with the resident to set up a relationship. In some instances the interviewer will not have met the resident before, so it will be the responsibility of the interviewer to make the resident feel at ease and comfortable during the interview. The cognitive assessment interviews are carried out in a face-to-face interview with the resident. Establish that the resident has an adequate comprehension of English before beginning the interview. The assessments are suitable for people who have English as their main language or are fluent in English as a second language. It may not be suitable for some Aboriginal or Torres Strait Islander residents, depending on their background.

Ask permission to proceed–‘May I ask you a few questions on your concentration and memory?’

The Psychogeriatric Assessment Scales (PAS)–Cognitive Impairment Scale

The full guidelines can be downloaded at www.mhri.edu.au/ pas.

The PAS provides the interviewer with an interview 'script' to follow, however the assessor may not be able to keep exactly to the script and further explanations can be provided. Where a resident has repeated difficulties understanding the instructions for a question please skip that question and return later. If necessary stop the assessment if the resident cannot understand the instructions to a number of questions. This resident will need to be rated on the checklist only. (See the checklist in the ACFI User Guide.)

If the resident cannot do the writing task because of a physical disability, then a '?' (question mark) is scored. If the resident refuses to do a task, this is counted as an incorrect response and 1 is scored. If the resident is concerned about whether their answer is correct the interviewer should not indicate any validation. Acknowledge in neutral phrases e.g. ok, thank you, now let's try this.

ACFI appraiser identification details

The person completing the PAS assessment should complete the ACFI Appraiser Identification Details Box. The box must be completed and the person doing so is signifying that he/ she is responsible for the accuracy of the record.

How to calculate PAS cognitive impairment score

Add questions 1 to 9		basic total	
Number of boxes with '?'s		?*	
*If ? = 0, then basic total is the total score			
*If ? is not = 0 proceed to next step			
Score should be pro-rated using this formula	$\frac{21 \times \text{basic total}}{(21 - ?)}$		

ACFI 7 Wandering
ACFI 8 Verbal Behaviour
ACFI 9 Physical Behaviour

To support a B, C or D rating in ACFI 7, ACFI 8 or ACFI 9, the relevant behaviour record must be completed.

If a behaviour record has been completed for the resident in the last six months, you may use that assessment if it continues to reflect the behavioural needs of the resident at the time of appraisal. The behaviour must impact on current care needs and require attention from a staff member.

The ACFI appraiser will be responsible for:

a. ensuring that the behaviour record has been initialled by the staff member who has observed the behaviour occurrence

b. the availability of a signature log for the period the behaviour record was completed.

Behaviour record

There are three behaviour records provided, one for each behaviour type (wandering, verbal behaviour and physical behaviour). Each behaviour type has specific behaviours.

These are named and described in the 'Descriptions of behavioural symptoms'. Only these specific behaviours may be included.

Record the code of the specific behaviour when it occurs, for seven (7) consecutive days.

Dashes or blank spaces indicate that the behaviour(s) did not occur in that hour/ time.

Note
If the resident is unavailable for 24 hours (e.g. illness or outing) when completing a record over consecutive days, an extra 24 hours can be added at the end of the recording period and the reason for the absence or unavailability on the missed day is to be noted on the record.

ACFI appraiser identification details

Although the data to complete the behaviour records may have been collected by a number of different care staff, only one appraiser should complete the ACFI Appraiser Identification Details Box for each of the behaviour questions. The box must be completed and the person doing so is signifying that he/ she is responsible for the accuracy of the record.

If you need to add an additional 24 hours to the record, photocopy a blank behaviour record, complete it for the additional day and include this in the ACFI Appraisal Pack.

Description of behavioural symptoms

All behavioural symptoms must disrupt others to the extent of requiring staff assistance.

Code	Wandering	
W1	Interfering while wandering	Interfering and disturbing other people or interfering with others belongings while wandering
W2	Trying to get to inappropriate places	Out of building, off the property, sneaking out of the room, leaving inappropriately, trying to get into locked areas, trespassing within the unit, into offices, other resident's room
Code	**Verbal behaviour**	
V1	Verbal refusal of care	Refusal (verbally uncooperative) to participate in required activities of daily living such as dressing, washing and hygiene
V2	Verbal disruption to others	Verbal demanding that is not an unmet need. Making loud noises or screaming that is not an unmet need. Swearing, use of obscenity, profanity, verbal anger, verbal combativeness.
V3	Paranoid ideation that disturbs others	Excessive suspiciousness or verbal accusations or delusional thoughts that are expressed and lead to significant and regular disturbance of others.
V4	Verbally sexually inappropriate	Repeated sexual propositions, sexual innuendo or sexually abusive or threatening language
Code	**Physical behaviour**	
P1	Physically threatens or does harm to self or others or property	Biting self or others Grabbing onto people Striking others, pinching others, banging self or furniture Kicking, pushing, scratching Spitting–do not include salivating of which person has no control, or spitting into tissue or toilet Throwing things, destroying property Hurt self or others–burning, cutting, touching with harmful objects Making physical sexual advances–touching a person in an inappropriate sexual way, unwanted fondling or kissing or sexual intercourse Chronic substance abuse–current and persistent drug and/ or alcohol problem
P2	Socially inappropriate behaviour that impacts on other residents	Handling things inappropriately–picking up things that don't belong to them, rummaging through others drawers, faecal smearing; Hiding or hoarding things–excessive collection of other persons objects Eating/ drinking inappropriate substances Inappropriate dress disrobing (outside of personal hygiene episodes), taking off clothes in public etc. Inappropriate sexual behaviour–rubbing genital area or masturbation in a public area that disturbs others
P3	Constantly physically agitated	Always moving around in seat, getting up and sitting down, inability to sit still Performing repetitious mannerisms–stereotypic movement e.g. patting, tapping, rocking self, fiddling with something, rubbing self or object, sucking fingers, taking off and on shoes, picking at self or clothing or objects, picking imaginary things out of the air/ floor, manipulation of nearby objects

ACFI 10 Depression

Modified Cornell Scale for Depression introduction

The Cornell Scale for Depression was designed to assess signs and symptoms of major depression in people with cognitive impairment, but can also be used to assess people for depression who do not have cognitive impairment. Phobias, obsessions and complex depressive ideation are not included because they require reliable self-report.

All symptoms are rated for severity in three grades:

0 = absent

1 = mild/ moderate

2 = severe

a = the interviewer is unable to evaluate the symptom.

The assessment includes information from semi structured interviews with:

1. an informant (e.g. staff carer)
2. the person of interest (resident).

The administration and scoring guidelines should be read and the assessor must be familiar with these before attempting the Cornell. The guidelines provide detailed information about how to ask each question and the meaning of the questions.

Information collection

The informant interview
The assessor should be asking informants to take note of any day-to-day behaviour such as anxiety, sadness, agitation or slowness of movement indicated by psychomotor symptoms. It is suggested that the primary carer or carers are interviewed first to obtain information about the resident's status. Staff should consult any charts or notes for background information (e.g. sleep disturbance, weight changes, diurnal variation in mood) if they do not have direct knowledge of the resident's behaviour in all Cornell areas.

The resident interview
Many Cornell items can be completed by direct observation of the resident during their daily routines. Ratings of some questions should be based mainly on direct observation i.e. anxiety, sadness, irritability, agitation, retardation. Questions on these items asked of the resident provide supporting information.

The final ratings should represent the assessor's clinical assessment but be congruent with the behaviour of the resident.

How to use the question prompts
The Cornell asks for observable behaviour–not "I think," but "What did you and your colleagues see or observe?" Ask staff to refer to the resident's file.

Each symptom begins with a question about the symptom occurring in the past week. If it occurred in the past week then ask the next prompt. If it DID NOT occur in the past week then score '0' and move on to the next symptom.

Scoring

Cornell Scale for Depression symptoms

A symptom should be recorded if it is occurring over the week prior to the completion of the ratings. It should be observable and noted by the majority of informants (care staff) on a day to day basis.

Step 1: Does the symptom occur?

a. It must have occurred in the **past week**

b. Some symptoms have questions that will exclude a rating due to dementia or other condition

c. Then if necessary, determine if it has a mild or severe effect.

Step 2. Defining mild and severe effects

Except where otherwise specified, the following two aspects are used to define mild and severe.

1. **Interference with everyday life:**
   - minor (requires regular encouragement to participate in activities of daily living and social/ interpersonal activities)
   - major (very limited or no participation in activities of daily living and social/ interpersonal activities).
2. **Frequency:**
   For the purposes of the ACFI depression assessment, the frequency of symptoms is defined as:
   - occasionally–intermittent (some days)
   - often–persistent (nearly every day).

   The combination of (1) interference with everyday life and (2) frequency provides the final rating of mild or severe for the symptom:

   Mild
   Minor interference with everyday life and symptoms occur occasionally; minor interference with everyday life and symptoms occur often; major interference with everyday life and symptoms occur occasionally.

   Severe
   Major interference with everyday life and symptoms occur often.

Completing the form

Score
Indicate only one of the following for each question:

'**a**' to indicate **unable to score**

'**0**' to indicate **absent**

'**1**' to indicate **mild/ moderate**

'**2**' to indicate **severe**

Who
Record how you received the information by completing as many of the following as is appropriate in the given boxes:

Staff to indicate you interviewed a staff carer

Other to indicate you interviewed some other informant

Interview to indicate you interviewed the resident

Observation to indicate you observed the resident.

ACFI appraiser identification details
Only one appraiser should complete the ACFI Appraiser Identification Details Box. The box must be completed and the person doing so is signifying that he/ she is responsible for the accuracy of the record.

Summary of signs and symptoms

Mood-related signs

1. **Anxiety**:
   Does the person have a chronically anxious expression or are they constantly ruminating or worrying?
2. **Ongoing Sadness**:
   Expressions, voice, tearfulness.
3. **Constant lack of reactivity, happiness to pleasant events**:
   Unable to enjoy an event that would normally give them pleasure.
4. **Constant irritability**:
   Easily annoyed, short tempered.

Behavioural disturbance

5. **Agitation**:
   Restlessness (unable to sit still for short periods–e.g. 30 minutes), constant hand wringing, hair pulling.
6. **Psychomotor**:
   Slowed movements, speech or reactions which are much slower than usual for the person.

7. **Multiple physical complaints**:
   In excess of what is usual e.g. hyperventilation, indigestion, heart palpitations, diarrhoea. Do not include symptoms which are side effects from medications or only related to gastrointestinal aliments.
8. **Acute loss of interest**:
   Much less involved in activities than usual and if this has significantly worsened in the past month or occurred recently (last week). It is important to determine when the first signs of loss of interest occurred and if these symptoms are becoming more marked over time.

Physical signs

9. **Appetite loss**:
   Eating much less than usual and showing less interest in eating.
10. **Weight loss**:
    Measurable in past month, not related to a current illness/ condition.
11. **Lack of energy**:
    Fatigues easily and cannot sustain any activity. This change has occurred in past month and continues in the week prior to the assessment.

Cyclic functions

12. **Diurnal variation in mood**:
    Mood symptoms much worse in morning.
13. **Difficulty falling asleep**:
    Cannot fall asleep, or falls asleep much later than usual.
14. **Multiple awakenings during usual sleep periods**:
    Do not rate if only going to toilet and then returns to sleep.
15. **Early morning awakenings**:
    Much earlier than usual, then not returning to sleep.

Ideational disturbance

16. **Suicidal**:
    Feels and indicates life is not worth living, regular suicidal wishes, makes suicide attempt.
17. **Self deprecation**:
    Constant self blame, feelings of failure, cannot be dissuaded.
18. **Pessimism**:
    Anticipation of the worst possible happening. Cannot be reassured or calmed
19. **Mood congruent delusions**:
    Delusions of poverty (e.g. thinks they have less money than actually do), illness (e.g. that present illness is a punishment) or loss (e.g. believe have no material possessions).

Part 2: Copies of assessment tools

ACFI 5 Continence–assessment

Continence Record

Resident name/ ID	Facility ID

ACFI appraiser identification details

Appraiser name	Appraiser profession
Signature	Date

Code	Description
1	incontinent of urine
2	pad change for incontinence of urine
3	pad has increased wetness
4	passed urine during scheduled toileting
5	incontinent of faeces
6	pad change for incontinence of faeces
7	bowel open during scheduled toileting

Hour starting @	Urinary Record Date		
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1500			
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1700			
1800			
1900			
2000			
2100			
2200			
2300			
# of episodes			

Hour starting @	Bowel Record Date						
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1600							
1700							
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2000							
2100							
2200							
2300							
# of episodes							

ACFI 6 Cognitive Skills–assessment

PAS–Cognitive Impairment Scale

Permission to use the Psychogeriatric Assessment Scales (PAS) Cognitive Impairment Scale was kindly provided by Professor Andrew Mackinnon and Professor Tony Jorm. More information can be found at www.mhri.edu.au/pas/.

Resident name/ ID	Facility ID

ACFI appraiser identification details

Appraiser name	Appraiser profession
Signature	Date

Psychogeriatric Assessment Scales (PAS) Cognitive Impairment Scale

I am going to name three objects. After I have said them I want you to repeat them. Remember what they are, because I am going to ask you to name them again in a few minutes.		
'apple' 'table' 'penny'		
Could you repeat the three items for me?		
Repeat objects until all three are learned. Stop after five unsuccessful attempts.		
Question 1: I am going to give you a piece of paper. Would you please write any complete sentence on that piece of paper?		**Mark score**
If sentence is illegible, ask "Could you read it for me?", and copy sentence onto sheet. NB. Sentence should have a subject and a verb and make sense. Spelling and grammatical errors are acceptable.		
Correct	0	☐
Incorrect or refusal	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 2: Now what were the three objects I asked you to remember?		**Mark score**
Score 0 for each object remembered, 1 if an error is made because object is not mentioned or subject refuses. Order of recall is not important.		
Apple	0	☐
Item not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Table	0	☐
Item not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	

Penny	0	
Item not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Please listen carefully to the following name and address, then repeat it: John Brown, 42 West Street, Kensington. Please go on remembering this name and address and I will ask you about it later.		
Question 3: I am now going to say the names of some people who were famous and I would like you to tell me who they were or why they were famous in the past.		**Mark score**
Score 0 for each person correctly identified, 1 if an answer is incorrect or subject refuses.		
Charlie Chaplin (actor, comedian, film star, comic)	0	
Incorrectly identified or refused	1	
Not asked (e.g. sensory or motor impairment)	?	
Joseph Stalin (soviet, Russian, WWII leader, communist leader)	0	
Incorrectly identified or refused	1	
Not asked (e.g. sensory or motor impairment)	?	
Captain Cook (explorer, sailor, navigator, discoverer)	0	
Incorrectly identified or refused	1	
Not asked (e.g. sensory or motor impairment)	?	
Winston Churchill (British/ English, prime minister, WWII leader	0	
Incorrectly identified or refused	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 4: New Year's day falls on what date?		**Mark score**
First of January/ first day of new year	0	
A wrong date, does not know, refusal	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 5: What is the name and address I asked you to remember a short time ago?		**Mark score**
Score 0 for each component remembered, 1 if a component is not mentioned or subject refuses. Order of recall is not important.		
John	0	
Component not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Brown	0	
Component not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	

42	0	
Component not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
West Street	0	
Component not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Kensington	0	
Component not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 6: Here is a drawing. Please make a copy of it here		**Mark score**
Hand subject the paper with two five-sided figures, point to the space underneath it.		
Correct	0	
Incorrect or refusal	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 7: Read aloud the words on this page and then do what it says.		**Mark score**
Hand the person the sheet with the words “Close your eyes”.		
Correct (subject closes eyes)	0	
Incorrect or refusal	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 8: Now, read aloud the words on this page and do what it says.		**Mark score**
Hand subject the sheet with the words “cough hard”.		
Correct (subject coughs)	0	
Incorrect or refusal	1	
Not asked (e.g. sensory or motor impairment)	?	
Question 9: Tell me what objects you see in this picture.		**Mark score**
Hand the four-object sheet to the person. Score 0 for each object remembered, 1 if an error is made because object is not mentioned or subject refuses. Order of recall is not important.		
Teapot, kettle	0	
Object not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Telephone	0	
Object not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	

Scissors	0	
Object not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
Fork	0	
Object not mentioned or subject refuses	1	
Not asked (e.g. sensory or motor impairment)	?	
That brings us to the end of the interview. Thank you very much for your time.		

How to calculate PAS Cognitive Impairment Score

Add questions 1 to 9 — basic total ☐

Number of boxes with '?'s — ?* ☐

*If ? = 0, then basic total is the total score

*If ? is not = 0 proceed to next step

Score should be pro-rated using this formula $\frac{21 \times \text{basic total}}{(21 - ?)}$ ☐

Total score	
	0–3 (including a decimal fraction below 4)
	4–9 (including a decimal fraction below 10)
	10–15 (including a decimal fraction below 16)
	16–21

Diagram 1

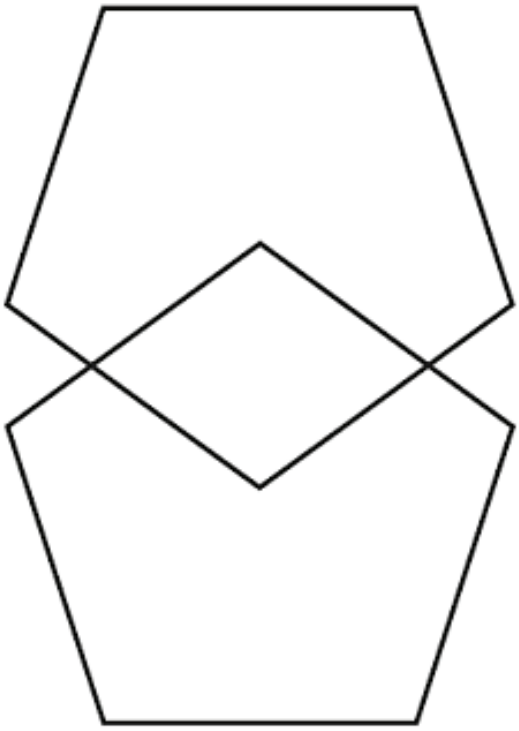
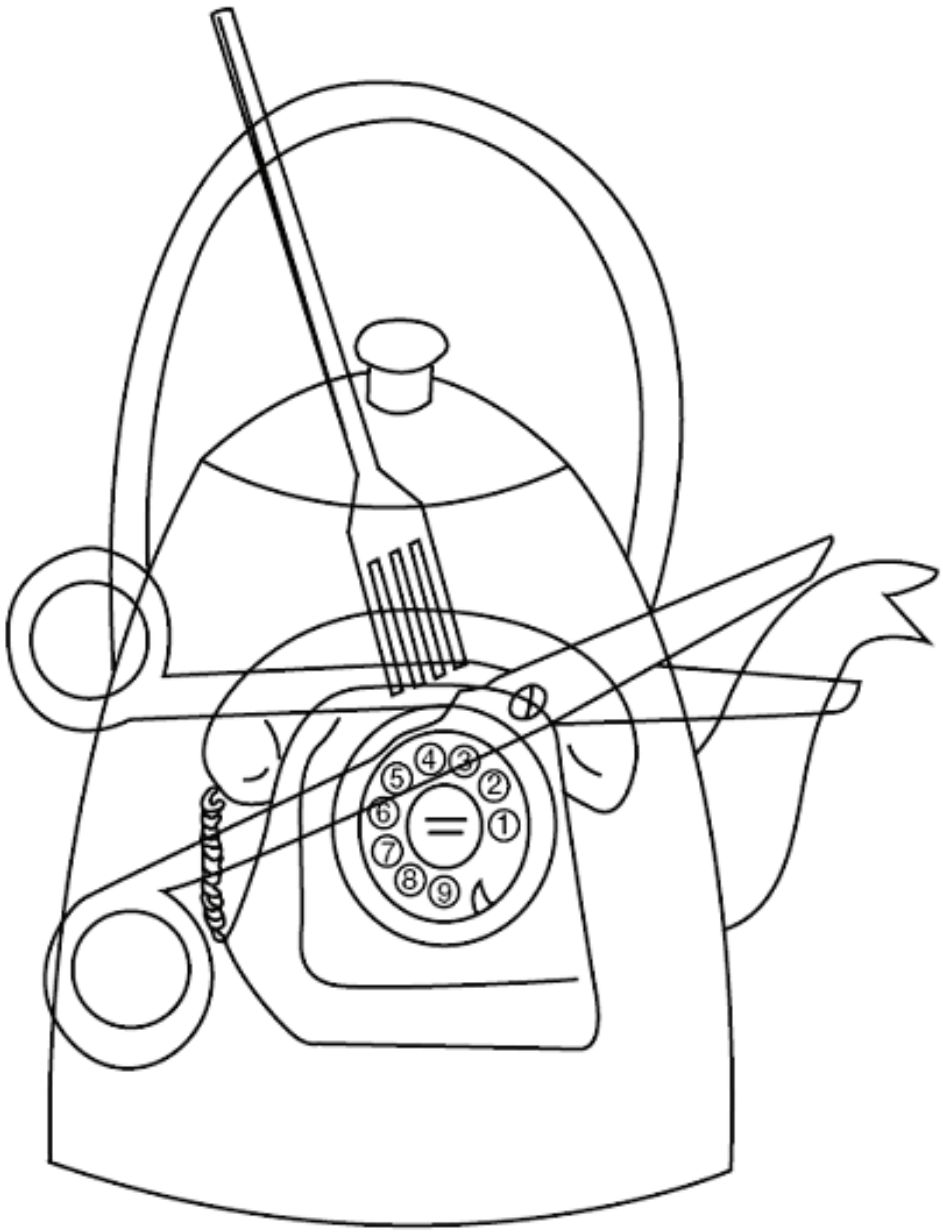


Diagram 2

Close your eyes

Cough hard

Diagram 3



Resident name/ ID	Facility ID

ACFI 7 Behaviour Record for Wandering

ACFI appraiser identification details

Appraiser name
Profession
Signature
Date

Record the behaviour code(s) of the behaviour(s) that occur every hour

W1 Interfering while wandering

W2 Trying to get to inappropriate places

Further description:

Date														
hour starting at	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
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Resident name/ ID	Facility ID

ACFI appraiser identification details

Appraiser name
Profession
Signature
Date

ACFI 8: Behaviour Record for Verbal Behaviour

Record the behaviour code(s) of the behaviour(s) that occur every hour

V1 Verbal refusal of care

V2 Verbal disruption to others

V3 Paranoid ideation that disturbs others

V4 Verbally sexually inappropriate advances

Further description:

Date														
hour starting at	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
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Total														

Resident name/ ID	Facility ID

ACFI appraiser identification details

Appraiser name
Profession
Signature
Date

ACFI 9: Behaviour Record for Physical Behaviour

Record the behaviour code(s) of the behaviour(s) that occur every hour

P1 Physically threatens

P2 Socially inappropriate

P3 Constantly physically agitated

Further description:

Date														
hour starting at	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
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Total														

ACFI 10 Depression

Resident name/ ID	Facility ID

ACFI appraiser identification details

Appraiser name	Appraiser profession
Signature	Date

Suggested introduction for 'interview with an informant'

"I'd like to ask you some questions about how X has been feeling during the last week. Please base your responses on what you've seen or heard yourself or what your colleagues have seen or heard. I am particularly interested in any changes you have noticed and the duration of those changes."

Suggested introduction for 'interview with a resident'

"I'd like to ask you some questions about how you have been feeling during the last week. You do not have to answer these questions and it will not affect your care if you refuse. You can ask me to stop at any time. Is it alright to ask the questions?"

Q's 1–4: mood-related signs	
1. Anxiety (anxious expression of emotional discomfort, worrying, frowning) Many people confuse anxiety and agitation. When we talk about anxiety, we are talking about mood, facial expressions and feelings. When we talk about agitation, we are referring to physical symptoms of restlessness. These signs may be related to worry, but there will be such things as pacing, hand-wringing and sighing when someone is agitated.	
Interviewing staff or other informant: • Has X/ she/ he been anxious in the last week? • Has X/ she/ he had an anxious, worried appearance? • Has X/ she/ he worried about things more than other people? Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Observe resident • Have you been feeling anxious in the last week? • Have you worried about things more than other people? Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

2. Sadness (in expression, voice, tearfulness)	
Interviewing staff or other informant: • Has X/ she/ he been sad or down in the last week? • Has X/ she/ he had a sad, unhappy appearance? • Has X/ she/ he cried? What was the cause? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Observe resident • Have you been sad or down in the last week? • Have you cried? What was the cause? • Does this happen occasionally or often? • For how long each time? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	
3. Lack of reactivity to pleasant events	
Interviewing staff or other informant: • If something pleasant were to happen today (like a visit from family or a trip out) would X/ she/ he be able to enjoy it, or would her anxiety or sadness get in the way? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • If something pleasant were to happen today (like a visit from family or a trip out) would you be able to enjoy it, or might your mood get in the way? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your life? (Does it affect your ability to enjoy activities that used to give you pleasure; does it affect your ability to enjoy pleasant surroundings; does it affect your ability to enjoy family or friends?)
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

4. Irritability, easily annoyed, short tempered	
Interviewing staff or other informant: • Has X/ she/ he been irritable–short-tempered, easily annoyed or unusually impatient–in the last week? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Observe resident during interview • Have you been feeling irritable, easily annoyed or short-tempered in the last week? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	
Q's 5–8: behavioural disturbance	
5. Agitation (physical restlessness, hand wringing, hair pulling)	
Interviewing staff or other informant: • Has X/ she/ he been so restless in the last week that they've been unable to sit still for even an hour? • Has she/ he done things like pacing up and down, wringing their hands or sighing? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Observe the resident • Have you been so restless in the last week that you have been unable to sit still for an hour? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

6. Retardation (slow movements, slow speech, slow reaction)	
Interviewing staff or other informant: • Has X/ she/ he spoken or moved very slowly in the last week? Exclude if due to a physical cause or medical diagnosis e.g. Parkinson's disease • Does she/ he seem to be thinking and reacting more slowly? • Is this more than usual as far as you know? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life	Interviewing the resident or observation: • Observe the resident–delayed response to questions, delayed motor reactions • Exclude if due to a physical cause or medical diagnosis e.g. Parkinson's Disease
Staff: Other:	☐ Interview ☐ Observation
Note: Do not rate symptoms that are related to a physical ailment e.g. Parkinson's Disease	
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

7. Multiple physical complaints (not gastrointestinal symptoms only)	
Interviewing staff or other informant: • Has X/ she/ he complained of physical symptoms in excess of what you would expect given her/ his physical health in the last week? • Exclude side effects from medication or gastrointestinal ailments (rate 0) • Has she/ he complained more than you or her/ his GP would expect? Things like pain, head/ back/ muscle aches, frequent urination, stomach cramps, palpitations, shortness of breath. • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • In the past week have you had more physical symptoms of (pain, head/ back/ muscle aches, frequent urination, stomach cramps, palpitations, shortness of breath) than is normal for you? • Have these things been bothering you? • Can you give me an example? • Does this happen occasionally or often? • How does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Guideline: Do not rate symptoms that are side effects from medications or those symptoms that are only related to gastrointestinal ailments.	
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

8. Loss of interest (in usual activities; acute change only in past month)

Interviewing staff or other informant:	Interviewing the resident or observation:
• Has X/ she/ he seemed less interested in her/ his usual activities or hobbies in the last week? • Has she/ he stopped doing things she used to do? • Can she/ he look forward to anything from which she/ he derives pleasure? • Can you give me an example? • How long has she/ he had this loss of interest? (rate 0 if longer than one month) • Has this been due to physical illness or disability? (rate 0 if yes) • Has this been due to persistent apathy associated with dementia? (rate 0 if yes) • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	• Have you seemed less interested in your usual activities or hobbies in the last week? • Have you stopped doing things you used to do? • Can you look forward to anything from which you derive pleasure? • Can you give me an example? • How long have you felt like this? • Has this been due to you feeling unwell? • Does this happen occasionally or often? • How much does it interfere with your everyday life? • Exclude if due to physical illness, disability or persistent apathy associated with dementia
Staff: Other:	☐ Interview ☐ Observation

Guideline: ratings are based on loss of interest in the past week. The item should be rated 0 if a) the loss of interest is long-standing; b) the person has not been engaged due to physical illness or disability; c) the person has persistent apathy associated with dementia.

Notes:

Score

unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

Q's 9–11: physical signs

9. Appetite loss (eating less than usual)

Interviewing staff or other informant:	Interviewing the resident or observation:
• How has X's appetite been over the last week compared to normal (i.e. not due to diet, changed medical condition or illness)? • Have you had to remind or encourage her/ him to eat? • Can you give me an example? • Have you had to encourage her/ him to eat nearly all the time? (rate 2 if yes)	• How has your appetite been over the last week compared to normal? • Has it decreased, have you felt less hungry? • Can you give me an example? • Have you had to remind yourself to eat or have others encouraged you to eat? (rate 1 if does not require encouragement) • If yes, does this happen occasionally or often?
Staff: Other:	☐ Interview ☐ Observation

Guideline: rate 1 if the person is still eating on their own in spite of decreased appetite. Rate 2 if they eat only with encouragement or urging from others.

Notes:

Score

unable to score = a absent = 0 still eating on their own in spite of decreased appetite = mild = 1 eats only with encouragement or urging from others = severe = 2	

10. Weight loss (acute change only)	
Interviewing staff or other informant: • Has X/ she/ he lost weight in the last month that she hadn't intended to?–ask staff to check any weight records (rate 0 if due to diet or exercise) • How much weight has she/ he lost? (rate 2 if > 2.5 kgs)	Interviewing the resident or observation: • Have you lost weight in the last month that you hadn't intended to–are your clothes looser on you? • How much have you lost?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 2 if weight loss is greater than 2.5 kilos in the past month.	
Notes: **Score**	
unable to score = a absent = 0 has lost weight in the last month = mild = 1 weight loss is greater than 2.5 kilos in the past month = severe = 2	

11. Lack of energy, fatigues easily (acute change only)	
Interviewing staff or other informant: • How has X's energy been over the last week? • If decreased, has it occurred for longer than one month? If yes, has it become worse in the last month? (score 0 if it has not become worse) • Has she/ he been tired all the time? • Has she/ he wanted to stay in bed or sleep during the day? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life	Interviewing the resident or observation: • Observe–does resident appear fatigued or drained of energy? • How has your energy been over the last week? • If decreased, has it occurred for longer than one month? If yes, has it become worse in the last month? • Have you been tired all the time? • Have you wanted to stay in bed or sleep during the day? • Can you give me an example? (heaviness in limbs/ back/ head; felt like you are dragging through the day) • Does this happen occasionally or often? • How much does it interfere with your everyday life
Staff: Other:	☐ Interview ☐ Observation
Guideline: rating should be based on the prior week. Rate 0 if the lack of energy is long-standing (more than a month) and it hasn't become worse in the ensuing weeks.	
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

Q's 12–15: cyclic functions	
12. Diurnal variation of mood (symptoms worse in morning)	
Interviewing staff or other informant: • Regarding her/ his mood in the last week, is there any part of the day when X feels better or worse? *(rate 0 if mood worse in afternoon/ evening)* • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?–mild or very noticeable worsening of mood	Interviewing the resident or observation: • Regarding your mood in the last week, is there any part of the day when you feel better or worse? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?–mild or very noticeable worsening of mood?
Staff: Other:	☐ Interview ☐ Observation
Guideline: this item is rated only if the mood is worse in the morning. Evening moodiness is assumed to be related to fatigue in people with dementia.	
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	
13. Difficulty falling asleep (later then usual)	
Interviewing staff or other informant: • Has X/ she/ he had difficulty falling asleep in the last week? (Difficulty is assumed to be more than 30 minutes) • Does it take her/ him longer than usual to fall asleep once she gets in bed? • Can you give me an example? • Does this happen every night? (score 2 if difficulty falling asleep every night)	Interviewing the resident or observation: • Have you had difficulty falling asleep in the last week? • Does it take you longer than usual to fall asleep once you get into bed? • Can you give me an example? • Does this happen every night?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 1 if the person has had trouble falling asleep only a few nights in the past week. Rate 2 if the person has had difficulty every night.	
Notes: **Score**	
unable to score = a absent = 0 difficulty falling asleep only a few nights in the past week = mild = 1 difficulty falling asleep every night = severe = 2	

14. Multiple awakenings during sleep	
Interviewing staff or other informant: • Has X/ she/ he been waking up in the middle of the night in the last week? • If yes, how long does she/ he stay awake? • Does she/ he get out of bed? Is this just to go to the toilet? • Does she/ he go back to sleep quite quickly? • Does this occur every night? (rate 0 if goes to toilet and returns to sleep easily; rate 1 if goes to toilet and can't return to sleep easily occasionally; rate 2 if goes to toilet and can't return to sleep every night) • Can you give me an example of what else she/ he does upon wakening in the middle of the night? • Does this happen occasionally or often? (rate 1 if occurs occasionally; rate 2 if occurs every night) • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Have you been waking up in the middle of the night in the last week, more than usual? • If yes, how long do you stay awake? • Do you get out of bed? Is this just to go to the toilet? • Do you go back to sleep quite quickly? • Does this occur every night? • Can you give me an example of what else you do upon wakening in the middle of the night? • How long do you stay awake? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 0 if the awakening is prompted by the need to go to the bathroom and the person has no trouble returning to sleep. Rate 1 if the restlessness has happened only occasionally and the person has not gotten out of bed (other than to use the bathroom). Rate 2 if the person gets out of bed for other reasons and/ or has been waking up every night.	
Notes: **Score**	
unable to score = a awakening prompted by the need to go to the bathroom and no trouble returning to sleep = absent = 0 restlessness occasional and the person has not gotten out of bed (other than to use the bathroom) = mild = 1 gets out of bed for other reasons **and/ or** has been waking up every night = severe = 2	

15. Early morning awakening (earlier than usual for client)	
Interviewing staff or other informant: • Has X/ she/ he been waking up earlier than usual in the last week? (Exclude use of alarm clocks or being disturbed by others) • If yes, does she/ he go back to sleep? (rate 1 if waking up on own accord and goes back to sleep) • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life? (Rate 2 if wakes earlier than usual and gets out of bed and can't go back to sleep)	Interviewing the resident or observation: • Have you been waking up earlier than usual in the last week? • If yes, do you go back to sleep? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 1 if wakes up on her/ his own but goes back to sleep. Rate 2 if she/ he wakes earlier than usual and gets out of bed for the day (i.e. cannot fall back asleep).	
Notes: **Score**	
unable to score = a absent = 0 wakes up on own but goes back to sleep = mild = 1 wakes earlier than usual and gets out of bed for the day = severe = 2	
Q's 16–19: ideational disturbance	
16. Suicide (feels life is not worth living, suicide attempt or wishes)	
Interviewing staff or other informant: • In the last week, has X/ she/ he said that life isn't worth living or that she would rather be dead? (rate 0 for a history of, but without current thoughts) • If yes, has she/ he spoken of wanting to harm herself? • If yes, has she/ he spoken of how she would do that? (rate 1 for passive thoughts–has no plan) • Can you give me an example? (rate 2 for active suicidal wishes and/ or any recent attempts, gestures or plans)	Interviewing the resident or Observation: • A. In the last week, have you had any thoughts that life isn't worth living? • B. In the last week, have you had any thoughts that you would rather be dead? • If yes to either A or B have you had any thoughts of wanting to harm or kill yourself? • If yes, have you thought about how you would do that? • Can you give me an example?
Staff: Other:	☐ Interview ☐ Observation
Guideline: Rate 1 for passive thoughts (feels life isn't worth living or would rather be dead but has no plan to end their life). Rate 2 for active suicidal wishes and/or any recent attempts, gestures or plans. A history of one or more suicide attempts without current passive or active thoughts is not scored.	
Notes: **Score**	
unable to score = a history of one or more suicide attempts without current passive or active thoughts = absent = 0 passive thoughts = mild = 1 active suicidal wishes and/ or any recent attempts, gestures or plans = severe = 2	

17. Poor self-esteem (self blame, self deprecation, feelings of failure)	
Interviewing staff or other informant: • How has X/ she/ he been feeling about herself/ himself in the last week? • Has she/ he been feeling especially critical of herself/ himself, feeling that she's/ he's done things wrong or let others down? (rate 1 for loss of self-esteem or self-reproach) • Has she/ he described herself/ himself as "no good" or "useless"?(rate 2 if feels worthless, inferior or no good) • Can you give me an example?	Interviewing the resident or observation: • How have you been feeling about yourself in the last week? • Have you been feeling especially critical of yourself, feeling that you have done things wrong or let others down? • Have you been feeling guilty about anything you have or have not done? • Have you been comparing yourself to others, or feelings worthless or like a failure? • Have you felt no good or inferior? • Can you give me an example?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 1 for loss of self-esteem or self-reproach. Rate 2 for feelings of failure or statements that she/ he is "worthless," "inferior," or "no good."	
Notes: **Score**	
unable to score = a absent = 0 loss of self-esteem or self-reproach = mild = 1 feelings of failure or statements that they are "worthless," "inferior," or "no good" = severe = 2	
18. Pessimism (anticipation of the worst)	
Interviewing staff or other informant: • Has X/ she/ he felt pessimistic or discouraged about her future over the last week? • Can she/ he see their situation improving? • Can you reassure her that things are ok? (Score 1 if can be reassured by self or others) • Can you give me an example?	Interviewing the resident or observation: • Have you felt pessimistic or discouraged about your future over the last week? • Can you see your situation improving? • Can you be reassured by others that things will be ok? • Can you give me an example?
Staff: Other:	☐ Interview ☐ Observation
Guideline: rate 1 if she/ he feels pessimistic but can be reassured by self or others. Rate 2 if she/ he feels hopeless and cannot be assured that their future will be okay.	
Notes: **Score**	
unable to score = a absent = 0 pessimistic but can be reassured = mild = 1 feels hopeless and cannot be assured = severe = 2	

19. Mood-congruent delusions (delusions of poverty, illness or loss)	
Interviewing staff or other informant: • Has X/ she/ he had ideas that other people would find strange? For example, does she/ he think she has no money or possessions or that she is being punished for something? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the resident or observation: • Have you had ideas or seen things that other people would find strange? For example, do you think you have no money or possessions or that you are being punished for something? • Can you give me an example? • Does this happen occasionally or often? • How much does it interfere with your everyday life?
Staff: Other:	☐ Interview ☐ Observation
Notes: **Score**	
unable to score = a absent = 0 minor interference with everyday life **and/ or** symptoms occur occasionally = mild = 1 major interference with everyday life **and** symptoms occur often = severe = 2	

Summary of results and total score	**Score**			
	Unable to score	absent	mild	severe
Mood related signs				
Chronic anxiety	a	0	1	2
Sadness	a	0	1	2
Lack of reactivity to pleasant events	a	0	1	2
Irritability, easily annoyed, short tempered	a	0	1	2
Behavioural disturbance				
Agitation	a	0	1	2
Psychomotor	a	0	1	2
Multiple physical complaints	a	0	1	2
Loss of interest	a	0	1	2
Physical signs				
Appetite loss	a	0	1	2
Weight loss	a	0	1	2
Lack of energy, fatigues easily	a	0	1	2
Cyclic functions				
Diurnal variation of mood	a	0	1	2
Difficulty falling asleep	a	0	1	2
Multiple awakenings during sleep	a	0	1	2
Early morning awakening	a	0	1	2
Ideational disturbance				
Suicide	a	0	1	2
Poor self-esteem	a	0	1	2
Pessimism	a	0	1	2
Mood congruent delusions	a	0	1	2
Column totals	**na**			
Assessment total				

Permission to use the Cornell Scale in the ACFI was kindly provided by Dr G.S.Alexopoulos.