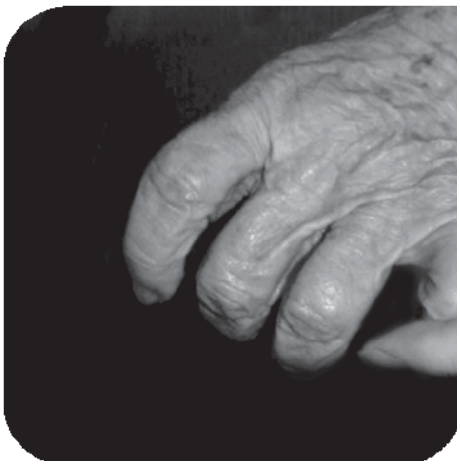
Australian Government
Department of Health and Ageing

Aged Care Funding Instrument (ACFI)

User Guide



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Introduction

The Aged Care Funding Instrument (ACFI) is a resource allocation instrument. It focuses on the main areas that discriminate care needs among residents. The ACFI assesses core care needs as a basis for allocating funding.

The ACFI focuses on care needs related to day to day, high frequency need for care. These aspects are appropriate for measuring the average cost of care in longer stay environments.

While based on the differential resource requirements of individual persons, the ACFI is primarily intended to deliver funding to the financial entity providing the care environment. This entity for most practical purposes is the residential aged care home. When completed on all residents in the facility the ACFI provides sufficient precision to determine the overall relative care needs profile and the subsequent funding.

The ACFI consists of 12 questions about assessed care needs, each having four ratings (A, B, C or D) and two diagnostic sections.

While the ACFI questions provide basic information that is related to fundamental care need areas, it is not a comprehensive assessment package. Comprehensive assessment will consider a broader range of care needs than is necessarily required in a funding instrument.

Note

This ACFI User Guide applies to ACFI appraisals from 1 July 2013. For earlier appraisals, readers are referred to the previous version of the ACFI User Guide. Compliance with this ACFI User Guide will automatically ensure compliance with the earlier version of the ACFI User Guide.

The ACFI as a calculator of the residential aged care subsidy

Three components of residential care subsidy are determined by the ACFI.

These are:

- **Activities of Daily Living** (ratings on Nutrition, Mobility, Personal Hygiene, Toileting and Continence questions are utilised to determine the level of the basic subsidy)
- **Behaviour Supplement** (ratings on Cognitive Skills, Wandering, Verbal Behaviour, Physical Behaviour and Depression questions are utilised to determine the behaviour supplement)
- **Complex Health Care Supplement** (ratings on Medication and Complex Health Care Procedure questions are utilised to determine the complex health care supplement).

The amount of each of these that is payable in respect of a particular resident depends on the ratings (A, B, C or D) for each of the ACFI questions (1–12). Other data such as diagnosis may be relevant to the calculation of subsidy for some questions.

Appendix 2 sets out the relationship between the ACFI questions and the three funding domains, and provides the question scores and category cut-off points.

Terminology

ACAP

The Aged Care Assessment Program is an important part of Australia's aged and community care system. It aims to assess the needs of frail older people and facilitate access to care services appropriate to their needs. The ACAP data dictionary supports the collection and reporting of the Aged Care Assessment Program Minimum Data Set, by providing definitions for all the data elements in that collection.

ACCR

The **ACCR** is the Aged Care Client Record or earlier equivalent, completed by an Aged Care Assessment Team/ Service. A copy of the ACCR content that the service received should be filed in the ACFI Appraisal Pack.

ACFI Appraisal Pack

The **ACFI Appraisal Pack** is the completed record of the resident's ACFI appraisal or reappraisal including all the evidence specified for inclusion.

Activities

Activities are the action steps to meet a care need. In each of the ACFI questions 1 to 4, the activities that are to be taken into account in completing the checklist which are informed by an assessment. Only these specified activities are to be taken into account in the appraisal.

Assessment summary

In ACFI questions 5 to 10, the appraiser will need to complete the **assessment summary** to indicate which evidence source(s) are included to support the rating.

Checklists

Checklists form the minimum data set (MDS). They are single-focussed items about the care needs within each question.

Clinical reports

A **clinical report** is not mandatory for any ACFI question. For ACFI 6 (Cognition) and ACFI 10 (Depression), existing clinical reports, **if available**, may be included in the ACFI Appraisal Pack to support the rating.

A clinical report for these purposes is a report that has been completed by **consultants** in the following disciplines: general or specialist medical practitioner, physician, geriatrician or psychogeriatrician, registered psychologist, nurse practitioner or clinical nurse (mental health)[1]. The details about the clinical report must be completed in the relevant ACFI assessment summary.

Domains

There are three ACFI **domains**:

- Activities of Daily Living (consisting of the ACFI questions–Nutrition, Mobility, Personal Hygiene, Toileting and Continence)
- Cognition and Behaviour (consisting of the ACFI questions–Cognitive Skills, Wandering, Verbal Behaviour, Physical Behaviour and Depression)
- Complex Health Care (consisting of the ACFI questions–Medication and Complex Health Care Procedures).

Notes

Notes provide further information about a domain to assist an assessor. Only the specified activities for each care need are to be taken into account in completing the checklist.

[1] This term refers to a registered nurse with formal qualifications in mental health.

Nurse practitioner

A **nurse practitioner** is a registered nurse working at a clinically advanced level of practice who meets the legislative requirements to prescribe (within limits), order certain diagnostics and to refer patients. As with nurses, regulation of nurse practitioners is the responsibility of the relevant state/ territory authority.

Registered nurse

A person licensed to practice nursing under an Australian state or territory nurses act or health professional act. Referred to as a Registered Nurse Division 1 in Victoria.

Scheduled toileting

Scheduled toileting for the purposes of question 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.

Source materials

In questions ACFI 11 and 12, and the diagnosis sections, the appraiser will need to complete the **source materials** to indicate which evidence source(s) support the rating. Only source documents which continue to reflect the status of the resident at the time of appraisal can be used. Copies of the source materials must be stored as part of the ACFI Appraisal Pack. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the last twelve months.

Usual care needs

The ACFI questions refer to **usual care needs**. This is the ongoing care need at the time of the appraisal, not any expected occasional needs and not any occasional or unusual needs that are present at the time of the appraisal.

For ACFI questions 1 to 4, these are the **day to day care needs** that are predictable and required for the specific activities.

Explanatory notes

ACFI questions 1 to 4

Each of these four questions ACFI 1 Nutrition, ACFI 2 Mobility, ACFI 3 Personal Hygiene and ACFI 4 Toileting, refers to a set of related care needs (e.g. dressing, washing and grooming in the Personal Hygiene question) and each care need has a set of defined activities. Each specified care need is to be considered (and rated for assistance needed) in the appraisal process.

ACFI questions 1 to 4 ratings

Each care need in these questions is rated using the following scales.

Independent: the resident requires no assistance or minimal assistance, or the care need is not applicable to the resident.

Supervision: comprises setting-up and standby

- **setting-up** activities are defined as assisting the person to initiate a specified activity or complete part of that activity. The setting-up activities that are taken into account are defined for each question.
- **standby** is defined as standing by during the stated specified activities to provide assistance (verbal or physical). For ACFI 1 Nutrition, there must be sufficient proximity to assist one-to-one as needed at the table/ eating place. For ACFI 2 Mobility, ACFI 3 Personal Hygiene and ACFI 4 Toileting, this is a commitment of staff on a one-to-one basis.

Physical assistance
Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Use of mechanical lifting equipment: this rating is only considered in the care need of 'transfers' in ACFI 2 Mobility.

Assessments

The details about the ACFI assessments must be completed in the relevant ACFI assessment summary.

Use of previously completed assessments

This refers to ACFI mandatory assessments (for question 5 this is the continence record, for question 6 this is the Psychogeriatric Assessment Scales - Cognitive Impairment Scale, for questions 7 to 9 it is the behaviour record, and for question 10 it is the Cornell Scale for Depression). If these assessments have been completed within the past six months and if they continue to reflect the care needs of the resident, they may be used for the purposes of ACFI appraisal.

For ACFI 5–Continence, where scheduled toileting has remained in place during the completion of the continence record, evidence of incontinence prior to the commencement of a scheduled toileting regime is to be included in the ACFI Appraisal Pack.

The ACFI process–5 steps

Step 1: Assessment

This guide specifies the required assessments. The checklist must be supported by an assessment. These are summarised in Table 1 and described under each question.

Step 2: Checklist

The ACFI appraiser will complete the checklist data. There is a direct relationship between the specific assessments described above and the checklist requirements.

Step 3: Rating A to D

The checklist leads directly via an algorithm to the rating (A, B, C or D) which provides the basis for resident classification.

Step 4: Submissions

The ACFI appraiser will ensure that the ACFI Appraisal Pack has been completed in accordance with these guidelines. The person authorised by the approved provider to complete and submit the ACFI Application for Classification must certify as part of the application that it is true and correct.

Step 5: Record keeping

The approved provider will ensure that the specified materials for audit and accountability purposes are retained and stored for future audit.

The following tables provide an overview of the ACFI questions, the required level of appraisal evidence and the assistance required for questions 1 to 4.

Table 1: ACFI at a glance

	Question	ACFI appraisal evidence
Note: the resident's ACCR must be included in the ACFI Appraisal Pack		
	Mental and Behavioural Diagnosis	• Disorders/ diagnosis checklists • Source materials checklists • Copies of source materials e.g. ACCR, GP comprehensive medical assessment, other medical practitioner assessments or notes
	Medical Diagnosis	
1	**Nutrition** Care need: readiness to eat / eating Assistance level = independent OR supervision OR physical assistance	• Assessment • Nutrition Checklist
2	**Mobility** Care need: transfers / locomotion Assistance level = independent OR supervision OR physical assistance OR mechanical lifting equipment	• Assessment • Mobility Checklist
3	**Personal Hygiene** Care need: dressing / washing / grooming Assistance level = independent OR supervision OR physical assistance	• Assessment • Personal Hygiene Checklist
4	**Toileting** Care need: use of toilet / toilet completion Assistance level = independent OR supervision OR physical assistance	• Assessment • Toileting Checklist
5	**Continence** Urinary continence and faecal continence Measurement = frequency	• Continence Assessment Summary • Continence Record • Continence Checklist • Documentary evidence of incontinence prior to the implementation of a scheduled toileting program (Note: Other types of logs or diaries may be used to complete the continence record providing they contain all the required information.)
6	**Cognitive Skills** Care need: needs arising from cognitive impairment Measurement = none, mild, moderate, severe	• Cognitive Skills Assessment Summary • PAS - CIS if appropriate • Cognitive Checklist (Note: A clinical report may be attached to provide supporting evidence)
7	**Wandering** Care need: absconding or interfering whilst wandering Measurement = frequency	• Wandering/ verbal/ physical behaviour assessment summary • Wandering/ verbal/ physical behaviour records • Behaviour checklists (Note: Other types of logs or diaries may be used to complete the behaviour records providing they contain the same information as in the supplied record)
8	**Verbal** Care need: verbal behaviour Measurement = frequency	
9	**Physical** Care need: physical behaviour Measurement = frequency	
10	**Depression** Care need: depressive symptoms Measurement = none, mild, moderate, severe	• Depression Assessment Summary • Cornell Scale for Depression • Depression Checklist • Diagnosis (Note: A clinical report may be attached to provide supporting evidence)
11	**Medication** Care need : assistance with medications Measurement = complexity, frequency and assistance time	• Source materials table • Medication Checklist • Medication chart
12	**Complex Health Care** Care need: complex health care procedures Measurement = complexity and frequency	• Complex Health Care Checklist • Diagnoses, assessments and directives as specified • If requested at validation–records of treatments

Table 2: Assistance required

Independent ⇩ Requires no supervision with the stated activities or is not applicable	**Supervision** ⇩ Requires supervision with the stated activities		**Physical assistance** ⇩ Requires one-to-one physical assistance with the stated activities
	Setting-up	Standby in the stated activities[2]	Physical
ACFI 1 Nutrition			
Readiness to eat	Place utensils in the resident's hand	Not applicable	Cutting up food or vitamising food
Eating	Not applicable	Stand by to provide assistance (verbal and/ or physical) OR daily oral intake when ordered by a dietitian for person with a PEG tube	Placing or guiding food into mouth for most of the meal
ACFI 2 Mobility			
Transfers	Locking wheels to enable transfers AND adjusting/ removing foot plates or side arms	Stand by to provide assistance (verbal and/ or physical)	Physically assist moving to or from chairs, or wheelchairs, or beds OR use of mechanical lifting equipment
Locomotion	Hand resident the mobility aid OR fitting of callipers, leg braces or lower limb prostheses	Stand by to provide assistance (verbal and/ or physical)	Need for staff to push wheelchair OR assistance with walking on a one-to-one basis
ACFI 3 Personal Hygiene			
Dress/ undress	Choosing and laying out appropriate clothing OR undoing and doing up zips, buttons or other fasteners including velcro	Stand by to provide assistance (verbal and/ or physical)	One-to-one physical assistance for dressing AND undressing i.e. putting on or taking off clothing AND footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings) OR fitting and removing of hip protectors, slings, cuffs, splints, medical braces and prostheses other than for the lower limb
Wash/ dry	Set up toiletries within reach, organise taps	Stand by to provide assistance (verbal and/ or physical)	Washing and drying body
Groom	Set up articles for grooming	Stand by to provide assistance (verbal and/ or physical)	Dental care OR hair care OR shaving
ACFI 4	**Toileting**		
Use of a toilet	Setting-up toilet aids, hand person the bedpan/ urinal, place ostomy articles in reach	Stand by to provide assistance (verbal and/ or physical)	Positioning resident for use of toilet or commode or bedpan or urinal
Toilet completion	Emptying of drainage or stoma bags or bedpans	Stand by to provide assistance (verbal and/ or physical)	Adjusting clothes AND wiping and cleaning of peri-anal area

[2] Refer to explanatory notes

Documentation requirements

The evidence specified here comprises the requirements for the completed ACFI Appraisal Pack.

Diagnosis questions

- a completed Mental and Behavioural Disorders Checklist
- a completed Medical Diagnosis Checklist
- a completed Source Materials Checklist for each question
- copies of the source materials; e.g. Aged Care Client Record (ACCR), GP comprehensive medical assessment, or other medical practitioner assessments or notes.

The filed source materials must identify the name and profession of the health professional who has made the diagnosis and the date on which it was made.

Activities of Daily Living (ADL) domain

ACFI 1 to 4 Nutrition, Mobility, Personal Hygiene and Toileting

- the completed contemporaneous assessments for Nutrition, Mobility, Personal Hygiene and Toileting (A list of suggested tools can be found at www.health.gov.au/acfi)

For a rating B,C or D:

- the completed checklists.

For the Activity of Daily Living questions, the completion of the checklist is to be based upon contemporaneous assessment or alternatively upon a previous assessment undertaken in the preceding six months if that assessment is consistent with current dependency of the resident and provides the information required to complete the checklist.

ACFI 5 Continence

- the completed Continence Assessment Summary
- the completed Continence Checklist.

For a rating of B, C or D:

- the completed Continence Record.

If claiming for scheduled toileting, you must provide documentary evidence that the resident was incontinent prior to the implementation of scheduled toileting e.g. ACCR or a continence flowchart completed prior to scheduled toileting being implemented.

Continence logs or diaries which have been completed in the past six months and are consistent with the current dependency of the resident may be used to complete the Continence Record if they contain all the required information.

Cognitive and Behaviour domain

ACFI 6 Cognitive Skills

- the completed Cognitive Skills Assessment Summary which identifies any reasons
  why the specified assessment (the PAS - CIS) could not be completed, the PAS - CIS score (if the PAS - CIS was completed) and if a clinical report provides supporting information
- the completed Cognitive Checklist.

For a rating of B, C or D:

- the completed PAS - CIS, if appropriate
- a copy of any clinical report if identified as providing supporting information in the Cognitive Skills Assessment Summary.

ACFI 7 to 9 Behaviour questions

- the completed Behaviour Assessment Summary
- the completed Behaviour Checklist.

For a rating of B, C or D:

- the completed Behaviour Record.

ACFI 10 Depression

- the completed Depression Assessment Summary
- the completed Depression Checklist.

For a rating of B, C or D:

- the completed Cornell Scale for Depression
- a copy of any clinical report if identified as providing supporting information in the Depression Assessment Summary.

For a rating of C or D:

- a copy of any diagnosis or provisional diagnosis of depression.

The diagnosis or provisional diagnosis, or reconfirmation of the diagnosis, should have been completed in the past twelve months. Diagnosis sources may include medical practitioner assessments or notes, comprehensive medical assessments and/or the Aged Care Client Record (ACCR). If a diagnosis or provisional diagnosis is being sought at the time of the appraisal (indicated in the Symptoms of Depression Checklist), then when it is obtained, a copy of it must be included in the ACFI Appraisal Pack.

Note: Behaviour Supplement
To qualify for the highest level of the Behaviour Supplement, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the **past 12 months**.

Complex Health Care domain

ACFI 11 Medication

- the completed checklist.

For a rating of B, C or D:

- the completed Source Materials Checklist
- a copy of the medication chart that was applicable during the appraisal period.

ACFI 12 Complex Health Care

For a rating of B, C or D i.e. where one or more complex health care procedures are provided on at least the specified frequency:

- the completed checklist
- copies of all required diagnoses and directives as specified below.

To support claims under ACFI 12.3,12.4a and 12.4b you are required to use an evidence based pain assessment tool. (A list of suggested tools can be found at www.health.gov.au/acfi)

(Where it is specified that a treatment record may be requested, this does not form part of the ACFI Appraisal Pack, but would need to be provided if requested for review.)

Completion requirements of ACFI evidence–the ACFI Appraiser Identification Details Box

The specified assessments used as evidence for ACFI questions 5 to 10 include an ACFI Appraiser Identification Box which must be completed by the person taking responsibility for the appraisal of that question.

ACFI Appraiser Identification Box

Name of appraiser	
Profession	
Signature	
Date	

For all ACFI questions , where the ACFI appraiser has chosen to use a previously completed assessment, in completing the **ACFI Appraiser Identification Box**, the ACFI appraiser is signifying that:

- he/ she is responsible for the accurate transcription of the information into the records for all ACFI questions,
- he/ she is responsible for including the previously completed PAS - CIS and/ or Cornell Scale for Depression in the ACFI Appraisal Pack, and
- that the information in the records and assessments continues to provide an accurate reflection of the status of the resident.

Record keeping

For each application for an ACFI classification, the completed ACFI Appraisal Pack must be retained and stored in a form that is readily available for audit purposes. It includes:

- all completed ACFI assessments
- assessment summaries
- completed checklists
- any clinical reports (or copies) which provide supporting evidence for questions 6 and 10
- diagnoses, assessments and directives as required for question 12
- source materials used for the completion of questions 11 and 12 and the diagnosis sections
- a copy of the ACCR(s) for the person
- a copy of the Application for Classification.

Mental and Behavioural Diagnosis

Description

This question relates to a documented diagnosis. If the resident has a mental and behavioural disorder(s) that has an impact on their current care needs for support and assistance, please indicate the diagnosis/ diagnoses in the checklist. You may tick more than one diagnosis, if appropriate.

Complete details about the diagnosis documentation in the source materials. The filed evidence must identify the name and profession of the health professional who has confirmed the diagnosis and it must be dated.

Source materials

Please indicate what source materials for this section are filed in the ACFI Appraisal Pack. You may tick more than one source.

Mental and Behavioural Diagnosis: indicate which sources of evidence have been filed in the ACFI Appraisal Pack	**Tick if yes**
Aged Care Client Record (ACCR)	☐ D1.1
GP comprehensive medical assessment	☐ D1.2
General medical practitioner notes or letters	☐ D1.3
Geriatrician notes or letters	☐ D1.4
Psychogeriatrician notes or letters	☐ D1.5
Psychiatrist notes or letters	☐ D1.6
Other medical specialist notes or letters	☐ D1.7
Other–please describe	☐ D1.8

If the resident has no disorder of relevance, place a tick in the first option on the checklist (no diagnosis) and proceed to Medical Diagnosis.

Note: Behaviour Supplement

To qualify for the highest level of the Behaviour Supplement, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis is required. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the **past 12 months**.

Mental and Behavioural Diagnosis Checklist

	Mental and behavioural disorders	**Tick if YES**
0	No diagnosed disorder currently impacting on functioning	
500	Dementia, Alzheimer's disease including early onset, late onset, atypical or mixed type or unspecified	
510	Vascular dementia e.g. multi-infarct, subcortical, mixed	
520	Dementia in other diseases, e.g. Pick's Disease, Creutzfeldt-Jakob, Huntington's, Parkinson's, HIV	
530	Other dementias, e.g. Lewy Body, alcoholic dementia, unspecified	
540	Delirium	
550A	Depression, mood and affective disorders, Bi-Polar	
550B	Psychoses e.g. schizophrenia, paranoid states	
560	Neurotic, stress related, anxiety, somatoform disorders e.g. post traumatic stress disorder, phobic and anxiety disorders, nervous tension/stress, obsessive-compulsive disorder	
570	Intellectual and developmental disorders e.g. intellectual disability or disorder, autism, Rhett's syndrome, Asperger's syndrome etc	
580	Other mental and behavioural disorders e.g. due to alcohol or psychoactive substances (includes alcoholism, Korsakov's psychosis), adult personality and behavioural disorders.	

Note: For categories 540, 550A, 550B, and 560 the diagnosis/ provisional diagnosis or reconfirmation of the diagnosis must have been completed in the past twelve months.

Medical Diagnosis

Description

This question relates to a diagnosed and documented disease or disorder excluding the mental and behavioural disorders recorded in the Mental and Behavioural Diagnosis. The health condition **must** be relevant to the current care needs of the person.

The health condition codes used here are the diagnostic codes used by Aged Care Assessment Teams/ Services. A subset of common examples is included on page 17. A complete listing titled '**ACAP code list for health condition–long**' is included in Appendix 1.

If the resident has a medical diagnosis that has a discernable impact on their current care needs, you should indicate the diagnosis in the checklist. You may tick more than one diagnosis, if appropriate.

Complete details about the diagnosis documentation in the source materials. The filed evidence must identify the name and profession of the health professional who has made the diagnosis and it must be dated.

Source materials

Please indicate what source material for this section is filed in the ACFI Appraisal Pack. You may tick more than one source.

Medical Diagnosis: indicate which sources of evidence have been filed in the ACFI Appraisal Pack	**Tick if yes**
Aged Care Client Record (ACCR)	☐ D2.1
GP comprehensive medical assessment	☐ D2.2
General medical practitioner notes or letters	☐ D2.3
Geriatrician notes or letters	☐ D2.4
Psychogeriatrician notes or letters	☐ D2.5
Psychiatrist notes or letters	☐ D2.6
Other medical specialist notes or letters	☐ D2.7
Other–please describe	☐ D2.8

In completing this question in the ACFI Appraisal Pack, the appraiser should identify each medical diagnosis that has a discernable impact on the care needs of the resident. The Application for Classification collects a maximum of three diagnoses. For residents who have more than three diagnoses, please identify the **three most significant** in terms of impact on care needs when you complete the Application for Classification.

Medical Diagnosis Checklist

CODE	If no diagnosis tick one of the following, otherwise provide full details below
0	☐ No diagnosed disorder currently impacting
9998	☐ No formal diagnosis available
9999	☐ Not stated or inadequately described
CODE	**Description of condition(s)/ disease(s)**

ACAP medical condition codes–common examples

Certain infectious and parasitic diseases	
0101	Tuberculosis
0102	Poliomyelitis
0103	HIV/AIDS
0104	Diarrhoea and gastroenteritis of presumed infectious origin
Neoplasms (tumours / cancers)	
0202	Stomach cancer
0203	Colorectal (bowel) cancer
0204	Lung cancer
0205	Skin cancer
0206	Breast cancer
0207	Prostate cancer
0209	Non-Hodgkin's lymphoma
0210	Leukaemia
Diseases of blood, blood forming organs, immune mechanism	
0301	Anaemia
Endocrine, nutritional and metabolic disorders	
0401	Disorders of the thyroid gland
0402	Diabetes mellitus type 1
0403	Diabetes mellitus type 2
0404	Diabetes mellitus–other specified/ unspecified
0405	Malnutrition
0406	Nutritional deficiencies
0407	Obesity
0408	High cholesterol
Diseases of the nervous system	
0602	Huntington's disease
0604	Parkinson's disease
0605	Transient cerebral ischaemic attacks (T.I.A.s)
0607	Multiple sclerosis
0608	Epilepsy
0609	Muscular dystrophy
0610	Cerebral palsy
0611	Paralysis-non-traumatic e.g. hemiplegia, paraplegia, quadriplegia, tetraplegia and monoplegia; excludes spinal cord injury code 1699
Diseases of the eye and adnexa	
0701	Cataracts
0702	Glaucoma
0703	Blindness e.g. both eyes, one eye, one eye and low vision in other eye
0704	Poor vision e.g. low vision both eyes, one eye, unspecified visual loss
Diseases of the ear and mastoid process	
0801	Meniere's disease e.g. vertigo
0802	Deafness/ hearing loss
Diseases of the circulatory system	
	Heart disease
0902	Rheumatic heart disease
0903	Angina
0904	Myocardial infarction (heart attack)
0905	Acute and chronic ischaemic heart disease
0906	Congestive heart failure (congestive heart disease)
0907	Other heart diseases e.g. pulmonary embolism, acute pericarditis, acute and subacute endocarditis, cardiomyopathy, cardiac arrest, heart failure
	Cerebrovascular disease
0911	Subarachnoid haemorrhage
0912	Intracerebral haemorrhage
0913	Other intracranial haemorrhage
0914	Cerebral infarction
0915	Stroke (CVA)–cerebrovascular accident unspecified
	Other diseases of the circulatory system
0921	Hypertension (high blood pressure)
0922	Hypotension (low blood pressure)
0925	Atherosclerosis
Diseases of the respiratory system	
1001	Acute upper respiratory infections e.g. common cold, acute sinusitis, acute pharyngitis, acute tonsillitis, acute laryngitis, upper respiratory infections of multiple unspecified sites
1002	Influenza and pneumonia
1003	Acute lower respiratory infections e.g. bronchitis, bronchiolitis and unspecified acute lower respiratory infections
1005	Chronic lower respiratory diseases e.g. emphysema, chronic obstructive airways disease, asthma
Diseases of the digestive system	
1101	Diseases of the intestine, ulcers, hernias (except congenital), enteritis, colitis, vascular disorders of intestine, diverticulitis, irritable bowel syndrome, diarrhoea, constipation
1103	Diseases of the liver e.g. alcoholic liver disease, toxic liver disease, fibrosis and cirrhosis of liver
1199	Other diseases of the digestive system e.g. disease of the oral cavity, salivary glands and jaws, oesophagitis, gastritis and duodenitis, cholecystitis, other diseases of the gallbladder, pancreatitis, coeliac disease
Diseases of the skin and subcutaneous tissue	
1201	Skin and subcutaneous tissue infections (e.g. impetigo, boil, cellulitis)
Diseases of the musculoskeletal system and connective tissue	
1301	Rheumatoid arthritis
1302	Other arthritis and related disorders (e.g. gout, arthrosis, osteoarthritis)
1303	Deformities of joints/ limbs–acquired
1305	Other soft tissue/ muscle disorders e.g. rheumatism
1306	Osteoporosis
Diseases of the genitourinary system	
1401	Kidney and urinary system–renal failure, cystitis
1402	Urinary tract infection
1403	Incontinence–urinary (stress, overflow etc–do not include unspecified)
Congenital malformations, deformations and chromosomal abnormalities	
1501	Spina bifida
1503	Down's syndrome
1504	Other chromosomal abnormalities
1505	Congenital brain damage/ malformation
Injury, poisoning or consequences of external causes	
1601	Injuries to head (includes injuries to ear, eye, face, jaw, acquired brain damage)
1604	Amputation of finger/ thumb/ hand/ arm/ shoulder
1605	Amputation of toe/ ankle/ foot/ leg
1606	Fracture of neck (includes cervical spine and vertebra)
1607	Fracture of rib(s), sternum and thoracic spine and vertebra
1611	Fracture of the femur (includes hip)
Symptoms and signs (without diagnosis, unspecified)	
1703	Breathing difficulties/ shortness of breath
1704	Pain
1706	Dysphagia (difficulty in swallowing)
1707	Incontinence–bowel/ faecal
1714	Abnormalities of gait and mobility e.g. ataxic and spastic gait, difficulty in walking
1715	Falls (frequent with unknown aetiology)
1716	Disorientation (confusion)
1717	Amnesia (memory disturbance, lack or loss)
1719	Restlessness and agitation
1720	Unhappiness
1722	Hostility
1723	Physical violence
1727	Malaise and fatigue
1729	Odema includes fluid retention

ACFI 1 Nutrition

Description
This question relates to the person's usual day to day assessed care needs with regard to eating. This question also applies to people receiving enteral feeding if they receive some nutrition orally on a daily basis.
Each care need in these questions is rated using the following scales.

Notes
For tube feeding refer to ACFI 12 Complex Health Care. For assisting a resident to the dining room or assisting residents who are unable to position their chair appropriately see ACFI 2 Mobility.

Physical assistance
Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Care needs
1. Readiness to eat
2. Eating

Checklist must be completed
Rate the level of assistance (independent/ not applicable OR supervision OR physical assistance) required for each care need.

Nutrition Checklist	**Assistance level (Tick one per care need)**
1. Readiness to eat Supervision is: • placing utensils in the resident's hand. One-to-one physical assistance is required for: • cutting up food OR vitamising food.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)
2. Eating Supervision is: • standing by to provide assistance (verbal and/ or physical) OR providing assistance with daily oral intake when ordered by a dietitian for a person with a PEG tube. One-to-one physical assistance is required for: • placing or guiding food into the resident's mouth for most of the meal.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)

ACFI 1 rating key
RATING A = 0 in both care needs (readiness to eat and eating)
RATING B = 0 in readiness to eat AND 1 in eating
RATING B = 1 in readiness to eat AND 0 in eating
RATING B = 1 in readiness to eat AND 1 in eating
RATING B = 2 in readiness to eat AND 0 in eating
RATING C = 2 in readiness to eat AND 1 in eating
RATING C = 0 in readiness to eat AND 2 in eating
RATING C = 1 in readiness to eat AND 2 in eating
RATING D = 2 in readiness to eat AND 2 in eating

ACFI 2 Mobility

Description
This question relates to the person's usual day to day assessed care needs with regard to mobility.

Notes
For manual handling for maintenance of skin integrity such as frequent changing of the position of a resident with severely impaired mobility refer to ACFI 12 Complex Health Care.

Physical assistance
Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Generally, a claim of D in ACFI 7 Wandering would not be accompanied by a D in ACFI 2 Mobility.

Care needs
1. Transfers
2. Locomotion

Checklist must be completed
Rate the level of assistance (independent/ not applicable OR supervision OR physical assistance) required for each care need. Please note that the care need 'transfers' has an extra assistance level of 'mechanical lifting equipment'.

Mobility Checklist	**Assistance level (Tick one per care need)**
1 Transfers Supervision is: • locking wheels on a wheelchair to enable a transfer AND adjusting/ removing foot plates or side arm plates OR • standing by to provide assistance (verbal and/ or physical). One-to-one physical assistance is required for: • moving to and from chairs or wheelchairs or beds. Requiring physical assistance with the use of mechanical lifting equipment for transfers.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance) ☐ 3 (Mechanical lifting equipment)
2. Locomotion Supervision is: • handing the resident a mobility aid OR • fitting of calipers, leg braces or lower limb prostheses OR • standing by to provide assistance (verbal and/ or physical). One-to-one physical assistance is required for: • staff to push wheelchair OR • assistance with walking	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)

ACFI 2 rating key
RATING A = 0 in both care needs (transfers and locomotion)
RATING B = 1 or 2 in transfers AND 0 in locomotion
RATING B = 0 in transfers AND (1 or 2) in locomotion
RATING C = 1 or 2 in transfers AND 1 in locomotion
RATING C = 1 in transfers AND 2 in locomotion
RATING D = 2 in transfers AND 2 in locomotion
RATING D = 3 in transfers

ACFI 3 Personal Hygiene

Description
This question relates to the person's usual day to day assessed care needs with regard to personal hygiene.

Notes

Physical assistance
Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Care needs

1. Dressing and undressing
2. Washing and drying
3. Grooming

Checklist must be completed
Rate the level of assistance (independent/ not applicable OR supervision OR physical assistance) needed for each care need.

Personal Hygiene Checklist	**Assistance level (Tick one per care need)**
1. Dressing and undressing Supervision is: • choosing and laying out appropriate garments OR • undoing and doing up zips, buttons or other fasteners including velcro OR • standing by to provide assistance (verbal and/or physical). One-to-one physical assistance is required for: • dressing AND undressing i.e. putting on or taking off clothing AND footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings) OR • fitting and removing of hip protectors, slings, cuffs, splints, medical braces and prostheses other than for the lower limb.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)
2. Washing and drying Supervision is: • setting up toiletries, or turning on and adjusting taps, OR • standing by to provide assistance (verbal and/or physical). One-to-one physical assistance is required throughout the process of: • washing and/ or drying the body.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)
3. Grooming Supervision is: • setting up articles for grooming OR • standing by to provide assistance (verbal and/or physical). One-to-one physical assistance is required for: • dental care OR hair care OR shaving.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)

ACFI 3 rating key
RATING A = 0 in all care needs (dressing and washing and grooming)
RATING B = 1 in any of the three care needs (dressing, washing, grooming)
RATING C = 2 in any of the three care needs (dressing, washing, grooming)
RATING D = 2 in all three care needs (dressing and washing and grooming)

ACFI 4 Toileting

Description
This question relates to the person's usual day to day assessed care needs with regard to toileting. It relates to the assessed needs with regard to use of a toilet, commode, urinal or bedpan. It also includes emptying drainage bags of residents who have stomas and catheters.

Notes
For location change related to toileting refer to ACFI 2 Mobility. For the clinical care of catheters and the administration of suppositories and enemas in continence management see ACFI 12 Complex Health Care.

Physical assistance
Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Care needs
1. Use of a toilet (setting up to use the toilet)
2. Toilet completion (the ability to appropriately manage the toileting activity)

Checklist must be completed
Rate the level of assistance (independent/ not applicable OR supervision OR physical assistance) required for each care need.

Toileting Checklist	**Assistance level (Tick one per care need)**
1. Use of toilet Supervision is: • setting up toilet aids, or handing the resident the bedpan or urinal, or placing ostomy articles in reach OR • stand by to provide assistance with setting up activities (verbal and/ or physical) One-to-one physical assistance is required for: • positioning resident for use of toilet or commode or bedpan or urinal	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)
2. Toilet completion Supervision is: • standing by while the resident toilets to provide assistance (verbal and/ or physical) with adjusting clothing or peri-anal hygiene OR • emptying drainage bags, urinals, bed pans or commode bowls. One-to-one physical assistance is required for: • adjusting clothing AND • wiping the peri-anal area.	☐ 0 (Independent/ NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)

ACFI 4 rating key
RATING A = 0 in both care needs (use of toilet and toilet completion)
RATING B = 1 in one or two care needs (use of toilet, toilet completion)
RATING C = 2 in one care need (use of toilet or toilet completion)
RATING D = 2 in both care needs (use of toilet and toilet completion)

ACFI 5 Continence

Description
This question relates to the person's usual assessed needs with regard to continence of urine and faeces.

Notes
For the administration of stool softeners, aperients, suppositories or enemas for continence management see ACFI 11 Medication and ACFI 12 Complex Health Care. For the care and management of an indwelling catheter or ostomy see ACFI 12 Complex Health Care.

Care needs
1. Urinary continence
2. Faecal continence

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).

Assessment
The required assessment for the completion of the checklist is the Continence Record. The Continence Record includes a three-day Urinary Record and a seven-day Bowel Record. Alternatively, continence logs or diaries that were completed within the six months prior to the appraisal may be used to complete the 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 (refer to Terminology for definition of scheduled toileting), you must provide documentary evidence of incontinence prior to the implementation of scheduled toileting e.g. ACCR or a flowchart completed prior to scheduled toileting being implemented.

Note: The appropriate section of the Continence Record from the ACFI Assessment Pack must be completed when claiming a B, C or D rating in this question.

A urine assessment (i.e. urine continence 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. faecal continence 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.

Complete the urinary record for three consecutive days and bowel record for seven consecutive days. In exceptional circumstances where the resident is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record. 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 faecal incontinence.

Code 1: incontinent of urine

Code 2: pad change for incontinence of urine

Code 3: increase in pad 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

Assessment summary table must be completed

Indicate which assessments were completed

Continence Assessment Summary	**Tick if yes**
No incontinence recorded	☐ 5.1
3-day Urine Continence Record	☐ 5.2
7-day Bowel Continence Record	☐ 5.3

Checklist must be completed
You must tick one selection from items 1–4 and one selection from items 5–8.

Continence Checklist		Tick if yes
Urinary continence		
1	No episodes of urinary incontinence or self-manages continence devices	☐ 1
2	Incontinent of urine less than or equal to once per day	☐ 2
3	2 to 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	☐ 3
4	More than 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	☐ 4
Faecal continence		
5	No episodes of faecal incontinence or self-manages continence devices	☐ 5
6	Incontinent of faeces once or twice per week	☐ 6
7	3 to 4 episodes weekly of faecal incontinence or passing faeces during scheduled toileting	☐ 7
8	More than 4 episodes per week of faecal incontinence or passing faeces during scheduled toileting	☐ 8

ACFI 5 rating key
RATING A = yes to (item 1) and (item 5)
RATING B = yes to (item 2) or (item 6)
RATING C = yes to (item 3) or (item 7)
RATING D = yes to (item 4) or (item 8)

ACFI 6 Cognitive Skills

Description
This question relates to the person's assessed usual cognitive skills.

Assessment
To support a B, C or D rating in ACFI 6, the Psychogeriatric Assessment Scales–Cognitive Impairment Scale (PAS - CIS) must be completed, unless there are specific reasons why its use is inappropriate.

If the PAS - CIS has been completed for the resident in the last six months, it may be used if it continues to reflect the cognitive status of the resident at the time of appraisal. If it is inappropriate to use the PAS - CIS, the checklist must still be completed.

If there is a clinical report available that supports your rating please indicate this in the assessment summary. The PAS - CIS should still be completed if appropriate. Refer to 'Terminology and Explanatory Notes' for details about a clinical report.

Assessment summary table must be completed
Indicate if an assessment was used or the reason why an assessment was not suitable. The PAS - CIS may not be suitable for some people of non-English speaking background. It may not be suitable for some Aboriginal or Torres Strait Islander residents, depending on their background. In some circumstances, resident impairments may prevent the use of the PAS - CIS.

Cognitive Skills Assessment Summary	**Tick if yes**	
No PAS - CIS undertaken–and nil or minimal cognitive impairment	☐ 6.1	
Cannot use PAS - CIS due to severe cognitive impairment or unconsciousness or have a diagnosis of 520, 530, 570 or 580	☐ 6.2	
Cannot use PAS - CIS due to speech impairment	☐ 6.3	
Cannot use PAS - CIS due to cultural or linguistic background	☐ 6.4	
Cannot use PAS - CIS due to sensory impairment	☐ 6.5	
Cannot use PAS - CIS due to resident's refusal to participate	☐ 6.6	
Clinical report provides supporting information for the ACFI 6 appraisal	☐ 6.7	
Psychogeriatric Assessment Scales–Cognitive Impairment Scale: enter score	☐ 6.8 ⇨	**SCORE**

Checklist must be completed

Cognitive Skills Checklist	Tick if yes
1 No or minimal impairment PAS - CIS = 0–3 (including a decimal fraction below 4) If no PAS - CIS assessment: No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care	☐ 1
2. Mild impairment PAS - CIS = 4–9 (including a decimal fraction below 10) If PAS - CIS assessment is inappropriate: May appear normal but on investigation has some problems in everyday activities. Memory and personal care: memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance) Interests: not independent in chores/ interests requiring reasoning judgement, planning etc. (i.e. cooking, use of telephone, shopping). Orientation: disorientation in unfamiliar places	☐ 2
3 Moderate impairment PAS - CIS = 10–15 (including a decimal fraction below 16) If PAS - CIS assessment is inappropriate: Has significant problems in the performance of everyday activities, requires supervision and some assistance. Memory: new material rapidly lost, only highly learned material retained Personal care: requires physical assistance with some ADLs (e.g. personal hygiene, dressing) Orientation: disorientation to time and place is likely Communication: possibly fragments of sentences, more vague	☐ 3
4 Severe impairment PAS - CIS= 16–21 If PAS - CIS assessment is inappropriate: Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions. Memory: only fragments of past events remain Personal care: requires full assistance with most or all ADLs Orientation: orientation to person only Communication: speech disturbances are common	☐ 4

ACFI 6 rating key

RATING A = yes to (item 1)
RATING B = yes to (item 2)
RATING C = yes to (item 3)
RATING D = yes to (item 4)

ACFI 7 Wandering

Description
This question relates to repeated attempts to leave the facility to enter any areas within or outside the facility where his/ her presence is unwelcome or inappropriate
–for example kitchens or other persons' rooms, or interfering while wandering in these places.

Assessment
To support a B, C or D rating in ACFI 7, a behaviour record must be completed by the facility. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the resident is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record.

If the 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.

Generally, a claim of D in ACFI 7 Wandering would not be accompanied by a D in ACFI 2 Mobility.

The ACFI appraiser will be responsible for:

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

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

Assessment Summary Table must be completed
Indicate the identified behaviour(s).

Wandering Assessment Summary	Tick if yes
No behaviour recorded	☐ 7.1
Interfering while wandering	☐ 7.2
Trying to get to inappropriate places	☐ 7.3

Checklist must be completed

Wandering Checklist	Tick if yes
Problem wandering does not occur or occurs less than once per week	☐ 1
Problem wandering occurs at least two days per week	☐ 2
Problem wandering occurs at least six days in a week	☐ 3
Problem wandering occurs twice a day or more, at least six days in a week	☐ 4

ACFI 7 rating key
RATING A = yes to (item 1)
RATING B = yes to (item 2)
RATING C = yes to (item 3)
RATING D = yes to (item 4)

ACFI 8 Verbal Behaviour

Description

This question relates to the following verbal behaviours:

a. verbal refusal of care

b. verbal disruption (not related to an unmet need)

c. paranoid ideation that disturbs others

OR

d. verbal sexually inappropriate advances directed at another person, visitor or member of staff.

Assessment

To support a B, C or D rating in ACFI 8, a behaviour record must be completed by the facility. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the resident is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record. If the 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

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

Assessment summary table must be completed
Indicate the identified behaviour(s).

Verbal Behaviour Assessment Summary	Tick if yes
No behaviours recorded	☐ 8.1
Verbal refusal of care	☐ 8.2
Verbal disruption to others	☐ 8.3
Paranoid ideation that disturbs others	☐ 8.4
Verbal sexually inappropriate advances	☐ 8.5

Checklist must be completed

Verbal Behaviour Checklist	Tick if yes
Verbal behaviour does not occur or occurs less than once per week	☐ 1
Verbal behaviour occurs at least two days per week	☐ 2
Verbal behaviour occurs at least six days in a week	☐ 3
Verbal behaviour occurs twice a day or more, at least six days in a week	☐ 4

ACFI 8 rating key
RATING A = yes to (item 1)
RATING B = yes to (item 2)
RATING C = yes to (item 3)
RATING D = yes to (item 4)

ACFI 9 Physical Behaviour

Description

This question relates to:

a. physical conduct by a resident that is threatening and has the potential to physically harm another person, visitor or member of staff or property (biting, grabbing, striking, kicking, pushing, scratching, spitting, throwing things, sexual advances, chronic substance abuse behaviours)

b. socially inappropriate behaviour that impacts on other residents (inappropriately handling things, inappropriately dressing/ disrobing, inappropriate sexual behaviour, hiding or hoarding, consuming inappropriate substances)

OR

c. being constantly physically agitated, (always moving around in seat, getting up and down, inability to sit still, performing repetitious mannerisms).

Notes

This question excludes where a person has a medical condition that might lead to injury, for example, through seizure or loss of consciousness, or where a person has a risk of falls related to poor mobility or balance, or frailty or a disease. It excludes a range of behaviours which might in the longer term be considered as damaging or health reducing such as smoking or non-compliance with a specialised diet.

Assessment

To support a B, C or D rating in ACFI 9, a behaviour record must be completed by the facility. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the resident is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record.

If the 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

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

Assessment summary table must be completed
Indicate which assessment was used and the identified behaviour(s).

Physical Behaviour Assessment Summary	Tick if yes
No behaviours recorded	☐ 9.1
Physically threatening or doing harm to self, others or property	☐ 9.2
Socially inappropriate behaviour impacts on other residents	☐ 9.3
Constantly physically agitated	☐ 9.4

Checklist must be completed

Physical Behaviour Checklist	Tick if yes
Physical behaviour does not occur or occurs less than once per week	☐ 1
Physical behaviour occurs at least two days per week.	☐ 2
Physical behaviour occurs at least six days in a week	☐ 3
Physical behaviour occurs twice a day or more, at least six days in a week	☐ 4

ACFI 9 rating key
RATING A = yes to (item 1)
RATING B = yes to (item 2)
RATING C = yes to (item 3)
RATING D = yes to (item 4)

ACFI 10 Depression

Description
This question relates to symptoms associated with depression and dysthymia (chronic mood disturbance).

Notes
It excludes behaviour which is covered in ACFI 8 Verbal Behaviour or ACFI 9 Physical Behaviour. It excludes physical illness or disability as recorded in Medical Diagnosis.

For a rating of C or D, there must be a diagnosis or provisional diagnosis of depression. Where an existing diagnosis or provisional diagnosis is not available, and the service has indicated that a diagnosis is being sought, then a conditional C or D rating, as appropriate, will be used to determine the resident's classification. A period of three months has been allowed for a service to obtain the diagnosis.

If the service is unable to provide a diagnosis or provisional diagnosis on request, then the resident's classification will be reviewed and recalculated using a rating of B for this question.

Assessment
The Cornell Scale for Depression (CSD) must be completed to appraise care needs at the B, C or D level. If this instrument has been completed for the resident in the last six months, you may use that assessment if it continues to reflect the care needs of the resident at the time of appraisal. The symptoms must impact on current care needs and require attention from a staff member. [If using the Cornell Scale with non-English speaking persons, the assessor should confer with an interpreter (this could include a family member or staff) where required to confirm any verbal signs or symptoms.]

A symptom should be recorded if it is occurring on a regular, persistent basis (reflects usual care needs). It should be observable and noted by a majority of informants on a day-to-day basis. The symptoms will be chronic, persistent and not directly related to day-to-day events in the care environment.

If there is a clinical report available that supports your rating please indicate this in the assessment summary. The Cornell Scale for Depression should still be completed. Refer to Terminology and Explanatory Notes for details about a clinical report.

If a diagnosis or provisional diagnosis of depression is available please indicate this in the assessment summary. The diagnosis/ provisional diagnosis, or reconfirmation of the diagnosis/ provisional diagnosis, should have been completed in the past twelve months. Diagnosis sources are the Aged Care Client Record (ACCR), GP comprehensive medical assessment, or other medical practitioner assessments or notes. Evidence of a diagnosis or provisional diagnosis of depression is to be documented in Mental and Behavioural Diagnosis and included in the ACFI Appraisal Pack.

Assessment summary table must be completed

Indicate whether a Cornell Scale for Depression (CSD) was undertaken and, if so, enter the score. Indicate whether a clinical report is provided.

Symptoms of Depression Assessment Summary	Tick if yes	Score
No Cornell Scale for Depression (CSD) undertaken	☐ 10.1	
Cornell Scale for Depression (CSD) –enter score	☐ 10.2	
Clinical report provided supporting information for the ACFI 10 appraisal Note: Cornell Scale for Depression must be completed	☐ 10.3	

Checklist must be completed

Symptoms of Depression Checklist	Tick if yes
CSD = 0–8 or no CSD completed Minimal symptoms or symptoms did not occur	☐ 1
CSD = 9–13 Symptoms caused mild interference with the person's ability to participate in their regular activities	☐ 2
CSD = 14–18 Symptoms caused moderate interference with the person's ability to function and participate in regular activities	☐ 3
CSD = 19–38 Symptoms of depression caused major interference with the person's ability to function and participate in regular activities	☐ 4
There is a diagnosis or provisional diagnosis of depression completed or reconfirmed in the past twelve months (diagnosis evidence required as per Mental and Behavioural Diagnosis)	☐ 5
Diagnosis or provisional diagnosis of depression being sought and will be made available on request within three months of the appraisal date	☐ 6

ACFI 10 rating key

RATING A = yes to (item 1)
RATING B = yes to (item 2)
RATING B = yes to (item 3) AND NOT (item 5 or item 6)
RATING B = yes to (item 4) AND NOT (item 5 or item 6)
RATING C = yes to (item 3) AND (item 5 or item 6)
RATING D = yes to (item 4) AND (item 5 or item 6)

ACFI 11 Medication

Description
This question relates to the needs of the person for assistance in taking medications. It relates to medication administered on a regular basis. Infrequent or irregular administration of medication(s) is not covered in this question.

Notes
For intravenous infusions and the administration of suppositories and enemas as part of bowel management see ACFI 12 Complex Health Care. Where a person is responsible for their own medication administration from a dose administration aid, this does not comprise assistance with medication for this question.

Definitions
Medication(s) refers to:

- any substance(s) listed in Schedule 2, 3, 4, 4D, 8 or 9 of the Standard for the Uniform Scheduling of Drugs and Poisons (and its amendments) and/ or
- medication(s) ordered by an authorised health professional or authorised for nurse initiated medication by a Medication Advisory Committee or its equivalent. This excludes food supplements, with or without vitamins, and emollients (e.g. sorbolene cream, aqueous cream, etc).

Authorised health professional means medical practitioner, dentist, nurse practitioner or other health professional authorised to prescribe by relevant state/ territory legislation.

Assistance means either standby (to provide physical or verbal assistance) or to provide physical assistance or extensive prompting so that the person completes the ingestion or takes medication by route ordered. There are three time periods associated with the level of assistance (less than 6 minutes, 6–11 minutes and more than 11 minutes).

Timing
For daily medications ordered by an authorised health professional, record the medication administration time in the Answer Appraisal Pack and calculate how many minutes are required for medication assistance over a 24 hour period. Time does not include preparation of medications e.g. packaging or crushing or daily administration of a subcutaneous/ intramuscular/ intravenous drug.

Administration
Does not include supervision of a resident injecting their medication.

Complete details about the evidence source in the source materials box. The evidence is the most recent medication chart or record completed within the last twelve months. Completion includes that the source document identifies the name and profession of the health professional who has undertaken the document and it must be signed and dated by that person.

Source materials

Medication chart to be filed with ACFI Appraisal Pack
Name of person(s) authorising medication(s)
Profession
Date completed

Completing the checklist is required

Medication Checklist	Tick if yes
No medication	☐ 1
Self-manages medication	☐ 2
Application of patches at least weekly, but less frequently than daily	☐ 3
Needs assistance for less than 6 minutes per 24 hour period with daily medications	☐ 4
Needs assistance for between 6 and 11 minutes per 24 hour period with daily medications	☐ 5
Needs assistance for more than 11 minutes per 24 hour period with daily medications	☐ 6
Needs daily administration of a subcutaneous drug	☐ 7
Needs daily administration of an intramuscular drug	☐ 8
Needs daily administration of an intravenous drug	☐ 9

ACFI 11: rating key

RATING A = yes to (item 1) or (item 2)
RATING B = yes to (item 3) or (item 4)
RATING C = yes to (item 5)
RATING D = yes to (item 6) or (item 7) or (item 8) or (item 9)

ACFI 12 Complex Health Care

Description
This question relates to the assessed need for ongoing complex health care procedures and activities. It excludes temporary nursing interventions e.g. management of temporary post-surgical catheters or stomas, management of minor injuries or acute illnesses such as colds/ flu.

The ratings in this question relate to the technical complexity and frequency of the procedures.

Only the stated procedures or health care needs that have been identified in a directive (that may include an assessment) by a registered nurse including nurse practitioner, or other appropriate medical or health professional, are taken into account. Identify the procedure required in relation to usual (not exceptional) care needs and record the frequency of this procedure. Where a minimum frequency is specified as 'at least weekly' and a frequency is less than this, it is not taken into account in calculating a rating.

A **nurse practitioner directive** refers to a nursing directive by a nurse practitioner that describes the complex health care procedure to be performed and the associated management and/ or treatment plan.

A **registered nurse directive** refers to a nursing directive by a nurse practitioner or registered nurse that describes the complex health care procedure to be performed and the associated management and/ or treatment plan.

A **medical practitioner directive** refers to a medical directive by a general or specialist medical practitioner or a consultant physician that describes the complex health care procedure to be performed and the associated management and/ or treatment plan.

An **allied health professional directive** refers to a directive by a chiropodist or podiatrist, chiropractor, dietitian, osteopath, physiotherapist, occupational therapist or speech pathologist that describes the complex health care procedure to be performed and the associated management and/ or treatment plan. The allied health professional must be appropriately qualified to develop the directive for that procedure.

Where the management and practice is to be undertaken by an allied health professional as listed above in the description of allied health professional directive, the allied health professional must be acting within their scope of practice.

Pain Management Assessments
To support claims under ACFI 12.3, 12.4a and 12.4b you are required to use an evidence based pain assessment tool. (A list of suggested tools can be found at www.health.gov.au/acfi)

Complex Pain Management
Under **item 4a** Complex Health Care, a directive that describes the complex pain management to be performed must be given by a registered nurse or a medical practitioner or an allied health professional included on the list of allied health professionals. Under item 4a, a registered nurse or an allied health professional may provide complex pain management and practice.

Under **Item 4b** pain management services would need to be provided by a listed allied health professional and the directive given by a medical practitioner or listed allied health professional.

It is permissible for the service to be provided by a different health professional than the one who gave the directive, provided they are included in the list of health professionals who can undertake the service and are operating within their scope of practice.

Under **Item 4b** to meet this requirement consistent **ongoing** treatment must be provided as required by the resident.

'Technical equipment designed specifically for pain management' refers to electro-therapeutic equipment such as TENS, interferential therapy, ultrasonic therapy, laser therapy and wax baths, The Department of Health and Ageing does not maintain an exhaustive list of equipment that can be included as this is subject to change over time.

ACCR is the Aged Care Client Record.

Where indicated, a Commonwealth review officer may request to see a record of treatment.

Note: A record of the treatment should be kept as long as the treatment is being provided in accordance with its directive.

Complete all complex health care procedures relevant to the resident

Score	Complex health care procedures	Requirements	Tick if yes
3	Blood pressure measurement for diagnosed hyper/ hypotension is a usual care need AND frequency at least daily	1. Medical practitioner directive AND on request: record	☐ 1
3	Blood glucose measurement for the monitoring of a diagnosed medical condition e.g. diabetes, is a usual care need AND frequency at least daily	1. Medical practitioner directive AND on request: record	☐ 2
1	Pain management involving therapeutic massage or application of heat packs AND Frequency at least weekly AND Involving at least 20 minutes of staff time in total	1. Directive [registered nurse or medical practitioner or allied health professional] AND 2. Evidence based pain assessment AND on request: record	☐ 3
3	Complex pain management and practice undertaken by an allied health professional or registered nurse. This will involve therapeutic massage and/ or pain management involving technical equipment specifically designed for pain management AND Frequency at least weekly AND Involving at least 20 minutes of staff time in total. You can only claim one item 4–either 4a or 4b	1. Directive [registered nurse or medical practitioner or allied health professional] AND 2. Evidence based pain assessment AND on request: record	☐ 4a
6	Complex pain management and practice undertaken by an allied health professional. This will involve therapeutic massage and/ or pain management involving technical equipment specifically designed for pain management AND Ongoing treatment as required by the resident, at least 4 days per week You can only claim one item 4–either 4a or 4b.	1. Directive [medical practitioner or allied health professional] AND 2. Evidence based pain assessment AND on request: record	☐ 4b
3	Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/ or chair or cannot self ambulate. The management plan must include repositioning at least 4 times per day.	1. Directive [registered nurse or medical practitioner or allied health professional] AND 2. Skin integrity assessment	☐ 5
3	Management of special feeding undertaken by an RN, on a one-to-one basis, for people with severe dysphagia, excluding tube feeding. Frequency at least daily.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional] AND 3. Swallowing assessment	☐ 6

Score	Complex health care procedures	Requirements	Tick if yes
1	Administration of suppositories or enemas for bowel management is a usual care need. The minimum required frequency is 'at least weekly'.	1. Directive [registered nurse or medical practitioner] AND on request: record	☐ 7
3	Catheter care program (ongoing); excludes temporary catheters e.g. short term post surgery catheters.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner]	☐ 8
6	Management of chronic infectious conditions • Antibiotic resistant bacterial infections • Tuberculosis • AIDS and other immune-deficiency conditions • Infectious hepatitis	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner]	☐ 9
6	Management of chronic wounds, including varicose and pressure ulcers, and diabetic foot ulcers.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional] AND 3. Wound assessment AND on request: record	☐ 10
6	Management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis.	1. Directive/ prescription [authorised nurse practitioner or medical practitioner]	☐ 11
3	Management of oedema, deep vein thrombosis or arthritic joints or chronic skin conditions by the fitting and removal of compression garments, compression bandages, tubular elasticised support bandages, dry dressings and/ or protective bandaging.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional]	☐ 12
3	Oxygen therapy not self managed.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner]	☐ 13
10	Palliative care program involving end of life care where ongoing care will involve very intensive clinical nursing and/ or complex pain management in the residential care setting.	1. Directive by [3]CNC/ CNS in pain or palliative care or medical practitioner AND 2. Pain assessment	☐ 14

[3]CNC (clinical nurse consultant) / CNS (clinical nurse specialist) is a registered nurse who has at least five years full time equivalent post registration experience and approved post-registration nursing qualifications in the specialty fields of pain and/ or palliative care.

Score	Complex health care procedures	Requirements	Tick if yes
1	Management of ongoing stoma care. Excludes temporary stomas e.g. post surgery. Excludes supra pubic catheters (SPCs)	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner]	☐ 15
6	Suctioning airways, tracheostomy care.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner]	☐ 16
6	Management of ongoing tube feeding.	1. Diagnosis or ACCR AND 2. Directive [registered nurse or medical practitioner or allied health professional]	☐ 17
3	Technical equipment for continuous monitoring of vital signs including Continuous Positive Airway Pressure (CPAP) machine.	1. Directive [registered nurse or medical practitioner] AND on request: record	☐ 18

ACFI 12 rating key

RATING A = score of 0 (no procedures)
RATING B = score of 1–4
RATING C = score of 5–9
RATING D = score of 10 or more

Appendix 1: ACAP code list for health condition–long

[From the AIHW web site: http://www.aihw.gov.au/publications/index.cfm/title/8127]

Certain infectious and parasitic diseases

0101	Tuberculosis
0102	Poliomyelitis
0103	HIV/ AIDS
0104	Diarrhoea and gastroenteritis of presumed infectious origin
0199	Other infectious and parasitic diseases n.o.s. or n.e.c. (includes leprosy, listeriosis, scarlet fever, meningococcal infection, septicaemia, viral meningitis)

Neoplasms (tumours/ cancers)

0201	Head and neck cancer
0202	Stomach cancer
0203	Colorectal (bowel) cancer
0204	Lung cancer
0205	Skin cancer
0206	Breast cancer
0207	Prostate cancer
0208	Brain cancer
0209	Non-Hodgkin's lymphoma
0210	Leukaemia
0211	Other malignant tumours n.o.s. or n.e.c.
0299	Other neoplasms (includes benign tumours and tumours of uncertain or unknown behaviour)

Diseases of the blood and blood forming organs and immune mechanism

0301	Anaemia
0302	Haemophilia
0303	Immunodeficiency disorder (excluding AIDS)
0399	Other diseases of blood and blood forming organs and immune mechanism n.o.s. or n.e.c.

Endocrine, nutritional and metabolic disorders

0401	Disorders of the thyroid gland (includes iodine-deficiency syndrome, hypothyroidism, hyperthyroidism, thyroiditis)
0402	Diabetes mellitus–type 1 (IDDM)
0403	Diabetes mellitus–type 2 (NIDDM)
0404	Diabetes mellitus–other specified/ unspecified/unable to be specified
0405	Malnutrition
0406	Nutritional deficiencies
0407	Obesity
0408	High cholesterol
0499	Other endocrine, nutritional and metabolic disorders n.o.s. or n.e.c. (includes hypoparathyroidism, Cushing's syndrome)

Mental and behavioural disorders

See Mental and Behavioural Diagnosis Checklist

Diseases of the nervous system

0601	Meningitis and encephalitis (excluding 'viral')
0602	Huntington's disease
0603	Motor neurone disease
0604	Parkinson's disease (includes Parkinson's disease, secondary Parkinsomism)
0605	Transient cerebral ischaemic attacks (T.I.A.s)[2]
0606	Brain disease/ disorders (includes senile degeneration of brain n.e.c., degeneration of nervous system due to alcohol, Schilder's disease)
0607	Multiple sclerosis
0608	Epilepsy
0609	Muscular dystrophy
0610	Cerebral palsy
0611	Paralysis-non-traumatic (includes hemiplegia, paraplegia, quadriplegia, tetraplegia and other paralytic syndromes, e.g. diplegia and monoplegia; excludes spinal cord injury code 1699)
0612	Chronic/ postviral fatigue syndrome

0699 Other diseases of the nervous system n.o.s. or n.e.c. (includes dystonia, migraines, headache syndromes, sleep disorders e.g. sleep apnoea and insomnia, Bell's palsy, myopathies, peripheral neuropathy, dysautonomia)

Diseases of the eye and adnexa

0701 Cataracts

0702 Glaucoma

0703 Blindness (both eyes, one eye, one eye and low vision in other eye)

0704 Poor vision (low vision both eyes, one eye, unspecified visual loss)

0799 Other diseases of the eye and adnexa n.o.s or n.e.c (includes conjunctivitis)

Disease of the ear and mastoid process

0801 Ménière's disease (includes Ménière's syndrome, vertigo)

0802 Deafness/ hearing loss

0899 Other diseases of the ear and mastoid process n.o.s. or n.e.c. (includes disease of external ear, otitis media, mastoiditis and related conditions, myringitis, otosclerosis, tinnitus)

Diseases of the circulatory system

0900 Heart disease

0901 Rheumatic fever

0902 Rheumatic heart disease

0903 Angina

0904 Myocardial infarction (heart attack)

0905 Acute and chronic ischaemic heart disease

0906 Congestive heart failure (congestive heart disease)

0907 Other heart diseases (pulmonary embolism, acute pericarditis, acute and subacute endocarditis, cardiomyopathy, cardiac arrest, heart failure–unspecifed)

0910 Cerebrovascular disease[2,3]

0911 Subarachnoid haemorrhage[2,3]

0912 Intracerebral haemorrhage[2,3]

0913 Other intracranial haemorrhage[2,3]

0914 Cerebral infarction[2,3]

0915 Stroke (CVA)–cerebrovascular accident unspecified[2,3]

0916 Other cerebrovascular diseases[2] (includes embolism, narrowing, obstruction and thrombosis of basilar, carotid, vertebral arteries and middle, anterior, cerebral arteries, cerebellar arteries not resulting in cerebral infarction)

0920 Other diseases of the circulatory system

0921 Hypertension (high blood pressure)

0922 Hypotension (low blood pressure)

0923 Abdominal aortic aneurysm

0924 Other arterial or aortic aneurysms (includes thoracic, unspecified, aneurysm of carotid artery, renal artery, unspecified)

0925 Atherosclerosis

0999 Other diseases of the circulatory system n.o.s. or n.e.c. (includes other peripheral vascular disease, arterial embolism and thrombosis, other disorders of arteries and arterioles, diseases of capillaries, varicose veins, haemorrhoids)

Diseases of the respiratory system

1001 Acute upper respiratory infections (includes common cold, acute sinusitis, acute pharyngitis, acute tonsillitis, acute laryngitis, upper respiratory infections of multiple and unspecified sites)

1002 Influenza and pneumonia

1003 Acute lower respiratory infections (includes acute bronchitis, bronchiolitis and unspecified acute lower respiratory infections)

1004 Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis and sinusitis, chronic diseases of tonsils and adenoids)

1005 Chronic lower respiratory diseases (includes emphysema, chronic obstructive airways disease (COAD), asthma)

1099 Other diseases of the respiratory system n.o.s. or n.e.c.

Diseases of the digestive system

1101 Diseases of the intestine (includes stomach/ duodenal ulcer, abdominal hernia (except congenital), enteritis, colitis, vascular disorders of intestine, diverticulitis, irritable bowel syndrome, diarrhoea, constipation)

1102 Diseases of the peritoneum (includes peritonitis)

1103 Diseases of the liver (includes alcoholic liver disease, toxic liver disease, fibrosis and cirrhosis of liver)

1199 Other diseases of the digestive system n.o.s. or n.e.c. (includes diseases of oral cavity, salivary glands and jaws, oesophagitis, gastritis and duodenitis, cholecystitis, other diseases of gallbladder, pancreatitis, coeliac disease)

Diseases of the skin and subcutaneous tissue

1201 Skin and subcutaneous tissue infections (includes impetigo, boil, cellulitis)

1202 Skin allergies (dermatitis and eczema)

1299 Other diseases of the skin and subcutaneous tissue n.o.s. or n.e.c. (includes bedsore, urticaria, erythema, radiation-related disorders, disorders of skin appendages)

Diseases of the musculoskeletal system and connective tissue

1301 Rheumatoid arthritis

1302 Other arthritis and related disorders (includes gout, arthrosis, osteoarthritis)

1303 Deformities of joints/ limbs–acquired

1304 Back problems–dorsopathies (includes scoliosis)

1305 Other soft tissue/ muscle disorders (includes rheumatism)

1306 Osteoporosis

1399 Other disorders of the musculoskeletal system and connective tissue n.o.s. or n.e.c. (includes osteomyelitis)

Diseases of the genitourinary system

1401 Kidney and urinary system (bladder) disorders (includes nephritis renal failure, cystitis; excludes urinary tract infection and incontinence)

1402 Urinary tract infection

1403 Stress/ urinary incontinence (includes stress, overflow, reflex and urge incontinence)

1499 Other diseases of the genitourinary system n.o.s. or n.e.c. (includes prostate, breast and menopause disorders, urinary incontinence (stress, overflow, reflex, urge)

Congenital malformations, deformations and chromosomal abnormalities

1501 Spina bifida

1502 Deformities of joints/ limbs–congenital

1503 Down's syndrome

1504 Other chromosomal abnormalities

1505 Congenital brain damage/ malformation

1599 Other congenital malformations and deformations n.o.s. or n.e.c.

Injury, poisoning and certain other consequences of external causes

1601 Injuries to the head (includes injuries to ear, eye, face, jaw, acquired brain damage)

1602 Injuries to arm/ hand/ shoulder (includes, dislocations, sprains and strains)

1603 Injuries to leg/ knee/ foot/ ankle/ hip (includes dislocations, sprains and strains)

1604 Amputation of the finger/ thumb/ hand/ arm/ shoulder–traumatic

1605 Amputation of toe/ ankle/ foot/ leg –traumatic

1606 Fracture of neck (includes cervical spine and vertebra)

1607 Fracture of rib(s), sternum and thoracic spine (includes thoracic spine and vertebra)

1608 Fracture of lumbar spine and pelvis (includes lumbar vertebra, sacrum, coccyx, sacrum)

1609 Fracture of shoulder, upper arm and forearm (includes clavicle, scapula, humerus, radius, ulna)

1610 Fracture at wrist and hand level

1611 Fracture of femur (includes hip (neck of femur)

1612 Fracture of lower leg and foot

1613	Poisoning by drugs, medicaments and biological substances (includes systemic antibiotics, hormones, narcotics, hallucinogens, analgesics, antipyretics, antirheumatics, antiepileptic, antiparkinsonism drugs, includes overdose of the above substances)
1699	Other injury, poisoning and consequences of external causes n.o.s. or n.e.c. (including all other injuries to the body, spinal cord injury, multiple fractures, unspecified dislocations, sprains, strains, fractures, burns, frostbite, toxic effects of substances of nonmedical source, complications of surgical and medical care)

Symptoms and signs n.o.s or n.e.c[4]

1701	Abnormal blood-pressure reading, without diagnosis
1702	Cough
1703	Breathing difficulties/ shortness of breath
1704	Pain
1705	Nausea and vomiting
1706	Dysphagia (difficulty in swallowing)
1707	Bowel/ faecal incontinence
1708	Unspecified urinary incontinence
1709	Retention of urine
1710	Jaundice (unspecified)
1711	Disturbances of skin sensation (includes pins and needles, tingling skin)
1712	Rash and other nonspecific skin eruption
1713	Abnormal involuntary movements (includes abnormal head movements, tremor unspecified, cramp and spasm, twitching n.o.s)
1714	Abnormalities of gait and mobility (includes ataxic and spastic gait, difficulty in walking n.e.c)
1715	Falls (frequent with unknown aetiology)
1716	Disorientation (confusion)
1717	Amnesia (memory disturbance, lack or loss)
1718	Dizziness and giddiness (light-headedness, vertigo n.o.s.)
1719	Restlessness and agitation
1720	Unhappiness (worries n.o.s.)
1721	Irritability and anger
1722	Hostility
1723	Physical violence
1724	Slowness and poor responsiveness
1725	Speech and voice disturbances
1726	Headache
1727	Malaise and fatigue (includes general physical deterioration, lethargy and tiredness)
1728	Blackouts, fainting, convulsions
1729	Oedema n.e.c. (includes fluid retention n.o.s.)
1730	Symptoms and signs concerning food and fluid intake (includes loss of appetite, excessive eating and thirst, abnormal weight loss and gain)
1799	Other symptoms and signs n.o.s. or n.e.c. (includes gangrene, haemorrhage from respiratory passages, heartburn, disturbances of smell and taste, enlarged lymph nodes, illness n.o.s.)
1899	Has other health condition not elsewhere specified

n.e.c. not elsewhere classified

n.o.s. not otherwise specified

[1] In any analysis of 'diseases of the nervous system' code 0500 'dementia in Alzheimer's disease' should be grouped with 0600

[2] In any analysis of 'cerebrovascular disease' code 0605 transient cerebral ischaemic attacks (TIAs) should be grouped with 0910

[3] Transient cerebral ischaemic attacks (TIAs) should be coded to 0605

[4] These codes should only be used to record certain symptoms that represent important problems in their own right, regardless of whether a related diagnosed disease or disorder is also reported

Appendix 2–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

Note: This information can also be found on page 6 of the Assessment Pack

Appendix 3–Interaction of the Aged Care Funding Instrument and the funding model