Evidence-Based Clinical Assessment Toolkit (EBCAT)

Introductory Guide

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Acronyms and Glossary

ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
BAF	Behavioural Assessment Form
BCOPE	Best Care For Older People Everywhere
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CCF	Care Continuum Framework
CDAMS	Cognitive, Dementia and Memory Service
CDC	Consumer Directed Care
CHA	Comprehensive Health Assessment (CHA) for Older People in the Health Care System
CHAOP	Comprehensive Health Assessment of the Older Person
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence Based Clinical Assessment Toolkit
EBCAT Topics	1. Nutrition; 2. Mobility; 3. Self Care (Personal Hygiene, Toileting) 4. Continence 5. Cognition 6. Behavioural Expressions (Wandering, Verbal & Physical, Mood) 7. Medicines 8. Pain; 9. Swallowing; 10. Skin & Wounds
EBCAT Workbooks	The toolkit is presented in six 'user friendly educational Workbooks' to walk the user through the process of using evidence-based clinical assessment tools for each domain of: • ADL Workbook (Topics 1-3) • Continence Workbook (Topic 4)

	• Cognition Workbook (Topic 5) • Behavioural Expressions Workbook (Topic 6) • Medicine Workbook (Topic 7) • Complex Health Workbook (Topic 8-10)
FRAT	Falls Risk Assessment Tool
GP	General Practitioner
IPA	International Psychogeriatric Association
KICA-Cog	Kimberley Indigenous Cognitive Assessment
MP	Medical Practitioner
M-VRBPI	Modified Resident Verbal Brief Pain Inventory
NATFRAME	National Framework for Documenting Care in Residential Aged Care Services http://webarchive.nla.gov.au/gov/20140803082152/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm
NCD	Neuro-Cognitive Disorder
NPI-NH	Neuro-Psychiatric Inventory for Nursing Homes
NRS	Numeric Pain Rating Scale
PAINAID	Pain Assessment in Advanced Dementia
PAS-CIS	Psychogeriatric Assessment Scales- Cognitive Impairment Scale
PCC	Person Centred Care
PMS	Physical Mobility Scale
PSRACS	Public Sector Residential Aged Care Services
QoC	Quality of Care
QoL	Quality of Life
RACF	Residential Aged Care Facilities
RNDC	Resident Nutrition Data Card
ROM	Range Of Movement
RUDAS	Rowland Universal Dementia Assessment Scale
SCP	Standardised Care Process
SCORE	Strengthening Care Outcomes for Residents with Evidence
VDS	Verbal Descriptor Scale

Acknowledgements

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Additional content matter expertise was provided to assist with the development of the materials. Applied Aged Care Solutions (AACS) worked with:

La Trobe University

Dr Deirdre Fetherstonhaugh (Director, Senior Research Fellow), Dr Michael Bauer (Senior Research Fellow) and Dr. Margaret Winbolt (Senior Research Fellow, Director Victoria and Tasmania Dementia Training Study Centre) from the Australian Centre for Evidence Based Aged Care (ACEBAC), Australian Institute for Primary Care and Ageing (AIPCA), La Trobe University provided feedback on the EBCAT framework and the process content of the workbooks (ADL, Continence, Medicines and Complex Health Workbooks).

Monash University

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PRACS Leadership Group

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Other Contributors

We would also like to thank Professor Rhonda Nay for her expert assistance. Professor Nay reviewed the Complex Health Workbook.

Chapter 1: Introduction

1.1 Purpose of the Introductory Guide

The Introduction Guide is a resource for the organisation's Nursing Management team. It is designed to provide the Nursing Management team with a guide to their role in the implementation of the Evidence-Based Clinical Assessment Toolkit (EBCAT). It also provides a description of the toolkits fundamental aspects.

As the same format and structure is used throughout all the EBCAT Workbooks, the Introduction Guide presents the background to the development of this structure and justification for the steps taken. A descriptive outline and visual overview of the six Workbooks, Assessment Packs and Quick Guides is presented along with an explanation of how they should be used and by whom to ensure effective implementation.

The Introduction Guide;

- Describes the benefits of the Evidence-Based Clinical Assessment Toolkit (EBCAT)
- Describes the aims of the EBCAT including topics such as:
    - Selecting evidence informed assessments
    - Meeting the ACFI requirements and the broader healthcare needs
    - Following a nursing care continuum process
    - The development of an accountable documentation system
    - Provision of an evidence informed rationale for the care required
- Provides an overview of the EBCAT methodology covering:
    - Principles
    - Framework
    - Phases
- Describes the Toolkit products
- Describes the Nursing Management role with toolkit implementation
- Provides an Administration Checklist to assess for readiness to implement the toolkit and to audit the toolkit process.

1.2 The Benefits of Using the EBCAT

During 2013, the Australian Government made changes to the Aged Care Funding Instrument (ACFI) requiring further evidence to support funding claims made by services for the activities of daily living and pain. In addition, more stringent penalties for providers with inaccurate or misleading ACFI appraisals were introduced from 1 July 2013. These changes highlighted the importance of robust documentation and evidence.

The Evidence-Based Clinical Assessment Toolkit (EBCAT) develops a clear linkage between the assessment process, a documentation system which is accountable, accurate and robust funding claims and quality care outcomes.

The toolkit collates evidence informed assessment and documentation approaches from a selection of Australian resources. It provides practical guidance, flowcharts, and process maps to assist the users and it encourages beyond compliance practices.

The set of six EBCAT Workbooks will support your facility to meet broader healthcare needs, ACFI evidence requirements and support the provision of quality care based on a robust documentation process and system.

1.3 The Aims of the EBCAT

The aim of the Evidence Based Clinical Assessment Toolkit (EBCAT) was to develop a clear linkage between assessment processes, clinical documentation, funding needs, quality care processes and outcomes. The Toolkit is designed to assist Public Sector Residential Aged Care Services (PSRACS) staff to systematically and consistently determine and manage resident care needs, by:

- Providing appropriate evidence informed tools to both meet the ACFI requirements and provide a comprehensive assessment of those care needs.
- Providing an evidence informed practice approach to care delivery, with the goals of improving the clinical and quality of life for the residents.
- Providing accountability for government regulators.
- Using evidence informed practices to drive the toolkit, with accurate and robust ACFI claiming flows ***from*** the successful use of the Toolkit.

The aims were met by:

  - Selecting evidence informed assessments
  - Meeting the ACFI requirements and the broader healthcare needs
  - Following a nursing care continuum process

- Producing an accountable documentation system
- Providing an evidence informed rationale for the care required

1.3.1 Evidence-based assessments

While the ACFI assessment pack determines some mandatory evidence informed assessments, there are other domains that do not have specified assessments, but have a requirement for an evidence informed tool. To meet the new ACFI requirements, the EBCAT provides assessments for the topics of nutrition, mobility, self-care and pain.

There are also other assessment tools that have been suggested in the toolkit to provide a broad and comprehensive coverage of all topics.

1.3.2 Assessment and funding documentation requirements

The toolkit demonstrates how to use the evidence (as collected following the toolkit instructions) to both meet the funding requirements in regard to the assessment evidence for the ACFI care domains and for the broader assessment of healthcare needs.

1.3.3 Care continuum process

It was important that the toolkit demonstrated how the assessment process would fit into the current nursing process. That is across the care continuum, because assessment is part of a continuous process from the admission point, to comprehensively assessing across the care needs, to developing the care plan, through to monitoring and evaluating the care plan throughout the stay of the resident as their needs change.

1.3.4 Accountable documentation system

Documentation of care is essential because all members of the staff are accountable to each resident for their actions and decisions. Accountability is also a vital function of professional, legal, accreditation and funding mechanisms and processes.

Documentation is a communication tool about what has been investigated and the information collected, what interventions have been tried for a particular problem with a particular resident and to identify what is and isn't working. Documentation should inform all staff on the current care needs, indicate clearly what is being done, provide the evidence of the effectiveness of care provision and direct the rationale for changes that may be needed. It provides the underlying basis for the best possible care delivery for each resident.

Good documentation supports the nursing process which drives the care delivered to residents. It should incorporate evidence informed practices, assessments and interventions,

utilise staff skills and enhance a quality care approach. The ACFI is an outcome of the documentation process, not the driver.

Good documentation provides an objective and transparent record for the reason that assistance is or is not required. The documentation should provide objective evidence to support the assessment and the associated actions. It should provide an objective description of why the care is needed, what care is provided and how the care outcomes will be evaluated.

1.3.5 Evidence-based rationale

An evidence informed approach to assessment and documentation should result in decisions that are accountable by:

(i) Linking the care decisions and care planning to the evidence informed information that has been collected (through the collation of information from documentation, interviews with the resident and their family, and the undertaking of assessments).

(ii) Linking the ACFI claims to the evidence-based information to provide accurate, robust and defendable claiming.

This was achieved by the development of a standardised approach based on the WHO definition of disability[1] ; it demonstrates how to link;

- The evidence based on diagnoses, clinical and personal history, and assessment outcomes, to an
- Impairment (problems in body function or structures), then to the
- Impact on the person's ability to execute and participate in everyday activities.

The evidence profile describes the type of evidence (e.g. diagnosis) and what aspects of care need it covers (e.g. dementia and subsequent memory impairment). The evidence profile provides the underlying basis for the care needed by the resident, and this helps support the reasons for the ACFI claim. The documentation trail is completed by identifying the source of the information. With a documentation trail in place, the facility is audit ready.

For example;

- A diagnosis of a right sided CVA (the source document is a Comprehensive Medical Assessment dated 01/01/2014), an identified moderate falls risk (the source document is the FRAT dated 02/01/2014), an impaired left sided movement (the source document was a Range of Movement assessment dated 05/01/2014), and

[1] www.aihw.gov.au/disability/technical-defintions-of-disability/

physiotherapy recommended mobility aid - 4 wheel frame- (the source document was a Physiotherapist Report dated 06/01/2014)

- The upper and lower left limbs, and the mobility function are impacted
- Resulting in impaired mobility, unstable gait and an on-going falls risk

This evidence is then used to identify strategies, assistance required and aids. Strategies (to address both clinical and quality of life issues) are developed to address the activity limitation and are included in the Care Plan.

- For example, the resident is to use a mobility aid (4 wheel frame) when walking in bedroom and outside of bedroom, the physiotherapist has documented that the resident requires staff supervision when mobilising with his/her mobility aid.

The strategies can then be turned into a number of goals in collaboration with the resident and the family. Goals give purpose to the care and provide a measurement basis for evaluating the strategies.

This type of evidence rationale shows a direct link between the evidence and the level of assistance required, it also incorporates the principles of Person Centred Care and consumer participation by involving the consumer throughout the process.

The intended outcome is to provide a transparent rationale for why the resident does or does not require a specific type of assistance, and to show where the information has come from to inform on this decision. The evidence can then deliver accurate, robust and the best possible ACFI claims.

Chapter 2: Methods to develop the EBCAT

2.1 Activities

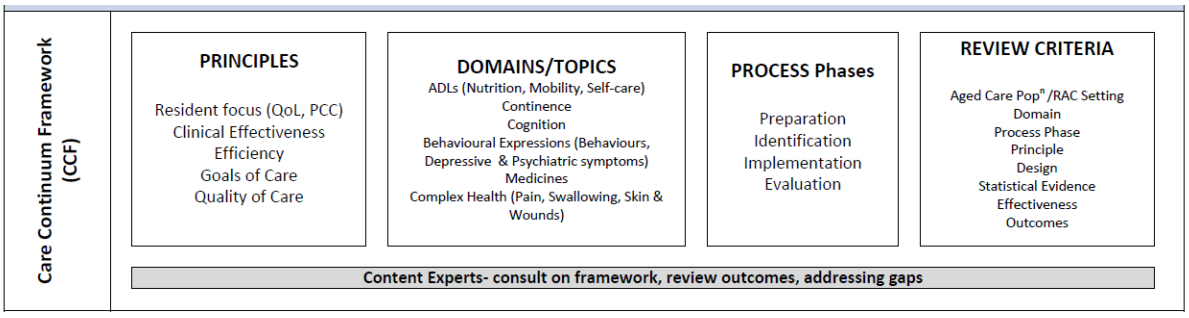
There were a number of activities in the development of the Evidence Based Clinical Assessment Toolkit (EBCAT). These included:

1. A systematic framework (Figure 2.1) and review template was developed in collaboration with the other content experts. The framework was developed to underpin the methodology of the Evidence Based Clinical Assessment Toolkit (EBCAT) to ensure that the selected tools fitted into a comprehensive and evidence informed nursing approach.

⇨ The framework covered:

- The development of **principles** to guide the selection and development of assessment tools and process guides
- The selection of **domains** based on ACFI topics that required assessments, to ensure the ACFI evidence requirement changes were covered.
- The **EBCAT process** being divided into **four phases** spanning the care continuum – preparation, identification, implementation and evaluation.
- The development of a **systematic review template** to ensure a consistent and accountable tool selection approach.

Figure 2.1: The Framework



2. A set of Australian resources were collated. A detailed list of the resources that underpinned the toolkit development is presented in each relevant workbook appendix. Twenty-five resources were identified as core documents to be included in the toolkit. These resources formed the starting point to the review process and the basis to the toolkit development. The core resources included were:

- ACFI resources e.g., ACFI User guide, ACFI Assessment Pack
- Australian Assessment Toolkits e.g., Best Care for Older People Everywhere. The Toolkit (2012), Best Practice Approaches to Minimise the Functional Decline in the Older Person (2007), A Guide for Assessing Older People in Hospital (2004), National Framework for Documenting Care in Residential Aged Care Services, PMG Pain Kit
- Victorian assessment tools developed for PSRACS e.g., SCORE Standardised Care Processes (SCPs), Comprehensive Health Assessment of the Older Person (CHAOP)
- Neuropsychiatric Inventory for Nursing Homes (NPI-NH)

3. A systematic review of the resources, to ensure a consistent and accountable selection approach of EBCAT materials.

All resources were systematically reviewed using a specifically designed review template. This ensured an objective, transparent and accountable process. The review process included:

Checking the relevance of the resource

- Did it meet the target population and setting (residential aged care), and planned users (nurses)
- What topic did it address
- What process did it address e.g., preparation, identification, implementation, evaluation

Reviewing the depth of the content and applicability of the resource against the care continuum phases (identification, implementation and evaluation)

- Purpose
- Administration guidelines
- Outcomes
- Feasibility

Reviewing the design and psychometric qualities of the resource

- Design strength
- Statistical evidence
- Evaluation strengths

4. A mapping of the reviews to broadly assess the extent to which the resources addressed the three care continuum phases (Identification, Implementation and Evaluation). The aim of the review mapping was to facilitate a succinct overview of each resource's contribution and the identification of gaps in the comprehensive assessment approach.

5. Filling the identified gaps using further targeted literature reviews covering an additional 33 resources which included:

- Assessment approaches to behaviours, mood and psychiatric symptomology e.g., IPA Guidelines for BPSD, Dementia Outcomes Measures Study, DSM-5, DTSC website, DCRC website
- Swallowing resources, Skin and Wound management resources
- Continence Tools for Residential Aged Care Services

6. Filling the identified gaps by developing practical guidance and visual tools to assist the toolkit user. For example the workbooks include:

- Flow charts to show the suggested process
- Case studies to provide practical examples
- How to keep track of the documentation and use the documentation to provide robust evidence; and
- How to complete the ACFI requirements with objective evidence

7. Development of the products:

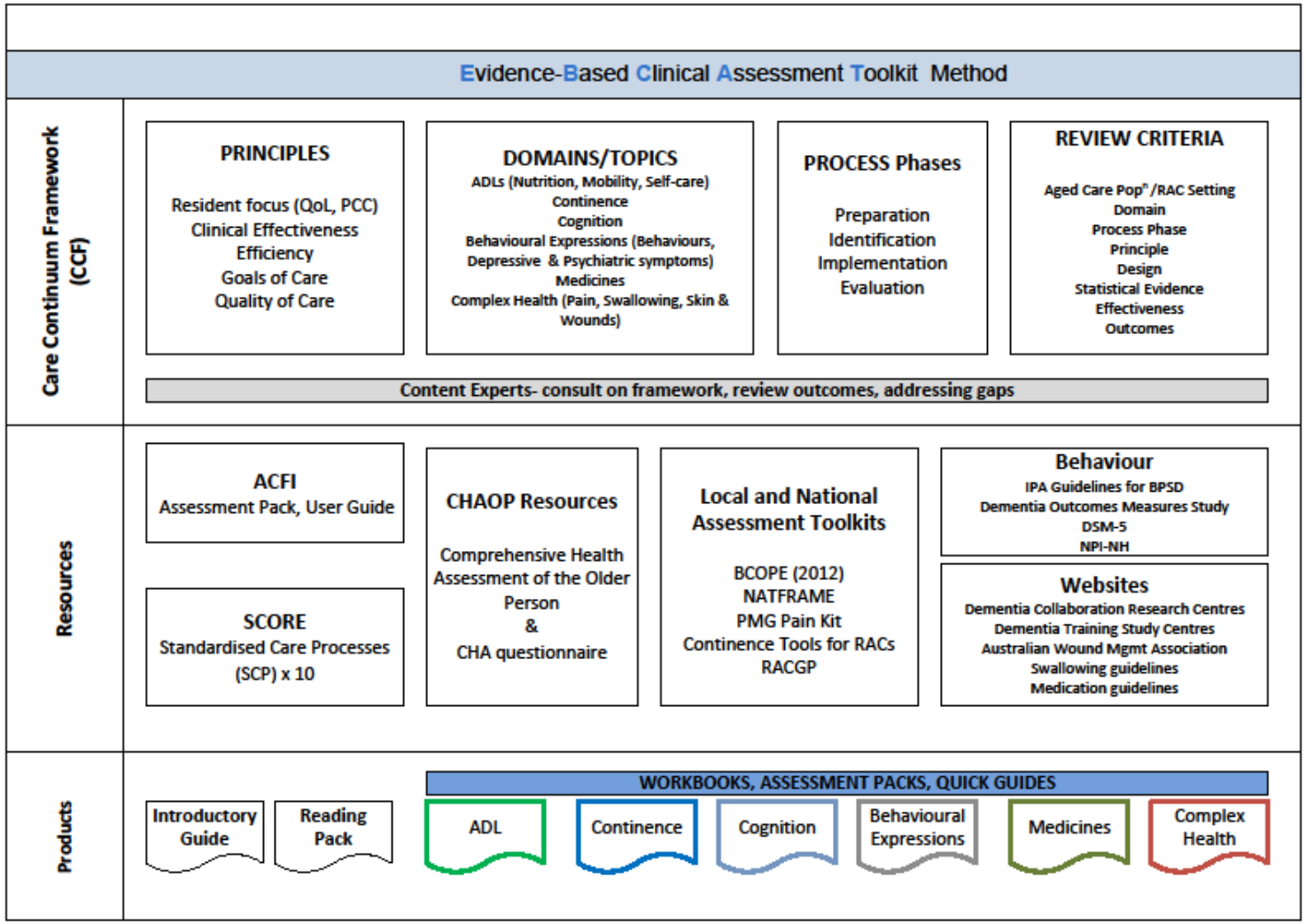
- Introductory Guide
- Reading Pack
- Six Workbooks, six Assessment Packs, and six Quick Guides covering
    - Activities of Daily Living (Nutrition, Mobility, Self-care)
    - Continence
    - Cognition
    - Behavioural Expressions (Behaviours, Depressive and Psychiatric symptoms)
    - Medicines
    - Complex Health (Pain, Swallowing, Skin and Wounds)

8. Toolkit Workshop for the purpose of receiving feedback from the PSRACS on the toolkit process and products

9. Final development of the Evidence Based Clinical Assessment Toolkit

The EBCAT framework, resources, products and activities are summarised in Figure 2.2. Please refer to the Final Report for specific details of the activities summarised in 1 to 9 above.

Figure 2.2: EBCAT Framework, Resources, Products and Activities



2.2 EBCAT Principles

The care continuum principles were selected to reflect quality practices in the care of older people in residential aged care.

2.2.1 Resident focus

The toolkit focuses not only on **quality of care**, but also the resident's **quality of life**, and supports the principles of Consumer Directed Care (CDC) and Person Centred Care (PCC).

Person-centred care places the individual at the centre of the care process through collaboration between the provider/staff and the resident. This is aimed at delivering a level of care that matches individual need, promotes independence, and respects client input and differences such as roles, culture and relationships.

2.2.2 Clinical effectiveness

This principle promotes the application of quality care practices and professional standards. By ensuring the assessments and interventions are evidence informed, have an objective basis, and are practical they will support accurate, reliable and consistent delivery of care that can be evaluated.

2.2.3 Goals of care

This principle promotes the use of goals in the care planning and evaluation activities and drives a standardised evaluation process that results in better care for the residents and a better documentation system. Goals can be used to turn resident choices and care strategies into interventions with objective outcomes. The toolkit demonstrates to staff how to (i) turn care strategies into goals and (ii) capture quality of life perspectives of the resident in a standardised and measureable manner.

(i) SMART goals are introduced as an example of a standardised approach to setting out goals that will provide measureable outcomes (for evaluation purposes). It provides a framework for training staff to undertake a consistent approach, which can be used across all topics. The SMART goal-setting framework (www.projectsmart.co.uk) produces goals that are **Specific, Measurable, Action-oriented, Realistic** and **Time-based**. Specific goals provide clarity, focus and direction. Objective measures can demonstrate the effectiveness of the goal setting. Action-oriented goals provide a clear strategy. The goal is to be realistic (i.e. can be met), and is set within a time frame. Making goals time-based enhances their ability to be measured and re-evaluated on an ongoing basis.

(ii) A Quality of Life goal setting questionnaire is introduced to provide a standardised approach to identify consumer preferences and satisfaction. An example of goal setting for Quality of Life issues is described in the Reading Pack.

2.2.4 Quality of care

The principle promotes that continuous monitoring and evaluation of care processes and outcomes is central to achieving a high quality of care approach. This is achieved through a systematic and rigorous review of the care process, to ensure the care that is delivered is effective and achieves the optimum care outcomes.

2.2.5 Efficiency

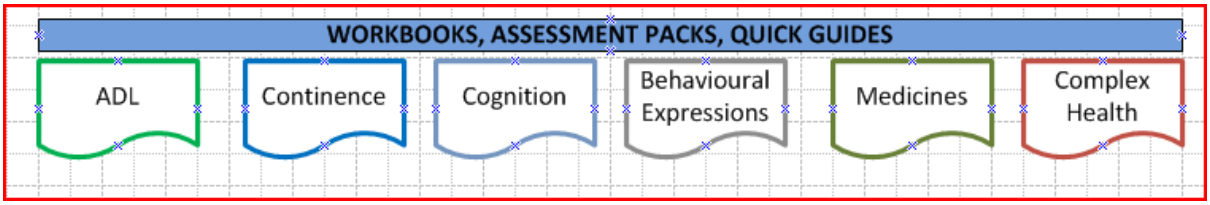
This principle supports maximising the efficient and cost-effective use of resources, optimised to fit into everyday care practices. Efficiency promotes health service integration with practical outcomes for all stakeholders that are affordable, successful and sustainable.

2.3 EBCAT Domains and Topics

The toolkit focuses on topics that require an evidence-based assessment to meet ACFI requirements, therefore not all complex health items and not all assessments required for a holistic and comprehensive assessment of needs are covered. For example the toolkit does not cover spiritual, cultural and social interests, the primary carer or legal issues.

The twelve (12) ACFI questions were grouped into six domains (or workbooks): Activities of Daily Living, Continence, Cognition, Behavioural Expressions, Medicines and Complex Health (Figure 2.3).

Figure 2.3: EBCAT Workbooks



The six workbooks have been subdivided into 10 topics which cover the ACFI questions as described in Table 2.1.

Table 2.1: EBCAT Workbooks, Topics and ACFI items

WB #	WB Title	Topic #	Covers	ACFI Questions
1	ADL	1	Nutrition	ACFI 1
	ADL	2	Mobility	ACFI 2
	ADL	3	Self-Care (Hygiene and Toileting)	ACFI 3, 4
2	Continence	4	Continence	ACFI 5
3	Cognition	5	Cognition	ACFI 6
4	Behavioural Expressions	6	Wandering, Verbal , Physical, Depressive symptoms, Psychiatric symptoms	ACFI 7, 8, 9, 10
5	Medicines	7	Medicines	ACFI 11
6	Complex Health	8	Pain	ACFI 12.3, 12.4a, 12.4b
	Complex Health	9	Swallowing	ACFI 12.6
	Complex Health	10	Skin and Wounds	ACFI 12.5, 12.10, 12.12

2.4 EBCAT Phases

The phases need to be understood by all stakeholders, that is, for those administering the process and for those undertaking the EBCAT process.

The phases were used to:

- Represent the care continuum across the nursing process; and
- Show the different steps and associated activities grouped under each phase of the EBCAT process

Each workbook follows the same process (refer to Figure 2.4). The process involves four phases:

1. Preparation phase
    - Nursing management determine what staff competencies are required
    - Care staff complete pre-reading as required (depending on their current knowledge, experience and skills)

2. Identification phase
    - Gather relevant documents and interview the resident and their family (collecting the medical and personal history)
    - Initial screening to identify possible issues and priorities
    - Comprehensive assessment of the topic and clinical risks

3. Implementation phase
    - Making referrals as required to complete the comprehensive assessment or to assist with management strategies
    - Developing personalised and appropriate interventions
    - Developing the care plan and goal setting
    - Ensuring documentation is completed including developing the evidence rationale
    - Completing the ACFI claims

4. Evaluation phase

    - Determining what needs re-assessing and perhaps implementing in a different way , by monitoring the progress of the:
        - Resident quality of life via personal goal setting
        - Resident care outcomes via goal setting, clinical indicators, audits

Staff administering the workbooks (e.g. nursing management) are pivotal in ensuring that the toolkit is set up properly to support implementation at the site. They also need to make sure that the process is continuously monitored and improved, to ensure the documentation and ACFI claiming is accurate.

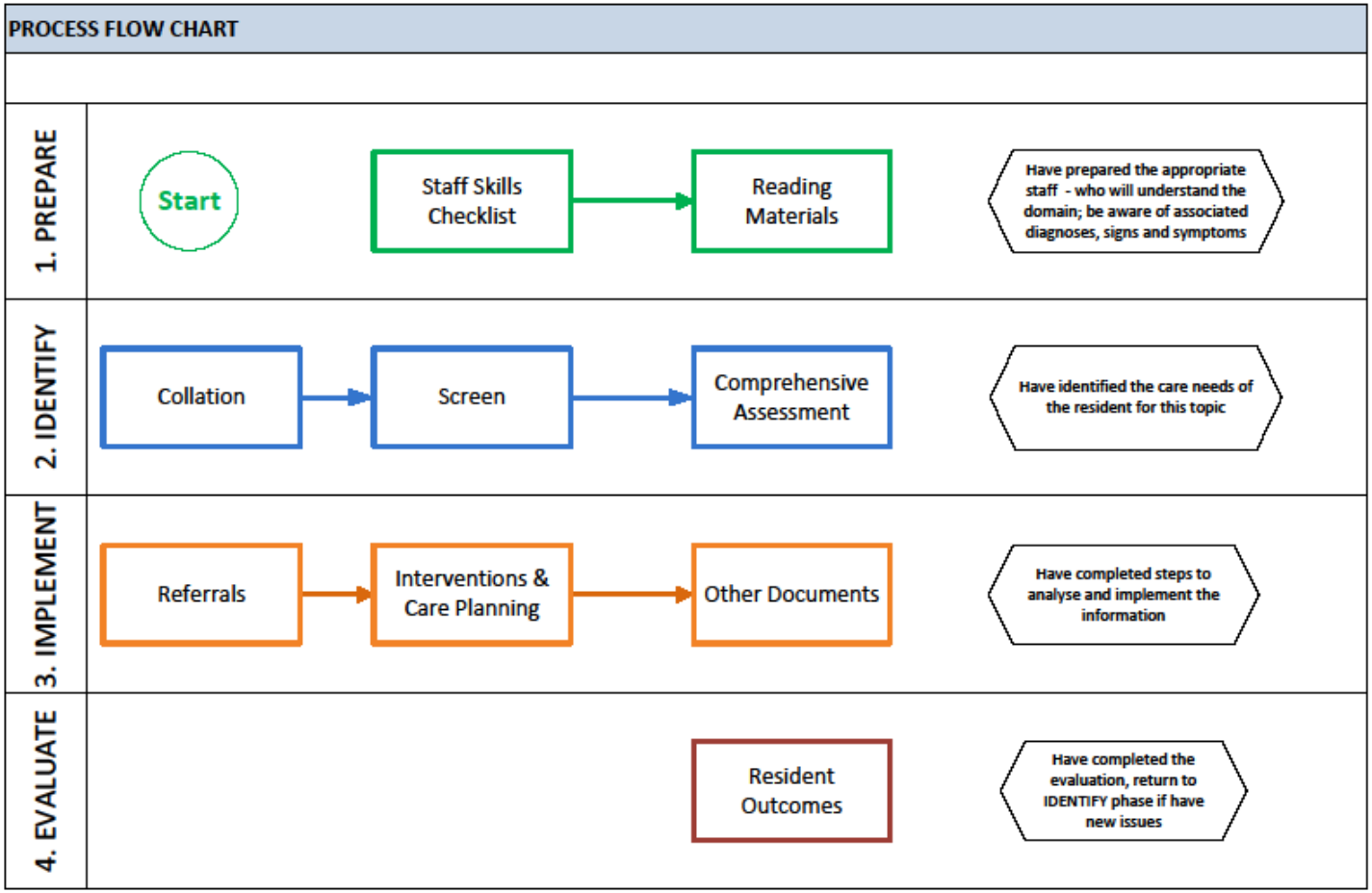
The administration role is further discussed in the section covering 'The Nursing Management Role'. Tables 2.1 to 2.5 present the steps that staff administering the workbooks, need to be familiar with to prepare their site for the implementation of the toolkit.

The ADL Workbook is used as an example in Tables 2.1 to 2.5 to illustrate the phases (e.g. identification), steps (e.g. collation) and activities (e.g. gathering history). The process is the same across the workbooks. The six quick guides (one for each workbook) will highlight any individual topic requirements and for example the recommended assessments for easy reference.

The following descriptions of these steps (Tables 2.1 to 2.5) should assist staff administering the workbooks to determine the skill set required, and the current availability of staff to fulfil those roles. This in turn helps to identify any education planning requirements for preparation to implement the EBCAT.

Staff administering the workbooks need to ensure staff roles and participation activities are clearly allocated for all of the steps across the phases. They also need to ensure that the EBCAT process is embedded in their work practices, and that staff understand their role and feel confident to complete their role in the EBCAT process.

Figure 2.4: Process Flow



2.4.1 Preparation Phase

During the development of the resources, a **preparation** phase was included (Table 2.2). This step involves administration activities to prepare the facility for implementation of the EBCAT, and staff reading preparation for the domain workbook content as required. The staff administering the workbooks need to determine the required staff knowledge, experience and skills to undertake the steps and activities in each phase. The reading materials are for staff requiring further background information.

Table 2.2: Preparation Phase and steps for the domain of ADLs

1.PREPARE	Activities	Outcomes
Staff Skills Checklist	☐ Determine the skills or competencies required to complete each activity	Due diligence is applied to the process
	☐ Identify staff or staff type competent to complete each activity	Management have identified the staff that fit the required skill set to complete activities within the process. It assists to select staff and determine the roles of staff to ensure the process can be completed, and assists to identify training and education needs
Reading Material	☐ Reading materials or summaries from the recommended resources are provided for each topic	Introduces basic information staff should understand about the topic

2.4.2 Identification Phase

Staff administering the workbooks should be aware of the scope of documents that could be used by the facility staff when completing these steps and activities (Table 2.3). Education and training may be required on the recommended assessment tools.

Table 2.3: Identification phase and Steps for the domain of ADLs

2. IDENTIFY	Activities	Outcomes
Collation	☐ Gathering the history from the resident and family	Preferences (related to the care, social and environmental aspects), what has been tried, what has worked. Involving the resident and family in their care underpins the principles of Person Centred Care (PCC) and Consumer Directed Care (CDC)
	☐ Gathering diagnoses, clinical information, personal history from file note (ACCR, CMA, AHP)	Diagnoses associated to care needs, swallowing, diet, mobility status, self-care status, aids, assistance required with care activity, information about other domains that may interact e.g. cognitive status
Initial Nurse Assessment	☐ For example the CHA (Comprehensive Health Assessment for Older People in the Health Care System)	May provide broader assessment info e.g. social and cultural needs). CHA covers: Eating and dietary needs; ROM; Swallowing assessment; Physical Function; Musculoskeletal assessment (posture, gait, limbs, and falls)
Comprehensive Assessment	☐ Range of Movement (ROM)	Assesses for ROM across all joints to inform on body structure and function
	☐ Grip Test	Assesses for strength of grip, good marker of physical performance
	☐ Resident Nutrition Data Card (RNDC)	Records: Medical History, medications, type of diet, diet texture, allergies, food likes/dislikes, appetite, chewing, swallowing ability, dexterity
	☐ Physical Mobility Scale (PMS)	Assesses the functional mobility status- position changes, transfers, mobilising
	☐ FRAT	Screens for falls risk, and assesses falls risk to determine strategies
	☐ Observational Performance Assessment	Assesses by observation the ability to undertake and complete a self-care task
	☐ Clinical Risks (SCP Unplanned Weight Loss)	Investigates when there is unplanned weight loss
	☐ Clinical Risks (SCP Dehydration)	Investigates when there is a dehydration risk
	☐ Clinical Risk (SCP Physical Restraint)	Investigates if at risk from physical restraints and assists to find alternatives
	☐ Clinical Risks (SCP Oral & Dental Hygiene)	Investigates oral and dental hygiene needs

2. IDENTIFY	Activities	Outcomes
	☐ Consider other assessments	Includes the awareness of the impact of other impairments e.g. cognition, sensory

2.4.3 Implementation Phase

Staff administering the workbooks are requested to complete the referral tables and consider the facility referral process (Table 2.4). Staff should also have access to the recommended references for evidence informed interventions and care planning.

Table 2.4: Implementation Phase and steps for the domain of ADLs

3. IMPLEMENT	Activities	Outcomes
Referrals	☐ Management to complete Referral Tables	Completed Referral Tables based on a due diligence approach (see below)
	☐ Referral Process	Provide a protocol and process that provides a documentation trail for the referral process, is there -a referral request template; - an information pack prepared for the Health Professional you refer out to; - an outcomes template for the Health Professional to report the outcomes to you; - a current log of Health Professionals (and their expertise) for referral out to
	☐ Occupational Therapist	Assessment/ aids for physical functioning, transfers
	☐ Physiotherapist	Assessment/Interventions for physical functioning, mobility, transfers, pain
	☐ Dietitian	Assessment/Interventions for dietary needs
	☐ Speech Pathologist	Assessment/Interventions of communication and swallowing needs
	☐ Dentist	Assessment/Interventions of dental and oral hygiene
	☐ Clinical Nurse specialist	Assessment/Interventions for nursing care
Interventions	☐ Nutrition care	Knowledge of evidence informed and practical nutrition interventions e.g. BCOPE p85-86
	☐ Falls care	Knowledge of evidence informed and practical falls risk interventions FRAT PACK; VQC
	☐ Mobility care	Knowledge of evidence informed and practical aids and interventions e.g. incidental activities
	☐ Self-Care	Knowledge of evidence informed and practical interventions to improving self-care activities
	☐ Staff / family education	Include education to staff and families education on intervention, risks, or resident choices
	☐ Social	Include personalised activities both internal and external to home
	☐ Physical Environment	Consider feasible modifications to the built environment

2.4.4 Evaluation Phase

The evaluation steps are consistent across the domains (Table 2.5). The staff administering the workbooks will need to select a Quality of Life (QoL) questionnaire if this recommendation is adopted. An example QoL questionnaire is provided in the reading pack. They also need to develop an evaluation plan for monitoring the progress of the implementation.

Table 2.5: Evaluation Phase and steps for the domain of ADLs

4. EVALUATE	Activities	Outcomes
Quality of Life Outcomes	☐ Repeat Quality of Life questionnaire (if suitable)	Objectively evaluate Quality of Life goals as relevant to the topic Never stop learning about the resident and their views on their life. Involving the resident in their care underpins the principles of Person Centred Care (PCC) and Consumer Directed Care (CDC)
	☐ Seek resident and/or family feedback	Involving the resident and family in their care underpins the principles of Person Centred Care (PCC) and Consumer Directed Care (CDC)
	☐ Seek staff feedback	Identify any incongruence between staff and consumer views; this may identify education opportunities for staff and/or family
Resident Care Outcomes	☐ Evaluate Care goals	Objectively evaluate care goals as relevant to the topic Never stop learning about the resident and their current needs
	☐ Monitor Incident Forms	Update risk assessments and strategies
	☐ Monitor Clinical Indicators	Update risk assessments and strategies
	☐ Monitor Resident File documents	Ensuring the Resident File documentation is current and congruent Ensuring the communication to care staff and other Health Professionals is congruent This would include all Progress Notes (by nursing/ AHP/Medical Practitioners etc), new assessments and Care Plans

Chapter 3: Products and Readiness Checklists

There are a number of domains and topics covered in the workbooks and associated materials (Table 3.1), but it should be noted that not all possible care aspects are included and additional assessment material should be included by sites as required. The Evidence-Based Clinical Assessment Toolkit (EBCAT) consists of the following products summarised in Figure 3.1 and detailed in Table 3.1.

Figure 3.1: EBCAT Products

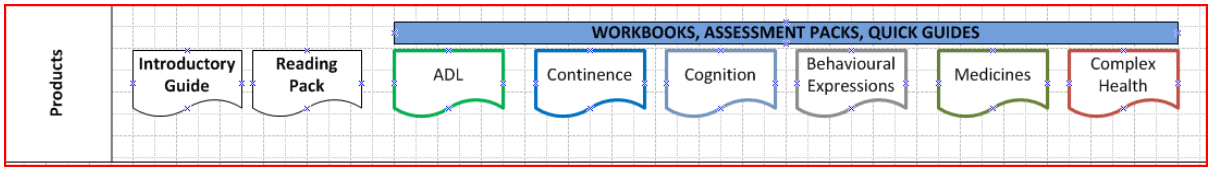


Table 3.1: EBCAT Products

Product	How used and who uses it
Introductory Guide	The Introductory Guide is aimed at the nursing management and lead nurse (administration group). The Introductory Guide: • Describes the benefits and aims of the Evidence-based Clinical Assessment Toolkit (EBCAT) • Provides an overview of the EBCAT methodology • Describes the Toolkit products and readiness checklists • Describes the Nursing Management role Provides and Administration Checklist to check for readiness to implement the toolkit and to audit the process.

Product	How used and who uses it
Workbooks	The EBCAT workbooks are designed to be used by the lead nurse. The workbooks should be used as a training tool by the lead nurse when training the care staff on the EBCAT. There are six workbooks which cover the domains of: • Activities of Daily Living • Continence • Cognition • Behavioural Expressions • Medicine • Complex Health Each workbook contains detailed information and case studies on how to complete the recommended assessment tools as part of a nursing-based process. The Appendices provide references for the suggested resources, and a workbook exercise to practice what has been learnt.
Assessment Packs	The assessment packs contains the recommended screen, assessment tools and relevant clinical risk tools. There is one assessment pack per workbook. The tools are used by the care staff when identifying the needs of the residents.
Quick Guides	The Quick Guides are designed for use by care staff. There is one quick guide per workbook. The Quick Guide is a quick reference to the EBCAT process and tools. It is recommended it be kept handy for use on the 'floor', whenever required.
Reading Pack	The Reading Pack, which is aimed at care staff, provides further reference information for the background reading section of each workbook. This pack contains reading material which cannot be sourced from the internet and permission has been obtained for its use in the EBCAT materials. References for other recommended background reading are provided in the workbook appendices, and are listed in the Nursing Management Role section. These references will need to be sourced by staff as required. There is also a sample Quality of Life questionnaire in the Reading Pack.

3.1 Administration Role and Checklists

The toolkit involves the participation of three types of staff.

Nursing Management

This group would typically consist of nursing staff who do not work 'on the floor', for example the Director of Nursing or Nurse Unit Manager.

The nursing management role includes:

- Preparing the toolkit and auditing for readiness to implement
- Selecting a lead nurse for the leadership role and to train the care staff
- Implementing the toolkit and monitoring the progress

Lead Nurse

This person will be selected by the Nursing Management group to lead the EBCAT process at the site. It is recommended they be a nurse (RN or EN).

The lead nurse role includes:

- Assisting the Nursing Management group to prepare the toolkit
- Training the care staff on how to implement the EBCAT process and tools
- Providing leadership to the care staff during the implementation of the process
- Assisting the Nursing Management group to monitor the progress

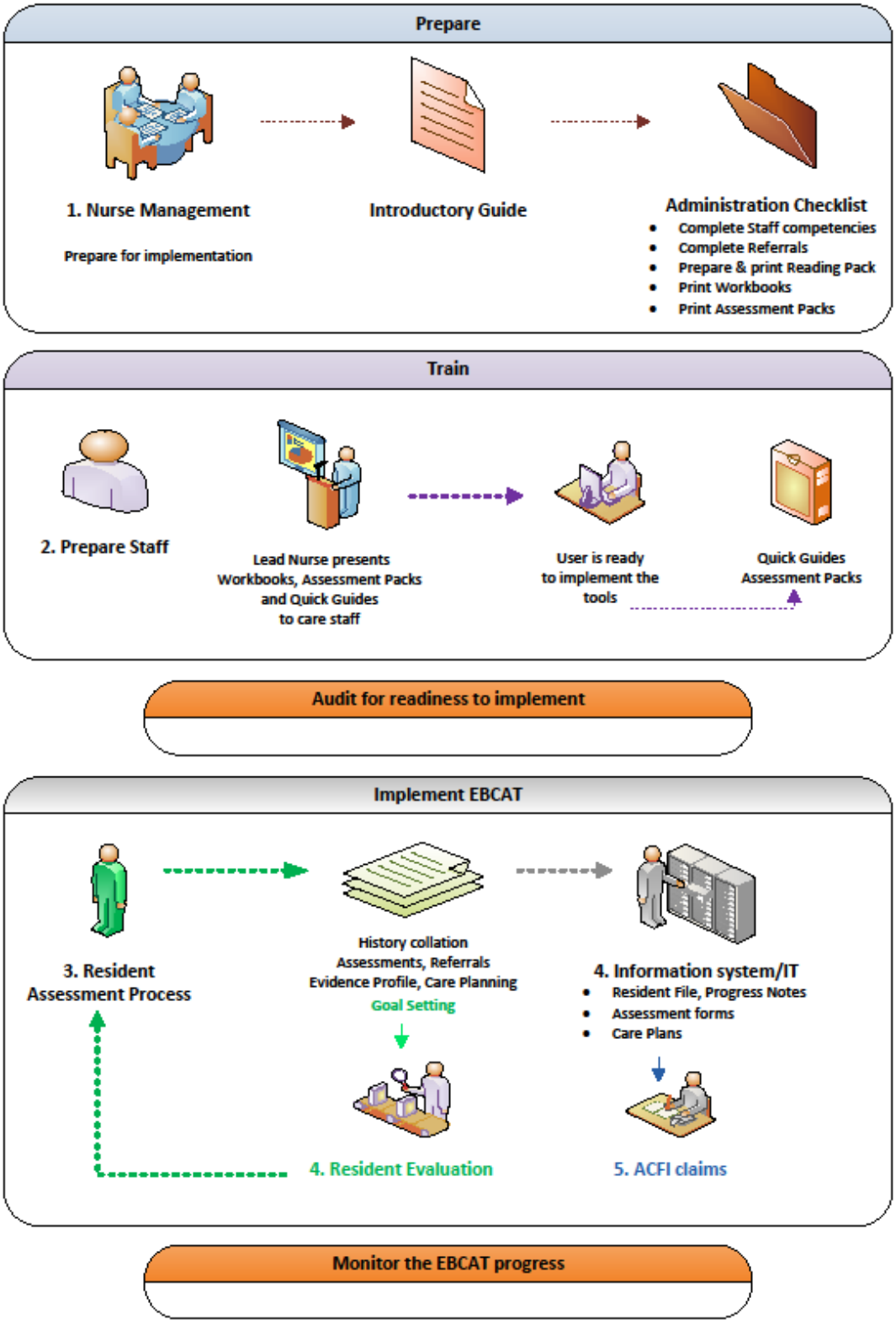
Care Staff

This group are the nurses (RN or EN) and Personal Care Workers who deliver the daily care to the residents 'on the floor'.

They receive the training and implement the EBCAT process and tools when undertaking the resident assessment process.

Figure 3.2 presents the administration (i.e. nursing management and lead nurse roles), and the activities are further explained.

Figure 3.2: Role of administration in the EBCAT process



3.1.1 Preparing the toolkit

It is suggested that nursing management and the lead nurse undertake specific steps to facilitate the successful implementation of the toolkit.

There are some activities that need to be completed before commencement of the training of care staff on the EBCAT process. Below is an overview of the suggested roles of the nursing management in preparation for the toolkit training. The nursing management may decide to include the lead nurse in this phase also. The activities involve:

- Familiarising themselves with the Introductory Guide and Quick Guides
- Complete the staff competency tables for each topic and address any skill deficits. Further explained below.
- Complete the referral tables for each topic for staff reference (it is recommended that a standard referral form and process be developed). Further explained below.
- Prepare the Reading Pack

1. Refer to Table 3.2 for the list of suggested reading resources. The Reading Pack will have the CHAOP resource (Modules 3, 4 and 7) inserted as this resource cannot be downloaded. The IPA guidelines require IPA membership, the update to the JBI 2000 best practice swallowing article requires access to a library resource, and the other resources can be downloaded using the links provided.
2. Selecting a Quality of Life questionnaire (a sample of a QoL questionnaire that provides goal setting outcomes is provided in the Reading Pack)

- Ensure the toolkit resources are readily available e.g., printed copies or other format
    - Reading Pack
    - Workbooks
    - Assessment Packs
    - Quick Guides

Table 3.2: Reading Pack References

Title	Reference
Best care for older people everywhere. (BCOPE)	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. http://www.health.vic.gov.au/older/toolkit/index.htm
Comprehensive Health Assessment of the Older Person (CHAOP)	Modules 3, 4 and 7 are provided in the Reading Pack. Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria Resource developed for comprehensive health assessment training for PSRACS (2013).
Guiding principles for medication management in residential aged care facilities	Department of Health and Ageing (2012), http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm
Identification and Nursing Management of Dysphagia in Adults with Neurological Impairment (2000; and updated in 2011 by Hines et al)	This original document has been updated by Hines et al (2011) Author: Joanna Briggs Institute (JBI) Reference: "Identification and Nursing Management of Dysphagia in Adults with Neurological Impairment"; *Best Practice Volume 4, Issue 2, (2000)* Sourced at: http://connect.jbiconnectplus.org/ViewSourceFile.aspx?0=4313 S. Hines, K. Wallace, L. Crowe, K. Finlayson, A. Chang & M. Pattie (2011). Identification and nursing management of dysphagia in individuals with acute neurological impairment (update). *Int J Evid based Healthc 2011; 9: 148-150.*
IPA Complete Guides to BPSD	This requires a IPA membership (involving a small fee), which is open to health professionals. IPA Complete Guides to Behavioral and Psychological Symptoms of Dementia (BPSD) –Nurses Guide and Specialists Guide Sourced at: www.ipa-online.org
Standards for Wound Management 2nd Edition (2010)	Author: Australian Wound Management Association (AWMA) Ref: Standards for Wound Management 2nd Edition 2010 Sourced at: http://www.awma.com.au/publications/2011_standards_for_wound_management_v2.pdf
The PMG Kit for Aged Care (2007)	Funded by the Australian Government, Department of Health and Ageing, under the National Palliative Care Program. This work is covered by copyright. The Kit may download in PDF format: https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi There is also a CD available.

3.1.2 How to complete the activity tables

For each topic, the nursing management role is to determine the staffing requirements to complete the various activities (refer Table 3.3). The activity tables are included in the Preparation Phase of each workbook topic. An example of a staff activity table is provided in Table 3.3.

The process includes:

- Identifying the required activities (examples provided e.g. Table 3.3)
- Assessing staff competency to complete the activities
- Addressing identified gaps

If the facility has identified gaps in the competencies of their staff for particular activities, then action needs to be undertaken to address the gap. For example, if there is a gap found in the competencies or qualifications of staff who can conduct a specialised 'swallowing assessment', the facility could consider further training of current staff, or accessing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Speech Pathologist) or Medical Practitioner who could complete the assessment. Refer to the appendix for copies of the tables for every topic.

Table 3.3: Example of a Staff Activity Table

Activity	Who is responsible for sign off	Who does the activity
Collating Documents		
Identifying Needs from collation documents		
Screening /Initial Assessment		
Assessments		
Specialised Assessment (e.g. Swallowing)		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Quality Resident Care outcomes		

3.1.3 How to complete the referral pathways table for each topic

For each topic, the nursing management role is to determine the available referral pathways, based on what your service can provide and what is available in your local area. The referral pathway should be documented and include a list of important website contacts to assist staff to find an appropriate practitioner or where to get expert advice. The referral pathway tables are found in the Implementation Phase of each workbook topic.

Table 3.4 below provides an example of how to set out a Referral Pathway table that can be accessed by all care staff.

If the facility has identified gaps in the referral pathways, action may need to be undertaken to address the gap or inform staff on how they should proceed. For example, if there is no access to particular type of required service such as a dementia behaviour management and assessment service, the facility could consider accessing a nurse consultant with the required clinical knowledge, or training a current staff member.

Table 3.4: Example Referral Table for Behavioural Expressions

Health Professional	Source	Contact
Medical Practitioner	Health Service X	Name, contact details
Geriatrician	Health Service X	Name, contact details
Psychogeriatrician	Health Service X	Name, contact details
Aged Psychiatry Services	Health Service X	Name, contact details
Behavioural Assessment Team	Health Service X	Name, contact details
Dementia Consultant	Health Service X	Name, contact details
DBMAS	Health Service X	Name, contact details

3.1.4 The referral process

It is also suggested that management consider the referral process and the availability of standardised forms. These should ensure the necessary information is provided to referred Health Professionals and that the facility receives the required information back from them. A good referral system will provide evidence and information for your documentation system which will support your ACFI claims and care process.

3.1.5 Leadership role and training

- Select at least one lead person to undertake and then train care staff
- Set up an education and training program for care workers that clarifies their role in the process
- Ensure the toolkit resources are readily available
  - Assessment Packs
  - Quick Guides
- Audit to check if your facility is ready to implement the toolkit. An administration checklist is provided (Table 3.5)
- Have a plan to implement and review the toolkit process and resident assessments

3.1.6 Monitoring the progress

- Care staff to implement the process using the Assessment Pack and Quick Guides
- Resident assessments, care plans and documentation completed
- Documentation for ACFI claims completed based on the EBCAT documentation
- Undertake quality audits of individual resident files to assess the effectiveness. A quality audit checklist is provided to audit resident files (Tables 3.6 & 3.7)

Table 3.5: Administration Checklist

Administration Checklist	Yes	Name	Signature	Date
Nurse Management familiar with Introductory Guide				
Review Activity Table				
Review your staffing competency to complete the activities				
Identify training requirements				
Referral Tables completed				
Referral Process documented and materials developed				
Clinical lead person/s selected				
Reading Pack prepared				
Copies of toolkit available (Workbooks, Assessment Packs , Quick Guide)				
List of collation documents identified - e.g. ACCR, CMA				
Planning of on-site toolkit training by clinical lead				
Staff training as required to complete activities e.g., to be competent to undertake an initial nurse assessment				
Toolkit training undertaken				
When your facility has completed the above list, you will be ready to implement the toolkit				

Table 3.6: Quality Audit Checklist

Quality Audit Checklist	Yes	Name	Signature	Date
Collation results documented				
Consumer interviews completed				
Initial Assessment completed				
Comprehensive Assessment Process completed for required topics				
Quality of Life questionnaire				
Care Plan completed/updated				
QoL goals written in collaboration with consumers				
Care goals written in collaboration with consumers				
Evidence profile is documented and accurate- reason for assistance is provided, source documents noted				
Resident file documents (progress notes, assessments, care plans) are congruent				
ACFI claims accurate				
ACFI claims completed/updated				
Evaluation process was completed on time (maybe NA)				
Has a date for next evaluation				
The toolkit has been effectively implemented when the above items can be checked off				

Table 3.7: Details behind the Quality Audit Checklist

Detailed Audit List for Resident ID	YES/ NA	Document details	Where stored	Signature	Date
Collation (check off what is utilised)					
Collation- ACCR					
Collation- CMA					
Collation- Admission documents					
Collation - other					
Assessments (check off what assessments are used)					
Social/Cultural Assessments					
Diversional Therapy Assessments					
Initial Nurse Assessment (e.g. CHA)					
GRIP Assessment					
ROM Assessment					
ACFI 1 Nutrition Assessment (RNDC)					
ACFI 2 Mobility Assessments (PMS)					
Falls Risk Assessment (FRAT)					
ACFI 3 Observational Performance Assessment					
ACFI 4 Observational Performance Assessment					
Continence Screen					
3 day Urine Record (Continence Tools for RACs)					

Detailed Audit List for Resident ID	YES/ NA	Document details	Where stored	Signature	Date
5 day Bowel Record (Continence Tools for RACs)					
ACFI Urine Record					
ACFI Bowel Record					
Scheduled toileting code used (4 or 7) and have diagnosis					
Continence Assessment Form and Care Plan					
ACFI 6 Assessment (PAS-CSI)					
Other Cognitive Assessment (KICA-Cog)					
Other Cognitive Assessment (RUDAS)					
Clinical Report relating to ACFI 6 (cognition)					
Behavioural Description List completed					
ACFI 7 Behaviour Record					
ACFI 8 Behaviour Record					
ACFI 9 Behaviour Record					
Modified Behaviour Assessment Form					
ACFI 10 Cornell Scale of Depression					
Claiming C or D in ACFI 10					
Diagnosis of depression (updated within last 12 months)					
Clinical Report relating to ACFI10 (depression)					

Detailed Audit List for Resident ID	YES/ NA	Document details	Where stored	Signature	Date
Self Administration of Medications (Item 11. 2)					
ACFI 11 Timing Record for Administration of Medications					
Medication Chart					
Pain Assessments: Abbey or PAINAID					
Pain Assessments: M-RVBPI					
Pain Intensity Scale					
Skin Risk Assessment: Waterlow or Braden or Norton					
Residential Care Services Skin Integrity Assessment					
Residential Care Services Wound Assessment & Progress Chart					
ACFI 12 claims (circle) 12.1/ 12.2/ 12.3/ 12.4/ 12.5/ 12.6/ 12.7/ 12.8/ 12.9/ 12.10/ 12.11/ 12.12/12.13/ 12.14/ 12.15/ 12.16/ 12.17/ 12.18					
ACFI 12 Directives (e.g., 12. X by MP or RN or AHP)					
ACFI 12 Diagnoses (circle) 12. 8/ 12.9/ 12.10/ 12.12/ 12.13/ 2.14/12.15/12.16/12.17					
ACFI 12 Records of Treatment(circle)					

Detailed Audit List for Resident ID	YES/ NA	Document details	Where stored	Signature	Date
12.1/ 12.2/ 12.3/ 12.4a/ 12.4b /12.7/ 12.10/ 12.18					
Quality of Life questionnaire					
Medical Diagnoses completed (ACFI Form)					
Mental & Behavioural diagnoses completed (ACFI Form)					
Standardised Care Processes (check off what is used)					
Choking					
Constipation					
Dehydration					
Depression					
Delirium					
Hypoglycaemia					
Oral & Dental Hygiene					
Physical Restraint					
Managing medications & polypharmacy					
Unplanned weight loss					
Referral Types (check off who is referred to)					

Detailed Audit List for Resident ID	YES/ NA	Document details	Where stored	Signature	Date
Physiotherapist					
Occupational Therapist					
Dietitian					
Speech Pathologist					
Medical Practitioner					
Aged Psychiatry Medical Specialist e.g. Psychiatrist					
Mental Health Professional					
Continence Consultant					
Memory Clinic					
DBMAS					
Behavioural/Dementia Consultant					
Wound/Skin Consultant					
Pain Consultant					
Pharmacist					
Other (describe)					

Appendix

Table A1: Suggested Staff Activities for Nutrition

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from collation documents		
Initial Assessment (e.g. CHA)		
Assessment (RNDC, ROM)		
Specialised Assessment (Swallowing)		
Specialised Assessment (Nutrition)		
Specialised Assessment (Physio therapy)		
Specialised Assessment (Aids)		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan- same as wrote it		
Evaluate Quality Resident Care outcomes		

Table A2: Suggested Staff Activities for Mobility

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from collation documents		
Screening /Initial Assessment (e.g. CHA)		
Assessment (PMS, FRAT, ROM, GRIP)		
Specialised Physical Functioning Assessment		
Documenting into file notes		
Determine and action Referrals- requires clinical interpretation of information		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Quality Resident Care outcomes		

Table A3: Suggested Staff Activities for Self-Care

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from collation documents		
Screening /Initial Assessment (e.g. CHA)		
Assessment (ROM, GRIP, observational Performance Assessment)		
Specialised Assessment (e.g. GRIP)		
Documenting into file notes-		
Determine and action Referrals		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan- same as wrote it		
Evaluate Quality Resident Care outcomes		

Table A4: Suggested Staff Activities for Continence

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from gathering documents		
Screening /Initial Assessment (e.g. CHA; Continence Toolkit Screen and extra questions)		
Charting Continence Toolkit for RACS • 3 day Bladder Chart • 7 day Bowel Chart		
Comprehensive Assessment (Continence Toolkit for RACS -Continence Assessment Form and Care Plan)		
Specialised Assessment		
Documenting assessment outcomes into file notes		
Determine and action Referrals		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan- same as wrote it		
Evaluate Quality Resident Care outcomes		

Table A5: Suggested Staff Activities for Cognition

Activity	Responsible for sign off	Does the activity
Gathering Documents		
Identifying Needs from gathering documents		
Screening /Initial Assessment (e.g. CHA p.5)		
Assessment – PAS-CIS		
KICA-Cog		
RUDAS		
Documenting assessment outcomes into files		
Determine and action Referrals- requires interpretation of information		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Quality Resident Care outcomes		

Table A6: Suggested Staff Activities for Behavioural Expressions

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from collation documents		
Screening		
Charting- Behaviour Records		
Assessment – BAF		
Assessment – CSDD		
Documenting into file notes		
Determine and action Referrals- requires interpretation of information		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents (audit training required)		
Review the Care Plan		
Evaluate Quality Resident Care outcomes		

Table A7: Suggested Staff Activities for Medicines

Activity	Responsible for sign off	Does the activity
Collating Documents (non-prescription medicine, authorised medicines and nurse initiated medicines)		
Timing Record- note this not a mandatory but assists to provide evidence for the claimed timing for administration of medications required for ACFI 11 checklist 4,5 & 6.		
Assessment for (Self-Administration)		
Medication Chart		
Documenting into file notes- same person who signs off medication chart that medicines were administered.		
Determine and action Referrals- requires interpretation of information		
Administration of medicines requiring assistance (depends on State regulations and local organisational policies and type of medication)		
Administration of a subcutaneous/ intramuscular/ intravenous drug		
Care Plan- ensure Medication Chart is current, report on Self-administration determination		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Review the Medication Chart		
Evaluate Resident Care outcomes		
Evaluate Quality Care outcomes		

Table A8: Suggested Staff Activities for Pain

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment/ Screen:		
Observational Assessment: Abbey Pain Scale or PAINAID		
Pain Intensity Tools		
Interview Assessment: M-RVBPI		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and Strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		

Table A9: Suggested Staff Activities for Swallowing

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment / Screen		
Specialised Swallowing Assessment and documenting of same		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and strategies based on goals and needs.		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		

Table A10: Suggested Staff Activities for Skin & Wound Management

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment and documenting into file notes: e.g. CHA		
Pressure Ulcer Risk Ax: Waterlow Pressure Ulcer Risk Scale		
Pressure Ulcer Risk Ax: Braden Risk Assessment Scale		
Pressure Ulcer Risk Ax: Norton Scale for Predicting Risk of Pressure Ulcer		
Residential Care Services Skin Integrity Assessment		
Residential Care Services Wound Assessment and Progress Chart		
Documenting assessment outcomes into file notes		
Determine and action Referrals		
Develop Interventions and strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		