Evidence-Based Clinical Assessment Toolkit (EBCAT)

Activities of Daily Living Workbook

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Other Contributors

Professor Rhonda Nay who reviewed the Complex Health Workbook.

Contents

List of Tables

List of Figures

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 Assessment Packs	Each workbook has an assessment pack. This contains the recommended screens, assessments and Standardised Care Processes recommended within the workbook.
EBCAT Introductory Guide	This document presents: Project methodology; Overview of products; and details of the Management role;
EBCAT Reading Pack	This document provides the background reading for all EBCAT Workbooks.
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 (Topics 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

Overview of the Toolkit Products

The Evidence-Based Clinical Assessment Toolkit (EBCAT) consists of the following products:

Resource	How used
Introductory Guide	The Introductory Guide is aimed at the lead nurse and the nursing management. It presents: the project methodology; an introduction to the products; and details on the Nursing Management role.
Reading Pack	The Reading Pack, provides further reference information for the background reading section of each workbook, it is aimed at care staff. This pack contains reading material which cannot be sourced from the internet. References for supporting material that can be sourced off the internet are provided in workbook appendices. There is also a sample Quality of Life questionnaire in the Reading Pack.
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.
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.
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.

Suggested Roles for Staff Implementing the Toolkit

The toolkit requires the participation of three types of staff as described below.

	Who and what they do in regard to the Toolkit
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. They are vital to ensuring, that the toolkit is set up properly to support implementation at the site, to ensure that the process is continuously monitored and improved, and to monitor the process to ensure the documentation and ACFI claiming is accurate. The nursing management role includes: o Preparing the toolkit and auditing for readiness to implement o Selecting a lead nurse for the leadership role and to train the care staff o Implementing the toolkit and monitoring the progress The nursing management role is described in detail in the Introductory Guide.
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: o Assisting the Nursing Management group to prepare the toolkit o Training the care staff on how to implement the EBCAT process and tools o Providing leadership to the care staff during the implementation of the process o Assisting the Nursing Management group to monitor the progress The lead nurse role is described in detail in the Introductory Guide.
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.

Introduction to the ADL Workbook

The ADL Workbook is one of six that form the Evidence Based Clinical Assessment Toolkit (EBCAT). The ADL Workbook covers the topics of Nutrition, Mobility and Self-care (which includes the activities of personal hygiene and toileting). This workbook is one of four resources relevant to the ADL domain which comprise:

- A Reading Pack
- ADL Workbook
- ADL Quick Guide
- ADL Assessment Pack

The toolkit aims to provide a resource to assist Public Sector Residents Aged Care Services (PSRACS) staff to systematically and consistently determine and manage resident care needs. The toolkit uses evidence-based clinical assessment tools for assessing and managing residents with the goals of improving the clinical and quality of life for the residents and demonstrating accountability to government regulators for example, with the Aged Care Funding Instrument (ACFI) requirements.

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

Activities of Daily Living (ADL) are central in the life of residents. ADL support is of a personal nature and is provided throughout the day and on all days of a resident's life. ADL activities performed using evidence informed approaches will contribute significantly to a resident's quality of care and quality of life outcomes. They provide daily opportunities to put into practice resident choice and participation and resident self determination.

The ADL care aspects are also a major focus of the funding system because of their importance to everyday care provision and the associated cost of the care. It is therefore essential that the facility ACFI claiming for ADL care is supported by the best possible assessment and documentation, to provide for accurate and evidence-based funding claims.

While the ACFI assessment pack determines some mandatory evidence-based assessments, the ADL domain does not have specified assessments. This ADL workbook will assist a service to meet the ADL evidence requirements using familiar and freely available Australian toolkits and resources including:

- The Comprehensive Health Assessment of the Older Person (CHAOP)- training has been provided to many PSRACS on this resource

- An Initial Nurse Assessment – e.g., the Comprehensive Health Assessment (CHA) for Older People in the Health Care System, which was designed for recording assessment results based on the Comprehensive Health Assessment of the Older Person (CHAOP) resource
- Standardised Care Processes (SCP) developed as part of the Strengthening Care Outcomes for Residents with Evidence (SCORE) project
- The NATFRAME (National Framework for Documenting Care in Residential Aged Care Services)
- Best Care for Older People Everywhere (BCOPE). The toolkit.

Topic 1: Nutrition

The Nutrition Topic

This topic focuses on nutrition. The Activities of Daily Living (ADL) workbook highlights the interplay between the topics of nutrition, mobility, personal care and toileting, and the impact of other domains on these activities.

Investigating Nutrition

The following four process steps should be followed when investigating nutrition (consistent across all ADL topics). The steps are:

1. **Preparation of staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. The background reading includes:
   - Comprehensive Health Assessment of the Older Person (CHAOP) Module 3 and 4
   - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

The references for these resources can be found in the ADL Appendix.

2. **Identifying** – gathering the resident's history by collating documents and talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, completing a comprehensive assessment approach and assessing the scope of the challenge. It is recommended that all new residents have a comprehensive assessment of nutrition. A comprehensive approach will include:

   File Notes Review:

   - Aged Care Client Record (ACCR) – Part 5 of which includes some information on nutrition
   - Comprehensive Medical Assessment – which (if available) may have, for example, sections on oral health, nutrition status, and dietary needs, which inform on nutritional issues

   Screen:

   - Initial nurse assessment e.g. CHA based on the 'Comprehensive Health Assessment of Older People' resource). The CHA provides a short initial nurse screen of swallowing status

Further Assessment:

The following assessment tools and Standardised Care Processes (found in the ADL Assessment Pack) are recommended for assessing nutrition and identifying the person's nutritional care needs. It is recommended that all new residents have these assessments completed:

- Resident Nutrition Data Card; and
- Range Of Movement assessment

The SCORE Standardised Care Processes are also recommended for addressing the clinical risks of choking episodes, unplanned weight loss, dehydration and oral and dental hygiene.

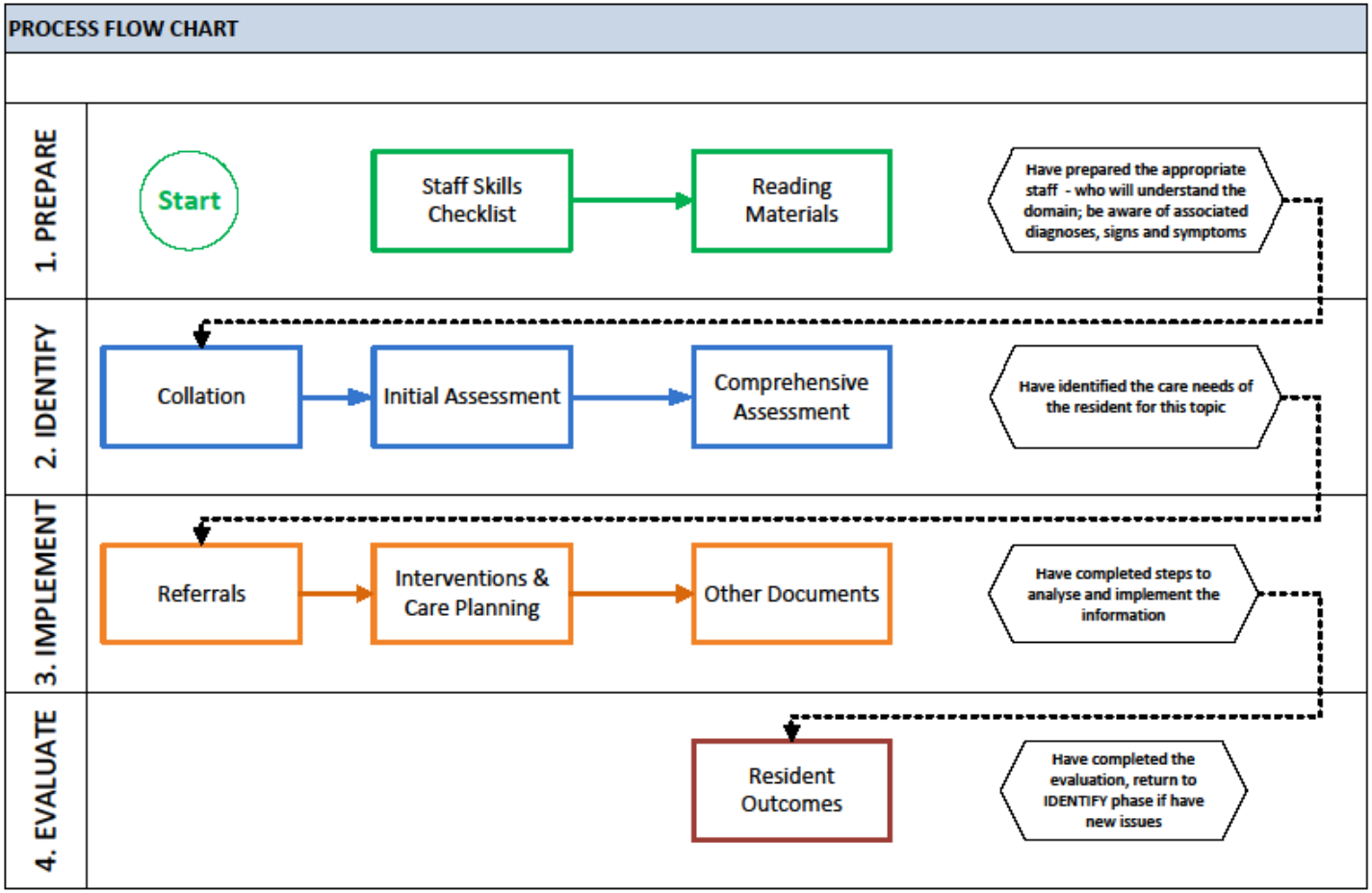
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

- Undertaking referral options to complete gaps or seek specialist advice
- Planning evidence informed care strategies to assist the person to maintain or possibly improve their participation ability
- Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
- Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
- Completing ACFI documentation

4. Evaluating – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

The overall nutrition process and associated activities is illustrated in Figure 1 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the ADL Workbook follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

Figure 1: Nutrition process



Getting Started with a Nutrition Example

This case study will be referred to as we discuss the nutrition topic.

Mrs. Green is an 83 year old woman in the Sunset Home has been diagnosed with dysphagia, that is, she is having trouble swallowing. This has only been a problem since the stroke she had a few months ago, but she has been hospitalised once since then with pneumonia. The speech pathologist has recommended a modified textured diet of thickened fluids and soft food.

The speech pathologist introduced exercises to improve her throat muscle movement, and the physiotherapist is helping to improve her range of motion and hand dexterity as both have been affected by the stroke. The speech pathologist has provided an education session for the care staff on how to position Mrs. Green at meal times to minimise the risk of choking, and Mrs. Green is to be supervised while eating at all times. All of this has been documented into her care plan.

Unfortunately, Mrs. Green has continued to lose weight over the last few months, she shows little interest in the food offered her, and her skin integrity is deteriorating, putting her at risk for pressure ulcers.

The nursing staff review Mrs. Green's care plan – they look at the file notes and talk with Mrs. Green. They find :

- *Mrs. Green has largely lost interest in food since moving to the home because she is missing spicy food*
- *She is very tired by the evening meal and finds it too much effort to try to eat*
- *She also misses having meals with her family. They were always a close knit group and she doesn't feel the same pleasure at mealtimes now*

A staff member talks with her family:

- *The family did not understand about her risk of choking on fluids and have been giving her, her favourite drinks*
- *The family have suggestions about specific spices that Mrs. Green use to cook with for both their taste and health benefits*
- *The family are very interested in sharing a family meal on weekends at the home, as the home has a private dining room*

The speech pathologist and dietitian agree to adding spices to Mrs. Green's meals.

All of this is discussed at the next care plan meeting and staff agree to try some things for one month and then re-evaluate whether it is working. They are:

1. *Adding specific spices to Mrs. Green's meals*
2. *Offering smaller and more frequent meals throughout the day when Mrs. Green is not as tired*
3. *Providing information about Mrs. Green's diet to the family and demonstrating to them how to position Mrs. Green when she eats and drinks*

4. *Inviting her family to eat with her in the private dining room on weekends*

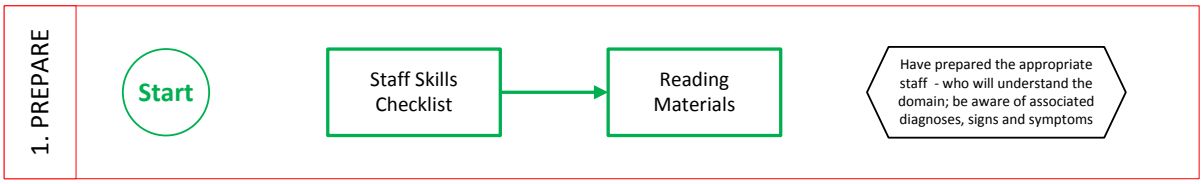
The staff turn these actions into the following goals:

- *Increase Mrs. Green's daily nutritional intake to stem the weight loss*
- *Educate the family on safe swallowing practices to reduce the risk of choking*
- *Increase Mrs. Green's sense of wellbeing (her quality of life) by inviting the family to frequently share a meal with her*

A month later, Mrs. Green and her family meet with the members of the care planning staff to evaluate how far they have come and discuss any changes that need to be made. They review the file notes (medical, allied health and nursing), ask Mrs. Green and her family and staff for input. The result?

- *Mrs. Green is improving physically – her weight has stabilised and she is slowing gaining weight. She is feeling stronger, and is not always as tired in the evening*
- *She is also feeling more hopeful about her recovery. Her personal goal is to try to return to a more normal diet*
- *Her family have enjoyed the shared meals and this will continue. They are also going to try taking her out on picnics or to their homes when possible*

Preparation



There are two specific aspects to **preparing** staff for the management of resident nutrition care needs. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 1 below provides a structure for management to identify which staff have the skills required to complete activities within the nutrition process. The process includes:

- Identifying the required activities (examples provided in Table 1)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in the nutrition assessment and management activity, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Speech Pathologist; Dietitian) who could complete the assessment.

The introductory guide also provides further instructions for nursing management in preparation for implementing this toolkit.

Table 1: Staff Activities for the Nutrition Process

Activity	Responsible for sign off	Do the activity
Collating Documents		
Identifying needs from collation documents		
Initial Nurse Assessment: e.g. CHA		
Assessment RNDC		
Assessment: Range of Movement		
Assessment: Physical Mobility Scale		
Assessment: Grip Test		
Specialised Assessment: e.g. Swallowing		
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		

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of nutrition issues in older people. It is expected that staff will have:

- A comprehensive understanding of the domain and how it is impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms to ensure poor nutrition is not missed
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practices associated with nutrition to assist with the development and implementation of evidence-based care plans

The background reading relevant to the nutrition topic is:

The **CHAOP** (Comprehensive Health Assessment of the Older Person- Modules 3 and 4 are found in the Reading Pack)**.** This resource is also relevant to the other ADL topics in this workbook.

- Module 3 covers Musculoskeletal Assessment (e.g., does the person have the hand dexterity and muscle flexibility to eat independently?).
- Module 4 covers Nutrition, Metabolism and Assessment- this module provides an overview of the upper gastrointestinal system, nutritional assessment, and oral examination procedures (by nurses). It also covers other topics associated with swallowing difficulties, skin integrity, malnutrition and dehydration.

The **BCOPE** resource (Best Care for Older People Everywhere – refer ADL Workbook Appendix) covers Nutrition on pages 77 to 109). The content is summarised in the following sections. Please note that the BCOPE was primarily written for hospital settings with intended transferability to a range of other care settings. The language and terminology used may not always suit residential aged care.

Some Basics

BCOPE (Best Care for Older People Everywhere) indicates in the Nutrition section (BCOPE p.83) that the following are **signs to watch for** when assessing nutrition. These signs are a likely indication that a referral to a dietitian for a comprehensive assessment is required. The signs are:

- Body mass index (BMI) less than 22 kg/m2, or seeming underweight
- Recent loss of appetite
- Loose-fitting clothes, jewellery or dentures
- Difficulties with chewing or swallowing, or evidence of tooth decay
- Significant, unintentional weight loss of over three kilograms (or half a stone) in the last three to six months
- Poor intake or refusing meals
- Constipation or diarrhoea
- Frequent infections
- Pressure ulcers

While something like body mass index (BMI) requires taking a specific measurement, most indications that something is amiss are readily observable by staff and families. When someone has a loss of appetite or a disinterest in eating, or when a person's clothes are

getting looser or rings are coming off fingers, anyone involved in her care is likely to be concerned. BCOPE (page 80) offers these potential **causes of under-nutrition:**

- **Factors relating to the food supply**, such as nutritional adequacy, range of choices and the individual's cultural, religious or personal requirements or preferences are all causes of under-nutrition in older people
- **Inadequate staffing resources** for meal set-up, eating assistance and encouragement may compromise access to food. Positioning of meal trays out of reach and difficulty in opening packaged foods can also restrict food access
- **Environmental and social factors** around eating can be an issue. These include the physical environment (for example, a dining room compared with bedside eating or the presence of unpleasant sounds or smells in the eating environment), social interactions at mealtime and insufficient time to eat a meal before it is taken away or becomes too cold to consume

Other causes of nutrition issues cited in this section of BCOPE include:

- **Interruptions** to mealtimes by [other activities], e.g. medication rounds
- **Missed mealtimes**, e.g. fasting for tests, away from the facility
- **Inadequate staff knowledge**, including attitudes and priority given to nutrition and the nature of interactions between older persons and carers at mealtimes
- **Cognitive impairment Depressed mood**; and
- **Illness or inactivity** which can cause a reduction in appetite.

In short, causes of poor nutrition can be:

- **Physiological**, such as gastrointestinal disorders, pain, swallowing difficulties, nausea, dental health issues, polypharmacy, sensory loss (e.g., vision, decreased sense of smell and taste which can affect the pleasure of eating), physical functioning (impaired dexterity, grip, arm strength and movement, ability to sit upright, ability to swallow, state of consciousness)
- **Psychological**, such as depression, anxiety, and grief; and
- **Social**, such as isolation, poverty, food insecurity and limited access

It should also be noted that an increasing number of older people have nutrition issues related to being overweight and obese, conditions that can be associated with challenges such as poor physical performance, functional limitations, cardiovascular disease, diabetes and high blood pressure. While some physiological causes maybe considered natural signs of aging rather than specific disorders, they can all impact on nutrition.

How Nutrition Interacts with Other Domains

Nutrition can also affect performance in a number of other health care domains such as:

Mobility and Skin
Good nutrition is important in maintaining muscle mass and strength which, in turn, are important for maintaining mobility. At the same time, being physically active assists with stimulating appetite and therefore assists with maintaining good nutrition. People with limited mobility are at risk of developing pressure sores. Optimum nutrition can help to maintain their skin integrity and avoid pressure sores.

Self-care (hygiene, toileting)
While we tend to relate mobility to walking and getting about, it is also important to maintain muscle strength and range of motion in the arms and hands in order to maintain independence in daily activities such as dressing, bathing, grooming and toileting. Some of that strength comes from good nutrition, and some comes from the exercise obtained from the act of eating.

Continence
Optimal fluid and fibre intake are important aspects of a continence management plan.

Cognition
People living with dementia may forget how to use utensils, may not recognise the purpose of the food placed in front of them, may be distracted by everything else happening in the room, and may obsess about particular foods while losing interest in others. Moderate or higher cognitive impairment usually requires a minimum of supervision with eating and drinking (and most ADLs) due to inability of the person to understand or follow the activity process.

Behaviours
When people with dementia develop diminished verbal abilities, they may express themselves through behaviours. For example, a person who takes biscuits off a plate and puts them in her purse is likely to be telling us that a) she likes biscuits, and b) she doesn't want to go hungry. But a person who walks excessively may be hungry or thirsty and unable to say so, or may not even be conscious of the need. The person may simply feel restless, and isn't quite sure why. Offering something to eat and drink may stop the excessive walking, fill the need and provide extra calories to avoid weight loss. They may require supervision during meal times to reduce interruption to the mealtime. (Can you think of other examples?)

Mood

Loss of appetite and weight loss can be a sign of depression. Therefore, being depressed can have a significant impact on nutritional status. The opposite – over-eating – can also be a sign of depression. They may require supervision during meal times to encourage or manage their nutritional intake.

People will grieve the loss of former abilities, such as loss of independence after a stroke, and it should be noted that mild mood changes (not just depression) can also impact on appetite.

Severe Psychological Symptoms

In rare cases a person may suffer delusions associated with food, such as believing others are trying to poison them.

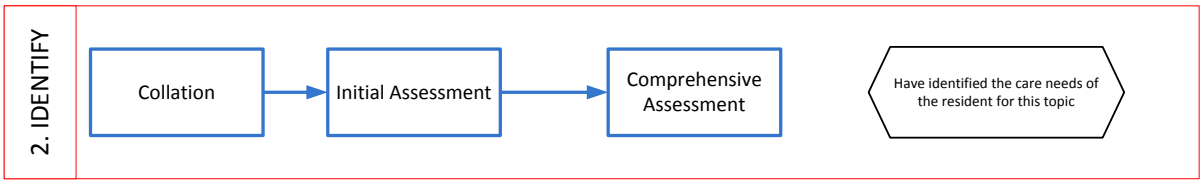
Medications

A range of medications may impact on food intake, including those that increase or decrease appetite as a side effect and medications that cause nausea. Many medications also have a tendency to affect the taste of food, making even well-liked foods less appealing. The side-effects from medications can be a cause of appetite changes, including both increases and decreases.

Complex Health Care

Pain often plays a role in nutrition. Someone with severe arthritis, who finds it painful to hold a spoon, can have difficulty retaining eating independence or interest in food. Pain anywhere – such as from sore feet, sore back– is also likely to produce a reduced desire to eat. Chronic pain can lower a person's mood and cause a person to withdraw from activities and events that were previously pleasurable such as meals.

Identification Process



The steps in the process of **identifying** are:

- Gathering the history from current documentation and information from carers, family and the consumer if possible
- Identifying a need (e.g. initial nurse assessment); and
- Completing a comprehensive assessment of the nutrition needs

Gathering the History

What documents (before you start assessing) do you have which provide information on the resident you are focusing on? You will be able to build a picture of the person's relevant history through current documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, information on signs and symptoms, and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for nutrition.

Document	Look for
ACCR	Diagnoses, swallowing status, dietary needs, aids and assistance
Medical Notes/CMA	Diagnoses, swallowing status, dietary needs, aids and assistance
Allied Health Professional notes/assessment (Dietitian, Speech Pathologist, Occupational Therapist)	Swallowing status, dietary needs, aids and assistance

Here are a few examples of how the collated diagnoses and issues that may be indicators of care needs:

Diagnoses/status	Examples of care needs
Dysphagia and or swallowing issues	May require vitamised/soft/thickened diet and monitoring or assistance with food/drinks
Diabetes	May require diabetic diet
Arthritis/ physical deterioration	Affecting ability to cut up food, requiring physical help or aides with food/drinks
Sensory loss- eyes, hearing, smell	That require strategies or aids to assist the management of food/drinks; e.g. crockery, plates and trays to assist the visually impaired e.g. supervision of meals to ensure nutritional needs are met for those with reduced motivation due to lack of smell
Communication issues of understanding others and/or communicating to others	That require strategies or aids to assist the management of food/drinks; For example, communication aides (language cards, picture cards) to assist the resident to participate in meal activities.

Resident and Family

It is important to include and seek input from the resident, all care staff and his or her family members. As you may recall in our description of Mrs. Green's story, following her stroke, the staff had begun an active program to try to strengthen her ability to swallow and prevent her from choking and also importantly, not losing weight.

Often of significant impact is the knowledge provided by the resident's carers (family and staff). They will understand the social context of meal times for a person. For example:

- Are they embarrassed and prefer not to eat in a group setting?
- Do they miss family meals?
- Do they like lively conversations at meal times or prefer silence so they can concentrate?
- What special foods will help to lift their spirits or interest in meals?

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA covers most domains and topics likely to impact on the health care needs of a person. Based on evidence informed practice, nurses (RN's and EN's) who have received training on a resource such as the Comprehensive Health Assessment of the Older Person (CHAOP) have the competencies to undertake a comprehensive health assessment. In particular for nutrition, the CHA (based on the CHAOP training) covers Eating, Dietary Needs and Swallowing.

If a resident has **a change in status**, the **two key questions** (from the CHA Eating and Dietary sections) to investigate (that will trigger further assessment) are as follows:

EATING:

Does the person need assistance with eating Yes □ No □

- If YES, then complete a comprehensive assessment.

What assistance does the person require with eating……

Identified issues……

DIETARY NEEDS:

Does the person have dietary restriction Yes □ No □

- If YES, then complete a comprehensive assessment

Dietary likes/dislikes ……

Identified issues ……

The CHA also has five swallowing items. The box below sets out the recommended assessment process for informing on these swallowing items.

Question	How investigated
Do they have difficulty swallowing?	Is there a diagnosis of dysphagia? Review the history- from notes, or interview resident and family Observe the resident's first meal
Has a gag reflex?	CHAOP Module 4 page 11 shows how to test a gag reflex
Have any difficulty swallowing food and fluid?	Is there a diagnosis of dysphagia? Review the history- from notes, or interview resident and family Observe the resident's first meal
Cough while eating and drinking?	Is there a diagnosis of dysphagia? Review the history- from notes, or interview resident and family Observe the resident's first meal
Require a texture modified diet?	Is there a diagnosis of dysphagia? Review the history- from notes, or interview resident and family

Note also that if the resident is at medium or high risk of malnutrition or has a chewing/swallowing issue, it is recommended that a referral to the appropriate allied health professional (speech pathologist for swallowing assessment, dietitian for nutritional advice) or their Medical Practitioner be made.

Comprehensive Assessment

For the nutrition domain, it is recommended that all new residents have a comprehensive assessment. The recommended full assessment approach for nutrition involves:

- **Initial nurse assessment** (e.g. the CHA). Based on evidence informed practice, it is recommended that nurses (RNs and ENs) should undergo a CHAOP type training to be competent in a broad assessment that collects information across the domains (found in the ADL Appendix).
- The **Resident Nutrition Data Card** (RNDC). This covers medical history, medications, type of diet, texture of required diet, allergies, food likes/dislikes, appetite, chewing and swallowing ability and dexterity, assistance required for eating, special utensils required, weight and height management, weight history, malnutrition risk guidelines.
- Furthermore, for all ADL topics, it is recommended that a **Physical Functioning Assessment** covering the **Range of Movement** (ROM) across all joints be completed

on residents. The items are recorded in the CHA. With regard to nutrition, this will inform on dexterity, ability to hold utensils, and eat independently. This can be completed by nursing staff who have received the associated training, but if no such person is available, the resident should be referred to the appropriate allied health professional, for example a physiotherapist.

Range of Movement (from the CHA)
Muscles: strength, tone and movement is recorded on a (0-5 scale), if less than 3 then disability is present

Joints : assess (get older person to copy movements with your hand placed over the joint)

- Crepitus
- Heat
- Redness
- Pain
- Deformity

Joints to assess:

- Temperomandibular
- Neck
- Shoulders
- Elbows
- Forearms
- Wrists
- Fingers and thumb
- Hips
- Knees
- Ankles
- Toes
- Spine

Based on evidence informed practice, it is recommended that nurses (with the appropriate training, for example RN or EN with CHAOP or similar evidence informed training on assessments) conduct the assessments using the tools recommended for Nutrition. Further information on all assessments is found in the ADL Appendix and copies are found in the ADL Assessment Pack.

ROM assessment items are found in the CHA and are explained further in the CHAOP Module 3 (found in the Reading Pack).

For further information about the recommended screens and assessments (CHA, RNDC, and ROM) refer to the ADL Appendix, and copies of the tools are found in the ADL Assessment Pack.

Clinical Risks

- If there is a choking event, it is recommended that Standardised Care Process Choking be commenced.
- If there is unplanned weight loss, it is recommended that Standardised Care Process Unplanned Weight Loss be commenced.
- If there is dehydration, it is recommended that Standardised Care Process Dehydration be commenced.
- To address oral and dental hygiene, it is recommended that Standardised Care Process Oral and Dental Hygiene be commenced.

Further information on all recommended Standardised Care Processes (SCP) is found in the ADL Appendix and copies are found in the ADL Assessment Pack.

As discussed earlier, nutrition is intertwined with most of the other ADL topics and other domains. The gathering and review of documents should include these other domains in order to avoid missing relevant information. The initial assessment (e.g. CHA) can be used to identify screening information across the ADL topics.

A many factors play a role in nutrition, let's go back to Mrs. Green and discuss how we used the Comprehensive Approach to support her care.

As illustrated in the case study of Mrs. Green, nutrition is more than swallowing, positioning, strengthening muscles, and changing food textures. Appetite is affected by:

- Being offered food we like the taste of
- The level of fatigue
- The attachment to the people we are eating with

Her nutritional needs have been considered by:

- Medical staff
- Nursing staff
- Speech Pathologist
- Dietitian
- And Mrs. Green and her family

All aspects of her care have been considered, not just nutrition.

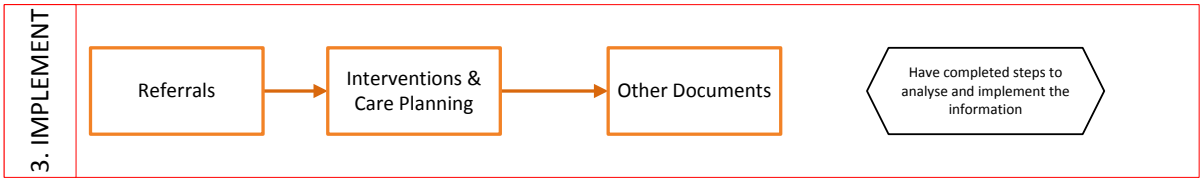
Bringing the information together

The staff collated current information and collected new information in collaboration with Mrs. Green and the family. They set out actions and goals based on the information to specifically meet Mrs Green's needs and wishes. As Mrs. Green's story progresses, her needs and goals will probably change and staff will need to gather further information and be flexible to meet her changing needs.

The actions for Mrs. Green included:

- *A specialised assessment for implementing safe eating*
- *The addition of specific spices to Mrs. Green's meals to make them more appealing to her*
- *Offering her smaller and more frequent meals throughout the day when Mrs. Green is not as tired which takes into account her physiological needs*
- *Including Mrs. Green and her family in her nutrition plan and providing information and training to the family to help them maintain an important role*
- *Inviting her family to eat with her in the private dining room on weekends*

Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning. The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process and the accountability systems, such as for the ACFI funding claims and quality of care aspects for accreditation

Referrals

The possible roles of various health professionals in the implementation process are described in the box below.

Reference: BCOPE Nutrition: p 96

Nursing:

- Seek information about social/cultural issues such as culturally appropriate meals and personal preferences
- Seek information from *persons*, family/carers regarding nutrition/meal preferences and feeding support needs
- Assess the need for supervision and assistance required with meals

Occupational Therapist:

- A functional assessment of disability and environmental modification if required, including prescribing necessary aids and providing advice about the positioning of meal trays and chairs

Speech Pathologist:

- Assessment and recommendations for managing dysphagia
- Assessment and management of oral hygiene issues
- Assessment and management of communication issues
- Assessment for the need for a texture-modified diet

Physiotherapist:

- Assess the level of functional capacity and develop an individualised functional

exercise programs, plus any additional specialised physiotherapy for specific conditions

Dietitian:

- A nutrition assessment for those at risk of under-nutrition using a nutrition screening tool
- Recommendations for specialised diets and nutritional supplements
- Nutrition risk screening and seeking information about social/cultural and personal preference issues, and taking appropriate action to address these issues

Dental/oral health screen:

- Each health service will need to identify which discipline is responsible for completing the dental/ oral health screen. It may be completed by nursing, medical or speech pathology staff, depending on local protocols

BCOPE provides a fairly comprehensive list of health professionals with a relationship to nutrition. Input and recommendations must also be sought, of course, from the resident's General Practitioner.

Referrals are made when a further assessment is needed, or the home does not have the expertise to undertake the assessment. With regard to nutrition, such a referral might be made when the services of a speech pathologist to assist the resident with swallowing exercises are needed.

We recommend that your nursing management develops referral lists, based on what your health service can provide, what is available in your local area and a list of important website contacts to find a practitioner or advice, as described in Table 2.

Table 2: Referrals for Nutrition

Health Professional	Source	Contact
Dentist	Local	Name, contact details
Speech Pathologist	Health Service	Name, contact details
Occupational Therapist	Health Service	Name, contact details
Physiotherapist	Health Service	Name, contact details
Dietitian	Health Service	Name, contact details
Clinical Nurse Specialist	Health Service	Name, contact details
Australian Dietitian's Association	website	http://daa.asn.au/
Australian Physiotherapists Association	website	http://www.physiotherapy.asn.au/

Interventions

In the identification phase, the residents' healthcare and personal needs are identified. The intervention program will address these identified issues, by developing strategies to improve or maintain the health status and their quality of life of the resident.

The intervention program targeting nutrition should involve evidence informed strategies (refer below) that address the nutrition needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Intervention Resources

The BCOPE resource lists strategies to improve nutrition in older persons (p.85-86) which may help to improve the person's nutritional status.

Strategies for nutrition (from BCOPE, page 85-86)

Some options to enhance the nutritional intake of a resident are:-

- Identify food preferences and usual intake and communicate these preferences to food services, the dietitian and staff completing menus.
- Ensure appropriate positioning for meals. The recommended position to consume meals is seated in a chair at a table. Check the table is the correct height for the chair and the food is within easy reach.
- When eating in bed, the person should be sat upright and supported in this position.
- Provide assistance with set up and access. Ensure the meal tray and items are placed within reach. Ensure items are opened and positioned within reach and that the older person is aware of the items.
- Provide encouragement. Often older people will have small appetites due to limited activity, illness or mood. Frequent prompting and encouragement with meals in

these cases is essential. The most nourishing foods should be consumed first. For example, have the main meal in preference to soup or have a milk drink instead of a cup of tea.

- Monitor and observe intake and weight. When an issue is identified, record food intake, and do regular checks of weight to measure the changes in nutritional status and the success of the nutrition management.
- Minimise interruptions.
- Provide a social environment for eating.
- Sufficient time should be allowed to complete meals in an unhurried manner.

Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

Facilities may have their own care plan or the NATFRAME Care Profile could be used as a starting point as a summary care plan. Although the NATFRAME Care Profile will probably not record enough details for your home, it is an example of how to collect and document information in a systematic, professional and accountable manner.

Goal Setting

Moving beyond compliance, the care planning should also address setting goals based on clinical outcomes and the resident's perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations).

SMART Goals are an example of a standardised approach to goal setting with measurable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

- **Specific**, that is, they provide clarity, focus and direction
- **Measurable -** Objective measures can demonstrate the effectiveness of the goals
- **Action-oriented**, that is, they provide a strategy for achieving them

- **Realistic** – they meet the resident's preferences, they are practical for staff to implement and they consider the efficient use of resources, because if they're not, we're just setting up for almost certain failure
- **Time-based**, meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis

Role of documentation

Documentation of care is essential because members of the care 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 also 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. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the nursing process which drives the care. It should incorporate evidence informed practices, assessments and interventions, utilise staff skills, and drive a quality care approach.

The documentation process should leave a trail that provides robust and accountable information, leaving your facility audit ready. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required
- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate)
- Record the evaluation of the care provided including the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this

assists the information and communication flow and allows the process to be tracked for quality purposes

- Incident forms should be completed recording nutrition and swallowing issues. This would be documented in the resident's goals and care plan.

Linking the Evidence

This is about showing the link between the evidence from the background and assessment information (what has been collected in the identification phase) and the care that has been provided to address the identified care needs (in the implementation phase).

The links are:

- Begin by looking at and noting any underlying issues (e.g. diagnosis) or symptoms (e.g. underweight), connect the link to the body structures and/or functions that are impacted (e.g. nutritional intake and mood are lowered)
- Describe the associated activity limitations (e.g. reduced appetite, reduced energy, lack of interest in food). It's important to look at remaining strengths (e.g. food preferences, pleasant events associated to eating)
- Describe the intervention program and how it addresses the limitations to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. food variety, provide a social environment)
- Finally, define the care goals (to gain three kilograms in two months) and resident goals (having a family meal) that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes.

For example, our goal is to address a resident's weight loss by doing the following:

- Set a specific target, for example to not lose weight over the next month
- Measure the weight at baseline and weekly, after one month interview the resident and family for their feedback
- Describe the action to achieve the goal, e.g., adding spices to the resident's food
- Check it is realistic, the resident and family collaborated with the development of the strategy, it fits into the normal practices, and it is affordable
- Make it time-based, to be reviewed after one month

Looking at how the care plan was further developed for Mrs. Green.

After involving Mrs. Green, her family, and various staff, it was decided at the next care plan meeting to try some things for one month and then re-evaluate whether they were working. They are:

1. *Adding specific spices to Mrs. Green's meals*
2. *Offering smaller and more frequent meals throughout the day when Mrs. Green is not as tired*
3. *Providing information about Mrs. Green's diet to the family and demonstrating to them how to position Mrs. Green when she eats and drinks*
4. *Inviting her family to eat with her in the private dining room on weekends*

The staff turn these actions into the following goals:

- *Increase Mrs. Green's daily nutritional intake to stem the weight loss*
- *Educate the family on safe swallowing practices to reduce the risk of choking*
- *Increase Mrs. Green's sense of wellbeing (her quality of life) by inviting the family to frequently share a meal with her*

The goal for Mrs. Green was to improve her swallowing (in part through exercises), decrease her tendency to choke and to maintain or increase her weight. Incident forms could be used to inform if Mrs. Green continued to choke. That documentation can be used to identify when, where, and how it happened, and can then be used for monitoring quality outcomes for the resident.

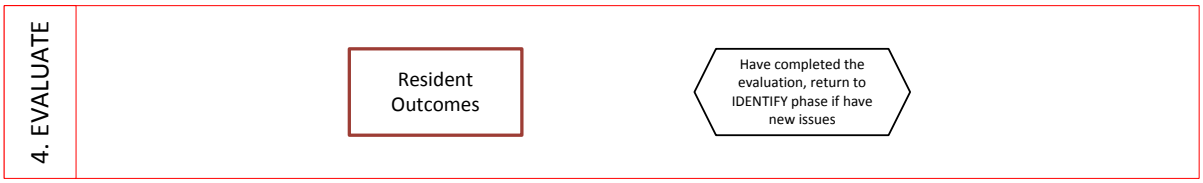
Completing the ACFI documentation

The data collected can now be used to complete the ACFI 1 checklists as described in Table 3.

Table 3: ACFI Question 1 Checklists

ACFI Question 1 Checklists	Where to find the information
Readiness to eat: Supervision - placing utensils in hand	ROM Assessment (dexterity and wrist)ACCR or Medical Practitioner notes Summary Care Plan
Readiness to eat: Physical Assistance - cutting up food or vitamising food	RNDC: Type of diet & Texture ACCR or Medical Practitioner notes Dietitian or Speech Pathologist notes ROM Assessment (dexterity and wrist) Summary Care Plan
Eating: Supervision -standing by to provide assistance	Documented impairments- physical, sensory, cognitive, behavioural Initial Nurse Assessment Speech Pathologist notes RNDC Chewing & Swallowing ability ACCR or Medical Practitioner notes Summary Care Plan
Eating: Supervision - daily oral intake for PEG feed	Dietitian or Speech Pathologist notes Summary Care Plan
Eating: Physical assistance - placing or guiding food into the resident's mouth for most of the meal	RNDC Eating Assessment (Total Assistance) ACCR or Medical Practitioner notes Speech Pathologist notes Summary Care Plan

Evaluation Process



Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways (e.g. happier, healthier)? What might have produced this outcome (e.g. family meals)? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and family.

- Resident Care Outcomes

  With regard to nutrition, for example, has the intervention stemmed the weight loss? This could be determined by recording the resident's weight.

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Outcomes

Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to

identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

An evaluation of Mrs. Green's care has shown that she has improved and the interventions are working. Mrs. Green and her family met with the members of the care planning staff to evaluate how far they have come and discuss any changes that needed to be made. They reviewed the progress notes and the notes made by Mrs. Green's doctor, dietitian and speech pathologist. They also assessed the outcomes against the goals included in her care plan. They found:

- Mrs. Green is improving physically – she is no longer losing weight and is being careful in her swallowing.
- She is getting stronger and more energetic, so that she no longer needs assistance eating in the evening
- She is also feeling more hopeful about her recovery. Her new goal – approved by the speech pathologist and dietitian – is to return over the next month to a more normal textured diet

Evaluation will show care staff what is or is not working and provide the basis for reviewing the interventions being used to achieve the goals. The evaluation provided the proof that what they had put in place to assist Mrs. Green had worked and improved her quality of life. New actions will also come out of the evaluation review, along with new goals.

Summary: Steps and Information Flow

Figure 2 below shows the nutrition topic phases and steps in the process. It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment;
- Completing the Comprehensive Assessment (RNDC, Physical Functioning, and completing Standardised Care Processes to address any clinical risks)

The implementation phase which comprises:

- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

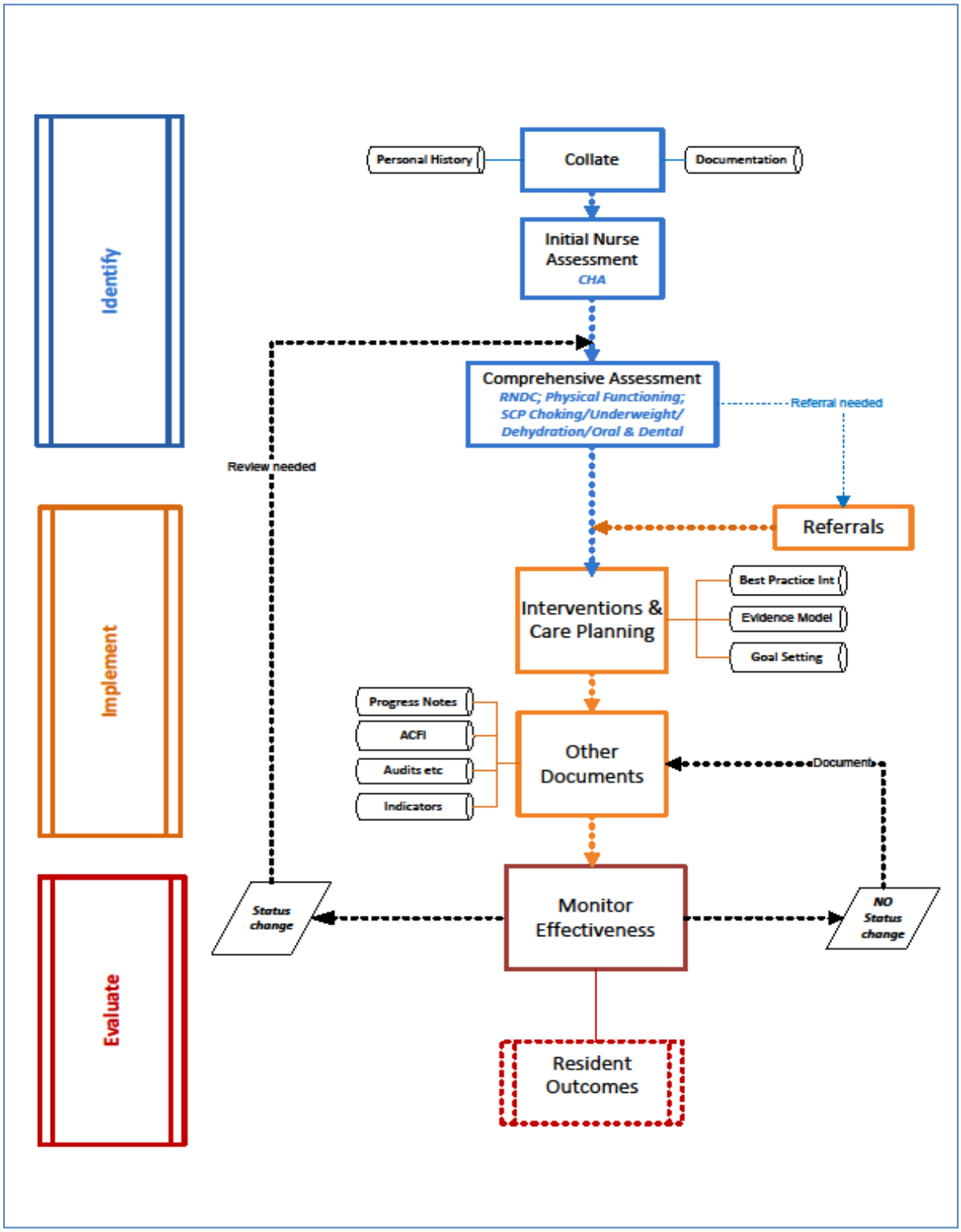
The evaluation phase which comprises:

- A review of the effectiveness of the interventions on resident outcomes
  Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the identification phase and the associated steps

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives a reason to follow a particular plan toward improved health.

Prepare | Identify | Implement | Evaluate

Figure 2: Nutrition Summary: Steps and information flow



Topic 2: Mobility

The Mobility Topic

This topic focuses on mobility. The Activities of Daily Living (ADL) domain highlights the interplay between the topics of mobility, nutrition, personal care and toileting, and the impact of other domains on these activities.

Investigating Mobility

The same four process steps are used across all the workbooks. The steps are:

1. **Preparation by staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. The background reading includes:
    - Comprehensive Health Assessment of the Older Person (CHAOP) Module 3
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

The references for these resources can be found in the ADL Appendix.

2. **Identifying** – gathering the resident's history by collating documents and talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, completing a comprehensive assessment approach and assessing the scope of the challenge. It is recommended that all new residents have a comprehensive assessment of mobility. A comprehensive approach will include:

File Notes Review:

- Aged Care Client Record (ACCR) – Part 5 of which includes some information on mobility
- Comprehensive Medical Assessment (CMA) – which (if available) may have, for example, related diagnoses and sections on mobility and transfers.

Screen:

- Initial nurse assessment e.g. Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA is based on the 'Comprehensive Health Assessment of Older People' resource and provides an initial assessment of transfers and physical functioning, and a detailed Range of Movement assessment.

Further Assessment:

The following assessment tools and Standardised Care Process (found in the ADL Assessment Pack) are recommended for comprehensively assessing mobility care needs. It is recommended that all new residents have these assessments completed:

- Physical Mobility Scale (PMS)
- Falls Risk tool (FRAT)
- Range of Movement (ROM)
- Grip test
- The Standardised Care Processes (SCP) Physical Restraints is also recommended for addressing clinical risks associated with physical restraints.

These tools are found in the ADL Assessment Pack and are referenced in the ADL Appendix.

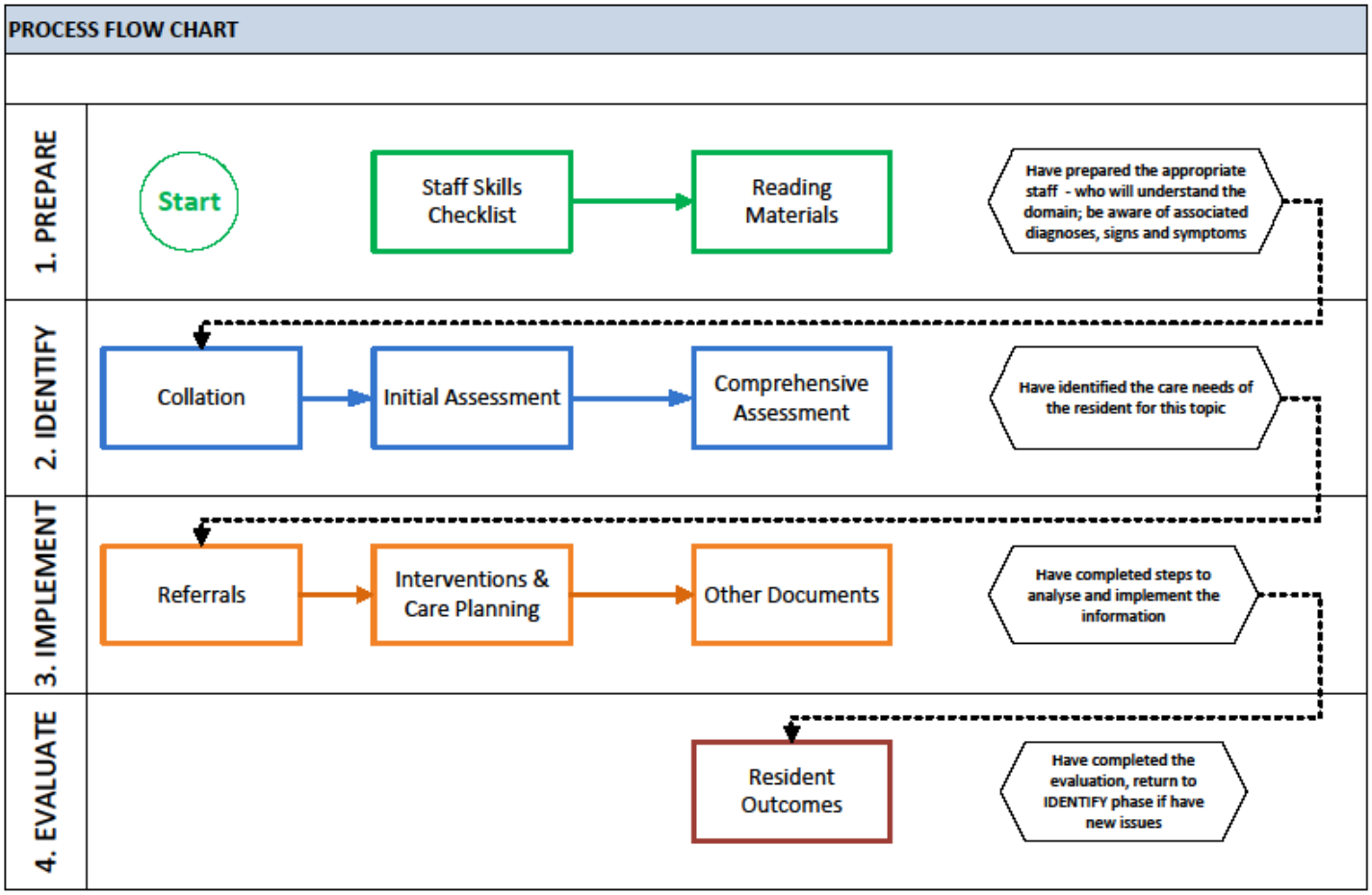
3. Implementing – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

- Undertaking referral options to complete gaps or seek specialist advice
- Planning evidence informed care strategies to assist the person to maintain or possibly improve their participation ability
- Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
- Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
- Completing ACFI documentation

4. Evaluating – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

The overall mobility process and associated activities is illustrated in Figure 3 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the ADL Workbook follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

Figure 3: Mobility process



Getting Started with a Mobility Example

This case study will be referred to as we discuss the mobility topic.

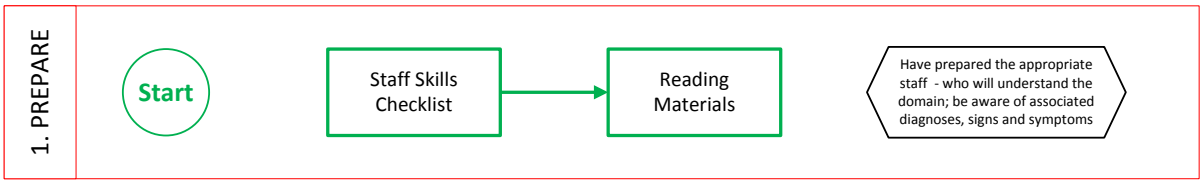
Mr. George Teal is an 85 year old man with a gait disorder aggravated by arthritis in his right foot and knee. Due to pain and weakness on his right side, he tends to walk somewhat lopsidedly and has had some recent falls. George has learnt to use a 4-wheel frame which improves his balance, when he remembers to use it.

George has no hesitancy about using his frame when he is reminded, but he almost always needs reminding, because he has symptoms of mild dementia, such as forgetting where he left things, repeating favorite stories, and diminished verbal abilities. He also has some loss of proprioception (recognising the position of his body in space and how he needs to move his body to get to a new destination), which added to his sometimes quick movements, has been part of the cause of some of his falls.

Nevertheless, both George and his family feel strongly that the advantages of staying mobile outweigh the risks of falling, even though one day a fall could mean a broken hip. He wants to be able to move around and sit outside in the garden to watch the birds - gardening and birds watching are still his favourite activities.

The question for staff and George (and his family) is how to manage his risk of falling while giving him the freedom to move about.

Preparation



There are two specific aspects to **preparing** staff for the management of resident mobility care needs. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 4 provides a structure for management to identify which staff have the skills required to complete the activities within the mobility process. The process includes:

- Identifying the required activities (examples provided in Table 4)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in specialised "physical functioning assessment", the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Physiotherapist) who could complete the assessment.

The introductory guide also provides further instructions for nursing management in preparation for implementing this toolkit.

Table 4: Staff Activities for the Mobility Process

Activity	Responsible for sign off	Do the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment: e.g. CHA		
Falls Risk Assessment		
Assessment: Range of Movement		
Assessment: Physical Mobility Scale		
Assessment: Grip Test		
Specialised Assessment e.g. Physical Functioning		
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		

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of mobility issues in older people. It is expected that staff will have:

- A comprehensive understanding of the mobility domain and how it can be impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practice associated with mobility - to assist with the development and implementation of evidence-based care plans

The background reading that is relevant to the mobility topic is:

- CHAOP Module 3 (Comprehensive Health Assessment of the Older Person), especially the Range of Movement section, p 12-24, (which can be found in the Reading Pack).
- BCOPE (Best Care for Older People Everywhere) which is summarised below, covering pages 61-70. The reference from the BCOPE is found in the ADL Appendix. Please note that the BCOPE was primarily written for hospital settings with intended transferability to a range of other care settings. The language and terminology used may not always suit residential aged care.

Some Basics

What do we mean by mobility?

Functional mobility is the capacity to move from one position (sitting, lying down, standing and so on) to another, to enable participation in normal daily routines and activities. Functional mobility includes, for example, bed mobility, transfers, walking, wheelchair mobility, driving and taking public transport. This mobility enables an individual to participate in a range of self-care, productive, and leisure activities. That independence, in turn, helps promote the individual's sense of self-worth and actualisation (BCOPE, 2012. p61).

But mobility goes beyond body strength and range of motion. It's also affected by the individual's energy levels, endurance, motivation and cognitive capacity.

Why is mobility important?

The combination of abilities to mobilise and participate in self-care is fundamental for interaction and control within a person's environment. These combined abilities enable an individual to maximise their:

- Opportunities for personal independence
- Social connectedness
- Security
- Activity
- Dignity

(BCOPE, 2012. p.61).

When this independence is compromised because people become less mobile and therefore less able to show their personal independence in caring for themselves, staff need to provide more support so those last four elements of connectedness, security, activity, and dignity are maintained.

What are some of the overall benefits of maintaining mobility?

Assisting individuals to maintain or regain mobility can help them:

- Maintain or improve their independence
- Prevent the decline that can come after a period of inactivity, such as following an illness
- Maintain or increase muscle strength through physical activity
- Decrease the risk of muscle shortening, joint distortions and reduced muscle capacity
- Decrease cardiovascular de-conditioning that can occur with prolonged periods of bed rest
- Decrease reduced aerobic capacity that can occur through changes in muscle metabolism
- Reduce the likelihood of falls.

(BCOPE, 2012. p.63).

Why is reducing the likelihood of falls important?

Falls, related injuries, and – this is not to be underestimated – the loss of confidence due to *the fear of falling* is common causes of morbidity in Australia. In hospital and residential care settings, the risk of falling is even greater than in the community setting because of acute illness, increased levels of chronic diseases and different environments and routines. More than half of all people living in residential aged care facilities have at least one fall each year. (http://www.health.vic.gov.au/agedcare/maintaining/falls_dev/Section_a2.htm)

While up to a half of these falls cause serious injuries such as fractures, falls with or without injuries are associated to de-conditioning and increases in risks of further falls and functional decline. Research has shown that interventions to minimise falls risk can reduce the risk of falling and fall-related injuries, even in older people at high risk. Staff involved in direct care in all health settings including residential care, have a key role in successfully implementing falls risk minimisation activities. (BCOPE, 2012 p.62).

How Mobility Interacts with Other Domains

Mobility can also affect performance in a number of other health care domains. For example (BCOPE, 2012, p61-63):

- People who are able to get themselves to the dining room and have adequate self-care to eat independently are likely to have more opportunities for personal independence and social connectedness. Being able to ambulate independently also

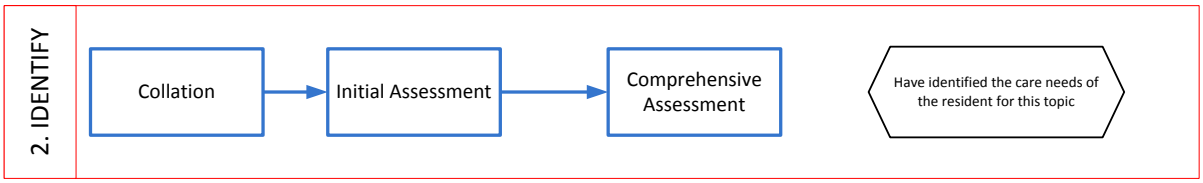
reduces the risk of under-nutrition. An older person's ability to walk to the toilet may also help them maintain continence, prevent constipation and bladder infections

- Mobility improves the ability of the resident to participate in activities which has a tendency to lift moods, decrease feelings of depression, and promote a sense of self-worth.
- People who are able to do things like walking and transferring in and out of bed, tend to have better strength, balance, and endurance, which assists aerobic capacity and maintaining cardiovascular conditioning.

As maintaining a person's ability to mobilise as far as possible is important for health, general functional performance and quality of life, it is important that the nursing team have contemporary knowledge about and be competent to**:**

- Perform a comprehensive assessment for falls risk, mobility and functional status. Then be confident to take action to minimise the likelihood of falls.
- Develop an individualised care plan to promote mobility with input from the resident and family.
- Understand how to assess and modify the environment to encourage independence and mobility.
- Know where to refer for individual or group exercise training for muscle strength, endurance and balance.
- Assist in the retraining of activities of daily living as needed.
- Supervise walking and transfers in those identified to be at risk of falling.
- Encourage physical activity via incidental exercise and participation in functional maintenance or enhancement programs, as appropriate. (Incidental exercise is the muscle workout you get in walking to the bathroom, for example). Enhancement programs might be formal exercise programs including things like chair yoga or Tai Chi.
- Understand bed safety including, for example: adjusting bed heights to allow for safe, independent, transfers; providing aids to assist with optimal transfers for patients getting out of bed.
- Understand the risks of restricting mobility and provide strategies to prevent de-conditioning.

Identification Process



The steps in the process of **identifying** are:

- Gathering the history from current documentation and information from carers, family and the consumer if possible;
- Identifying a need (e.g. initial nurse assessment); and
- Completing a comprehensive assessment of the mobility needs

Identification of care needs and Mr. Teal's case study:

While George and his family have made their wishes clear – he wants to remain as mobile as possible, and his family agrees that's important for both his physical health and mental well-being – it's up to staff to help keep him as safe as possible.

They will begin by gathering all the information they can. For example, here are some of the things they need to know:

What diagnoses does he have, and what symptoms does he display?

What is the extent of the impairment, and what can be done to improve or maintain his gait?

What is known about his falls? What do we know about when, where, and why past falls have happened? For example, do they happen late in the day when he is tired? Do they happen in crowded areas or near some other potential obstacle? Do they happen because George is distracted and not concentrating on moving carefully? Do they happen in areas that might be at risk to others, too, such as a slippery floor or tripping on an unsecured carpet? Do they happen indoors or outdoors?

What part does physiological impairment, pain or cognitive impairment play?

Then they can consider interventions such as physiotherapy, reminders to use mobility aids or pain management.

Gathering the History

What documents (before you start assessing) do you have which provide information on the resident you are focusing on? You will be able to build a picture of the person's relevant history through current documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, information on signs and symptoms, and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for mobility.

Document	Looking for
ACCR	Diagnoses, mobility status, mobility assistance needs, aids
Medical Notes/CMA	Diagnoses, mobility status, mobility assistance needs, aids
Allied Health Professional notes/assessment (e.g. Physiotherapist, Occupational Therapist)	Diagnoses, mobility status, mobility assistance needs, aids

Here are a few examples of how the collated diagnoses and issues may be indicators of care needs:

Diagnoses/impairments/strengths	How impacts on the care needs
Musculoskeletal diseases e.g. Arthritis and physical deterioration	Affecting endurance and strength, and may require physical help or aides with mobility
Limb deformities, amputation	May require prostheses, wheelchair or other aids, may need assistance to use these aids.
Diseases of the nervous system e.g. Parkinson's disease, hemiplegia	May require physical assistance with walking or a wheelchair.
Cerebrovascular diseases e.g. stroke	May require a lifting machine for transfers
Sensory loss- eyes, hearing,	That require strategies or aids to assist the management of mobility; e.g. consistent staff approach to where aids are left for easy access to assist the visually impaired e.g. supervision of walking to reduce the likelihood of falls
Communication issues of understanding others and/or	That require strategies or aids to assist the management of mobility;

Diagnoses/impairments/strengths	How impacts on the care needs
communicating to others	For example, communication aides (language cards, picture cards) to assist the resident to participate in the physical activity of walking.
Physical functioning (dexterity, grip, ROM, upper limbs, lower limbs, sitting upright)	Affects mobilising and transferring, using aides.
Pain	Pain can affect physical strength, concentration and mood.
Cognition (moderate to severe cognitive impairment)	Moderate or higher impairment usually requires supervision with transfers/walking due to inability of the person to understand or follow the activity process. Reminders to use mobility aids.
Behavioural issues (interfering while wandering, inappropriately trying to get out of the building)	May require redirecting or supervision.
Behavioural issues (grabbing onto others when walking)	May require supervision when ambulating in busy areas e.g. corridors.
Mood issue (slow movement, loss of interest)	May require supervision/encouragement to mobilise.

Resident and Family

It is important to seek input from the resident, his or her family members and staff directly caring for Mr Teal. Mr Teal and his family will probably have valuable information to assist staff about both his clinical needs and what is important for his enjoyment of life, for example:

- What strategies for pain have or have not worked?
- What have been the triggers for falls?
- Do they occur at a particular time of the day or during any specific activity?
- What are his personal interests?
- What would most improve or maintain his enjoyment of life?

Meeting the needs of a resident is a team effort and input from a variety of sources both professional and non professional will assist the understanding of the resident's needs.

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA covers most domains and topics likely to impact on the health care needs of a person. Based on evidence informed practices, nurses (RN's and EN's) who have received training on a resource such as the Comprehensive Health Assessment of the Older Person (CHAOP) have the competencies to undertake a comprehensive health assessment.

It is recommended that all new residents have:

- An initial nurse assessment (e.g. **CHA** tool – found in the ADL Assessment Pack) which will identify mobility and physical functioning needs. The CHAOP manual and training covers how to assess for mobility, the musculoskeletal system, transfers, mobility and the Range of Movement
- **Falls Risk Assessment Tool (FRAT**- found in the ADL Assessment Pack**)** is recommended for screening for risk of falls for *all* residents on admission

The relevant CHA items for Mobility are listed below; it is recommended that a positive screen from any one of the indicated items should trigger the completion of the **PMS** assessment (**Physical Mobility Scale**).

PHYSICAL FUNCTION: If no to any of the following six items then complete the PMS assessment

Can the person walk unaided?	Yes	☐	No	☐
Can the person:				
Turn over in bed?	Yes	☐	No	☐
Move from supine to sit?	Yes	☐	No	☐
Move from sit to stand?	Yes	☐	No	☐
Move from bed to chair?	Yes	☐	No	☐

What mobility aids does the person use?

MUSCULOSKELETAL: If no to any of the following then complete the PMS assessment

Posture				
Is their body erect?	Yes	☐	No	☐
Is their head upright?	Yes	☐	No	☐
Normal curvature cervical/thoracic/lumbar	Yes	☐	No	☐
Gait				
Is gait coordinated?	Yes	☐	No	☐
Is turning co-ordinated and easy?	Yes	☐	No	☐
Normal curvature cervical/thoracic/lumbar	Yes	☐	No	☐

Limbs

Alignment	Yes	☐	No	☐
Deformity, contractures	Yes	☐	No	☐
Muscle tone	Yes	☐	No	☐

Range of Movement (these items do not trigger the PMS)

Muscles: strength, tone and movement is recorded on a (0-5 scale), if less than 3 then disability is present

Joints : assess (get older person to copy movements with your hand placed over the joint)

- Crepitus
- Heat
- Redness
- Pain
- Deformity

Joints to assess:

- temperomandibular
- neck
- shoulders
- elbows
- forearms
- wrists
- fingers and thumb
- hips
- knees
- ankles
- toes
- spine

Has the person fallen in the past 3 months?

The Falls Risk Assessment Tool (FRAT) is recommended for assessing the risk of falls.

The FRAT is a validated assessment tool and can be completed by the nursing staff (with the appropriate training, for example RN or EN with CHAOP or similar evidenced informed training).

It is first a *screening* tool, that is, it provides a risk score and identifies residents most at risk. Secondly, it is an *assessment* tool that identifies risk factors and assists with the planning and management of the at-risk residents. This widely distributed resource provides a comprehensive approach to falls.

- The FRAT risk assessment tool is supported by: Detailed guidelines
- Multidisciplinary intervention strategies to reduce falls and falls injury
- Staff development and training information and material
- A range of other material related to guidelines for prescribing medication, an incident form, environmental checklists, brochures, and additional resources and recommended; and
- It produces objective data that can be used for Clinical Indicators

The FRAT divides people into three risk classifications:

- **Low**: Provide standard care and follow general patient safety principles.

- **Medium**: Provide standard care, but integrate into the care plan strategies that target the identified areas of risk.

- **High**: Commence Fall Alert Protocol. Patient has a high likelihood of a fall occurring.

Mobility is not just about the lower body as hand and arm strength are also an important elements. Someone with severe arthritis who cannot grip effectively can be prone to accidents because they cannot grip a walking frame firmly enough if it is bumped, for example.

The Range of Movement (ROM) of joints provides information about a person's dexterity (along with information about the upper and lower limb joints); the ROM and grip strength together may inform about the person's ability to use mobility aids and to transfer independently. ROM assessment items are found in the CHA and are explained further in the CHAOP Module 3 pages 12 to 23 (found in the Reading Pack).

Based on evidence informed practice, it is recommended that nurses (with the appropriate training, for example RN or EN with CHAOP or similar evidence informed training) undertake the recommended tools for Mobility.

Comprehensive Assessment

In addition to the completing an initial nurse assessment and FRAT, the comprehensive approach includes the:

- **PMS (Physical Mobility Scale** is found in the ADL Assessment Pack) to be completed if triggered from the initial nurse assessment, and re-assessed when there is a change in mobility status
- The **grip strength assessment** (refer to the Mobility Appendix)

The Physical Mobility Scale (PMS) was developed by Australian physiotherapists working in residential aged care to specifically show resident functional mobility and to provide information regarding each resident's need for supervision or assistance from one or two staff members and equipment during position changes, transfers, mobilising and personal care.

The PMS can be completed by the nursing staff (with the appropriate training, for example RN or EN with CHAOP or similar evidence informed training).

It has 9 items scored from 0-5 (dependent to independent scale) and produces objective information for care planning on:

- Positional changes (lying to side, lying to sit, sit to stand and reverse)
- Balance (sitting, standing)
- Transfers
- Ambulation
- Aids

A grip assessment can be used if the facility has the equipment and the trained staff. Grip strength is considered a good marker of physical performance in older people and is more feasible than many short physical performance batteries (J Nutritional Health Aging 2012; 16(9): 769-74).

Further information about the recommended screens and assessments (CHA, ROM, RNDC, PMS and Grip Test) are found in the ADL Appendix, and copies of the tools are found in the ADL Assessment Pack.

Clinical Risks

The Standardised Care Process 'Physical Restraint' is a tool that can help you investigate and find alternatives to physical restraints. Further information about the recommended Standardised Care Process 'Physical Restraint is found in the ADL Appendix, and copies of the tools are found in the ADL Assessment Pack.

"Physical Restraint is 'the intentional restriction of a resident's voluntary movement or behaviour by the use of a device, or removal of mobility aids, or physical force' (Department of Health and Ageing (DOHA), 2004 p.6)

"Physical restraint is most often used to manage need driven behaviour and prevent falls. However, the evidence indicates restraint does not prevent falls or fall related injuries (DOHA, 2007) and is likely to exacerbate behaviours. "(SCP Physical Restraint p.1)

If physical restraint is used to prevent falls, it is recommended that the clinical risk tool associated to physical restraints be investigated.

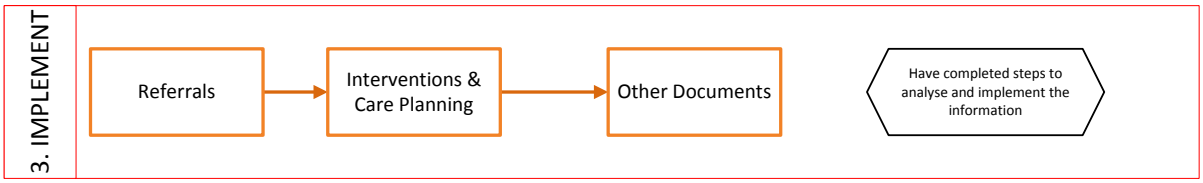
Bringing the information together

As is the case with all of the EBCAT topics, the assessor should also consider the impact from other domains and care topics. These might include:

- Cognitive impairment (e.g. as identified in the Cognition domain)
- Sensory impairment (e.g. as identified in an initial nurse assessment)
- Physical impairment (e.g. as identified in an initial nurse assessment)
- Behavioural issues (e.g. as identified in the Behaviour domain)
- Psychological/Psychiatric symptoms (e.g. as identified in the Cornell Depression Scale)

Once you become familiar with what you have to do (the steps) and how to do it (the process), the basics apply to all the topics and domains in this toolkit. You will always need to know how to apply it to individuals.

Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning.

The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process and the accountability systems, such as for the ACFI funding claims and quality of care aspects for accreditation

Considering Mr. Teal's case study:

George is at medium risk for falls according to the FRAT assessment, and he has some mild symptoms of dementia that contribute to his forgetfulness with regard to using his 4-wheel frame, but curtailing his mobility has risks of its own.

He and his family – as well as the staff – are especially concerned about maintaining his quality of life as long as possible. Here are some of the solutions they developed to help him continue with his two favourite pastimes, gardening and bird watching, both of which make being outdoors especially pleasurable for him.

To maximise his bird watching opportunities (and the opportunities for other residents with that interest) the staff has:

- *Ordered some bird activity resources– e.g., bird books and posters, bird feeders and bird seed*
- *The bird feeders have been hung outside in the garden where they can be observed from inside as well*
- *George's family have purchased a pair of lightweight binoculars with a strap that George can easily handle*
- *A time has been set for staff to assist George to sit outside. The chair has arms (so that he can more easily lift himself up again if he chooses to) and is placed in a position where staff can visually supervise him*
- *Once a week, a volunteer from the local bird watching club comes to sit outside and*

talk with him about birds

To maximise his gardening opportunities, (and the opportunities for other residents with that interest) the staff has:

- *Ordered some gardening resources – garden books and posters, seeds, tools, light pots and a raised garden bed*
- *Started an activity with residents of planting seeds of various herbs in paper cups, ready to go into the raised garden beds or pots*
- *Placed seating in a sheltered place in the garden for George and other residents and where staff can visually supervise the residents*
- *Found a volunteer to help with the garden activities*

Referrals

If there is an identified need for a specific physical functioning assessment that cannot be provided on site, a referral to a physiotherapist or medical practitioner will be needed. A referral to an Occupational Therapist for specific aides to assist bed transfers could also be considered.

We recommend for mobility assessment and programs nursing management develop referral lists, based on what your health service can provide, what is available in your local area and a list of important website contacts to find a practitioner or advice (Table 5).

Table 5: Referrals for Mobility

Health Professional	Source	Contact
Occupational Therapist	Health Service	Name, contact details
Physiotherapist	Health Service	Name, contact details
Clinical Nurse Specialist	Health Service	Name, contact details
Australian Physiotherapists Association	website	http://www.physiotherapy.asn.au/

Interventions

In the identification phase, the resident's healthcare and personal needs were identified. The intervention program will address these identified issues, by developing strategies to improve or maintain the resident's health status and their quality of life.

The intervention program targeting mobility should involve evidence informed strategies (refer below) that address the mobility needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Following is a sample item from Mr. Teal's care plan related to mobility. Note that the items in this care plan are representative. Not *everything* in his care plan is listed here. Note that in the case of George, poor balance, cognitive impairment, history of falls, and minimising environmental risks (and perhaps more) would all be helpful in creating his care plan. For example, activities related to exercise and self-care could be encouraged and made part of his care plan.

Being outdoors daily to watch and listen to the birds and/or putter in the garden is of great importance to George. To reduce the risk of a fall the following steps will be followed for one month and then re-evaluated. (This assumes no falls occur. A fall will automatically trigger a re-evaluation.)

1. *Staff and family will be educated regarding the resident's right to take some risks, and the possible consequences of those risks (e.g., risk of a fall.)*
2. *Staff and family will also be educated on falls risk management –e.g., keeping his frame close at hand, how to prompt him to use the frame, and good shoes etc.*
3. *To establish a routine, weather permitting, George will go outside at approximately 10:00 a.m., and, if he wishes, again at 3:00 p.m.*

4. *The garden visits will be fully supervised for the first two weeks to help him establish a routine of going to the chair set up for him, and sitting with his binoculars in hand (secured around his neck) and his frame directly in front of him. Carers are to check the chair is not wet from rain or dew*
5. *Staff and the physiotherapist will practice with George both getting settled into the chair, and getting up again*
6. *After two weeks, George's carer will be assigned to check on him every 15 minutes while he remains outside, and he will be expected to stay no more than one hour before being invited in for tea or other refreshments*
7. *Family members are encouraged to sit or walk outdoors with him whenever they visit*
8. *Should he choose to, George may also go outdoors at other times, especially when gardening activities are taking place outdoors*

Intervention Resources

For a general overview of the wide range of strategies that can be used to assist mobility, refer to the FRAT (found in the ADL Assessment Pack) – it has examples of multidisciplinary intervention strategies to reduce falls and injuries from falls.

Another useful resource is the Victorian Quality Council (VQC) website (http://www.health.vic.gov.au/qualitycouncil/downloads/falls/research.pdf), they have developed an extensive list of guidelines to minimise personal risk factors associated to falls (across many settings not limited to residential aged care), which cover actions that can be considered to address particular issues. Again, these strategies need to be considered in light of the resident's profile. The website provides strategy ideas related to:

- Leg muscle weakness
- Poor balance
- Use of more than 4 medications associated to falls
- Cognitive impairment
- Postural hypotension
- Incontinence
- Sensory loss
- Poor condition of feet
- Fear of falling
- Poor nutritional status
- History of falls and
- Minimising environmental risks

Using Incidental activities to promote mobility

Incidental activities are those where physical activity occurs as part of routine activities, for example, walking to the toilet, dressing, and getting up from the dining table. Because it involves activities people are familiar with, it tends to be less anxiety-provoking than starting a new physical activity. It also has a purpose, so if a person is not interested in a formal physical activity program, these personal care and domestic tasks are a beneficial form of exercise (BCOPE, 2012, p.67).

The environment

Another area of assessment to be addressed is the environment. While there may be limited ability to make major changes your facility's built environment, small changes to the physical environment can impact on the social environment and the quality of life of the residents.

Remember what we wrote about in Mr. Teal's story:

- The birdfeeders were hung outside large window areas
- The internal chairs were placed so that residents could watch the birds and the garden from a comfortable and stable position
- External seating was placed in a position so that staff could observe the residents when outside
- We made sure George had a safe and comfortable place to sit outside and watch for and listen to birds
- There were gardening resource options - inexpensive large plastic pots or raised gardening beds
- Books and posters to encourage an interest (in birds or gardening) amongst staff, residents and visitors

Other changes may aim to minimise environmental risk and protect resident safety – a slippery floor, window glare, uneven pavement for example.

Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

Facilities may have their own care plan or the NATFRAME Care Profile could be used as a starting point e.g. as a summary care plan. Although the NATFRAME Care Profile will probably not record enough details for your home, it is an example of how to collect and document information in a systematic, professional and accountable manner.

Goal Setting

Moving beyond compliance, the care planning should also address setting goals based on clinical outcomes and the resident's perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations).

SMART Goals are an example of a standardised approach to goal setting with measureable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

- **Specific**, that is, they provide clarity, focus and direction
- **Measurable -** Objective measures can demonstrate the effectiveness of the goals
- **Action-oriented**, that is, they provide a strategy for achieving them
- **Realistic** – **they meet** th**e resident**'s preferences, they are practical for staff to implement and they consider the efficient use of resources, because if they're not, we're just setting up for almost certain failure
- **Time-based**, meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis.

Role of Documentation

Documentation of care is essential because members of the care 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 also 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. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the nursing process which drives the care. It should incorporate evidence informed practices, assessments and interventions, utilise staff skills, and drive a quality care approach.

The documentation process should leave a trail that provides robust and accountable information, leaving your facility audit ready. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required.
- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate) Record the evaluation of the care provided and the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes.
- Incident forms should be completed recording episodes of falls. The analysis of such incidents should take into consideration the resident's right to take risks. For example, a resident who is capable of making his own decisions may choose to walk outside even though he cannot be fully supervised at all times. This would be documented in the resident's goals and care plan

Linking the Evidence

This is about showing the link between the evidence from the background and assessment information (what has been collected in the identification phase) and the care that has been provided to address the identified care needs (in the implementation phase).

The links are:

- Begin by looking at and noting any underlying issues (e.g. diagnosis) or symptoms (e.g. gait disorder), connect the link to the body structures and/or functions that are impacted (e.g. unstable mobility)
- Describe the associated activity limitations (e.g. reduced independence in mobility,). It's important to look at remaining strengths (e.g. food preferences, pleasant events associated to eating)
- Describe the intervention program and how it addresses the limitations to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. changes to the physical environment to provide safe access to the garden)
- Finally, define the care goals (to reduce falls) and resident goals (having a family meal, access to the garden) that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes.

Below is an example of linking the evidence from the case study of Mr Teal:

- There was a diagnosis of arthritis and dementia.
- From the identification process, we identified the body structures/ functions that were affected. The arthritis affected George's right foot and knee (e.g. lower body weakness with associated pain), and the dementia affected his cognitive impairment (e.g., forgetting to use the mobility aid). These issues resulted in reduced ability to safely move around, and reduced opportunity to continue favourite pastimes of bird watching and gardening.
- Strategies and subsequent interventions were developed to address the activity limitations by assisting him to improve or maintain his health status (a clinical goal) and ensure continued participation in pleasurable activities such as bird watching, moving around the garden and seating to offer external views to the garden (quality of life goal). Staff and family members were also educated about risk taking, and how to prompt use of the mobility aid, and pain management.
- The aims of the care plan were defined as goals (e.g. provide education sessions including knowledge tests for staff within two months, provide safe access to the external garden twice a day for George) that will be evaluated.

Completing the ACFI documentation

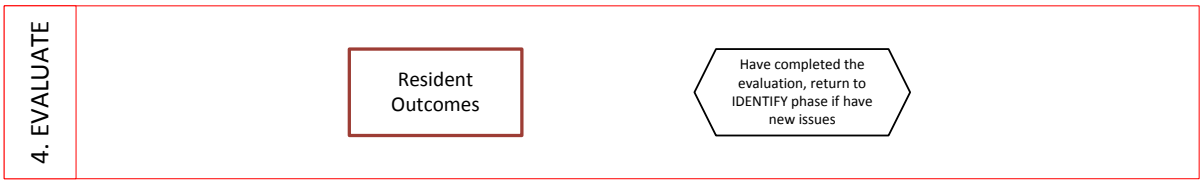
The data collected can now be used to complete the **ACFI 2 checklists** as described in Table 6.

Table 6: ACFI Question 2 Checklists

ACFI Question 2 Checklists	Where to find the information
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)	ROM and Grip test inform on ability to manipulate the wheelchair parts, lower and upper body limbs (muscle strength and ROM) Physiotherapist assessment/OT notes will inform on aids and staff assistance required. ACCR or Medical Practitioner notes will inform on diagnoses, impairments, aids and assistance required. Documented impairments- physical, sensory, cognitive, behavioural
Transfers - supervision is Standing by to provide assistance (verbal and/or physical)	PMS: Transfers (4)= supervision
Transfers- physical assistance is Moving to and from chairs or wheelchairs or beds	PMS: Transfers (2 or 3)= physical assistance ROM and Grip test inform on muscle strength, ROM of upper and lower limbs and transfer ability. Physiotherapist assessment/OT notes can inform on transfer ability and staff assistance required. ACCR or Medical Practitioner notes can inform on diagnoses, impairments, aids and assistance required. Documented impairments - physical, sensory, cognitive, behavioural.
Requiring physical assistance with the use of mechanical lifting equipment for transfers	PMS: Transfers (0 or 1) = use of mechanical lifting equipment ACCR or Medical Practitioner notes can inform if use of mechanical lifting equipment is required. Physiotherapist assessment/OT notes can

ACFI Question 2 Checklists	Where to find the information
	inform if use of mechanical lifting equipment is required.
Locomotion- supervision is Handing the resident a mobility aid OR Fitting of callipers, leg braces or lower limb prostheses OR Standing by to provide assistance (verbal and/or physical)	FRAT (at risk of falls) can inform on use of mobility aids and if supervision is required. ROM and Grip test inform on muscle strength, ROM of upper and lower limbs. Physiotherapist assessment/OT notes can inform on locomotion ability and if supervision is required. ACCR or Medical Practitioner notes can inform on mobility aids and assistance required Documented impairments- physical, sensory, cognitive, behavioural.
Locomotion- supervision is Standing by to provide assistance (verbal and/or physical)	PMS: Ambulation/Mobility (1).
Locomotion- physical assistance is Staff to push wheelchair OR Assistance with walking	PMS: Ambulation/Mobility (3). ROM and Grip test inform on muscle strength, ROM of upper and lower limbs. Physiotherapist assessment/OT notes can inform on use of wheelchairs and if assistance with walking is required. ACCR or Medical Practitioner notes can inform on assistance required to use wheelchairs or walking. Documented impairments- physical, sensory, cognitive, behavioural.

Evaluation Process



Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways (e.g. happier, healthier)? What might have produced this outcome? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and family.

  Has he been able to continue his favourite pastimes of bird watching and moving around the garden?

- Resident Care Outcomes

  Has the supervision of his mobility been successful? For example, has he been able to safely move around with reduced falls?

  Has his seating position been arranged to allow him to look outside into the garden and observe the bird life?

  Have staff and family members been educated about risk taking, and how to prompt use of the mobility aid? Was this effective? Has his pain been assessed and treated successfully?

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Outcomes

Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

An evaluation of Mr. Teal's care has shown that he has improved and the interventions are working. Mr. Teal and his family met with the members of the care planning staff to evaluate how far they have come and discuss any changes that needed to be made. They reviewed the progress notes and the notes made by Mrs. Teal's doctor, nursing staff and physiotherapist. They also assessed the outcomes against the goals included in his care plan one month after it was written. They found:

- Staff and family members had been educated about risk management and about how to look out for George's safety with frequent reminders about using his frame and keeping it close at hand
- The pain treatment interventions had helped him to walk with better balance.
- Due to the weather George did not go outside each morning at a set time, but he did get out often. He also showed great interest in sitting near the window that faced the birdfeeder and the garden, so that his spirits were good even when he was unable to get outside
- Some adjustment had to be made to the chair (it was chosen because it had sturdy arms that could help residents gain traction as they lifted their body to a standing position), but that only worked when it had a thick outdoor cushion on it

Evaluation will show care staff what is or is not working and provide the basis for reviewing the interventions being used to achieve the goals. The evaluation provided the proof that what they had put in place to assist Mr. Teal had worked (with some minor changes) and improved his quality of life. New actions will also come out of the evaluation review, along with new goals.

Summary: Steps and Information Flow

Figure 4 shows the mobility topic phases and steps in the process. It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment (including Physical Functioning, Musculoskeletal System and ROM) and a Falls Risk Assessment
- Completing the Comprehensive Assessment (Physical Mobility Scale, Grip and completing Standardised Care Processes to address any clinical risks)

The implementation phase which comprises:

- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

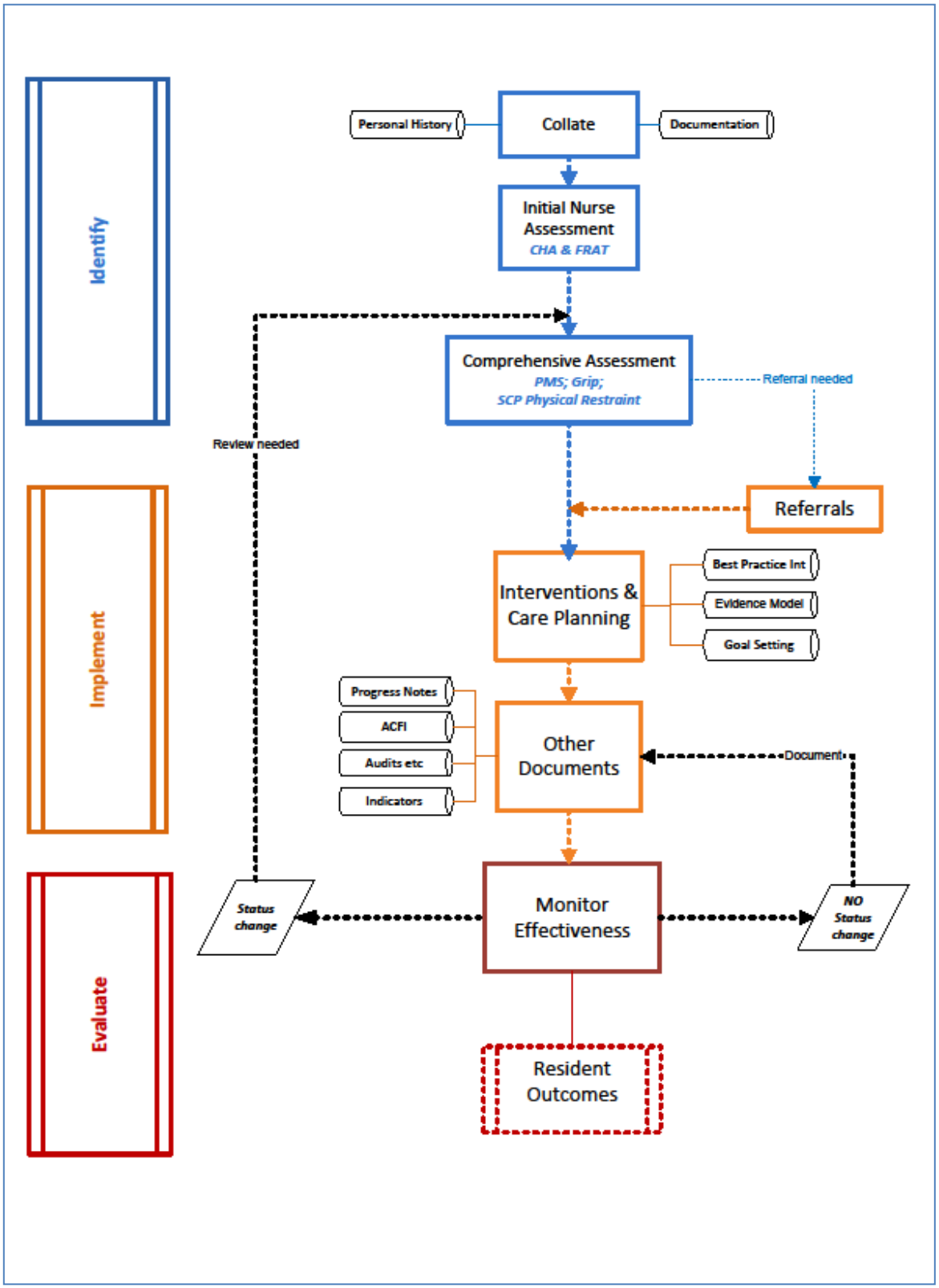
The evaluation phase which comprises:

- A review of the effectiveness of the interventions on resident outcomes
  Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the identification phase and the associated steps

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives us a reason to follow a particular plan toward improved health.

Prepare | Identify | Implement | Evaluate

Figure 4: Mobility Summary: Steps and information flow



Topic 3: Self-Care

The Self-Care Topic

This topic focuses on self-care, in particular the daily activities of personal hygiene and toileting. This is the third and final topic in the Activities of Daily Living Workbook. There is a connection between the topics of nutrition, mobility, personal hygiene and toileting, in the assessment tools and the impact of other domains on these activities.

Investigating Self-Care

The following four process steps should be followed when investigating self-care activities (consistent across all ADL topics). The steps are:

1. **Preparation by staff** – background reading and identification of staff with the competencies to complete the required activities. The background reading includes:
    - Comprehensive Health Assessment of the Older Person (CHAOP) Module 3 and 4
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

The references for these resources can be found in the ADL Appendix.

2. **Identifying** – gathering the resident's history by collating documents and talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, completing a comprehensive assessment approach and assessing the scope of the challenge. It is recommended that all new residents have a comprehensive assessment of self-care. A comprehensive approach will include:

File Notes Review:

- Aged Care Client Record (ACCR) – Part 4 of which includes some information on self-care abilities
- Comprehensive Medical Assessment – which (if available) may have, for example, self-care status for activities of daily living

Screen:

- Initial nurse assessment e.g. Comprehensive Health Assessment (CHA) for Older People in the Health Care System. Tthe CHA is based on the 'Comprehensive Health Assessment of Older People' resource, and provides a short initial nurse assessment for self-care areas

Further Assessment:

The following assessment tools (found in the ADL Assessment Pack) are recommended for assessing self-care and identifying the person's functional status. It is recommended that all new residents have these assessments completed:

- Physical Mobility Scale (PMS)
- Range Of Movement (ROM) assessment
- Grip assessment (optional)
- Observational performance assessment

Standardised Care Processes (SCP) are also recommended for addressing the clinical risks of oral and dental hygiene. And the SCP Physical Restraints for addressing clinical risks associated with physical restraints.

These tools (initial assessment, further assessment and the SCPs) are found in the ADL Assessment Pack and are referenced in the ADL Appendix.

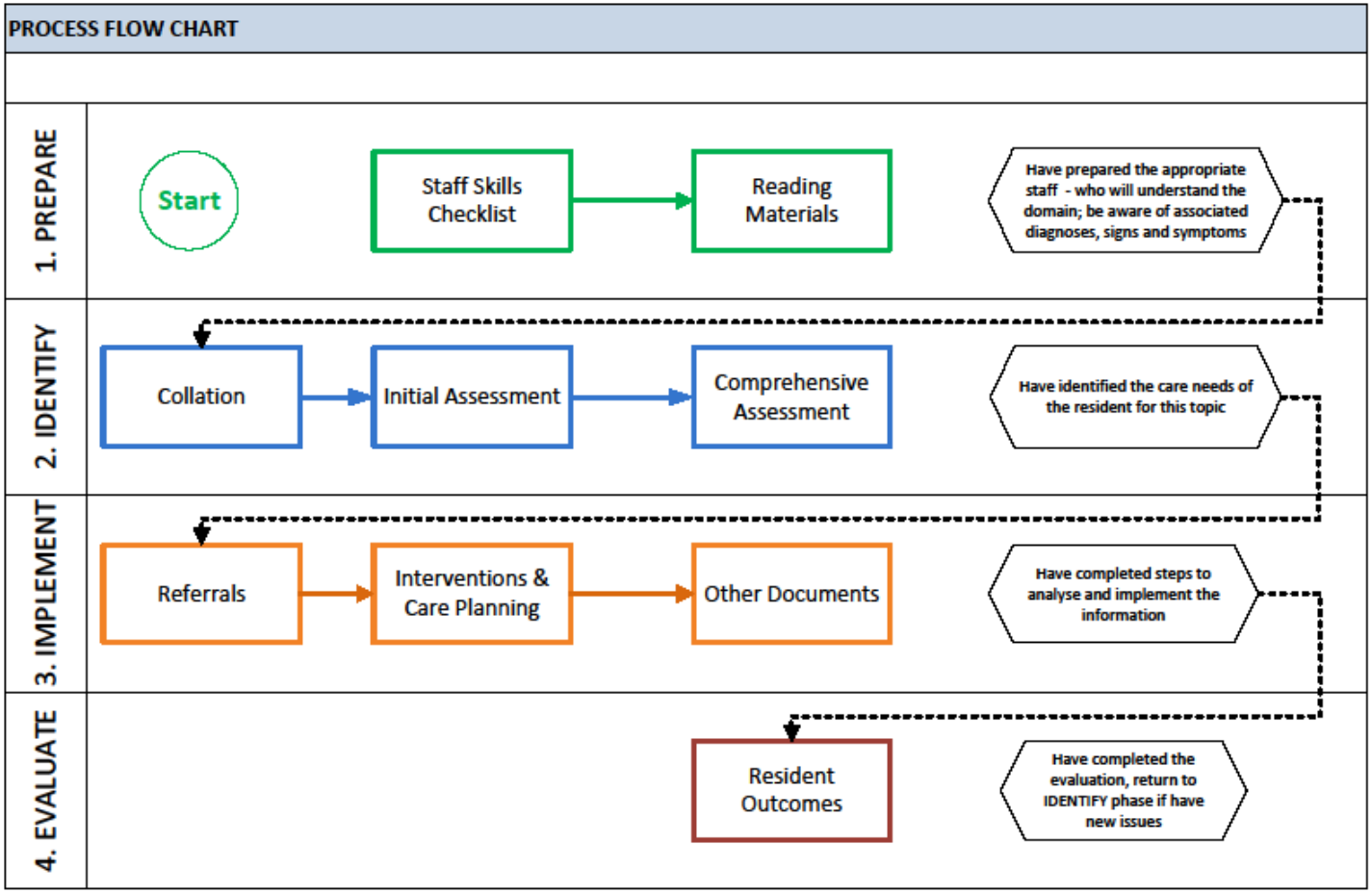
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

    - Undertaking referral options to complete gaps or seek specialist advice
    - Planning evidence-based care strategies to assist the person to maintain or possibly improve their participation ability
    - Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
    - Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
    - Completing ACFI documentation

4. Evaluating – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

This overall self-care process and associated activities is illustrated in Figure 5 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the ADL Workbook follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

Figure 5: Self-Care process



Getting Started with a Self-Care Example

This case study will be referred to as we discuss the self-care topic.

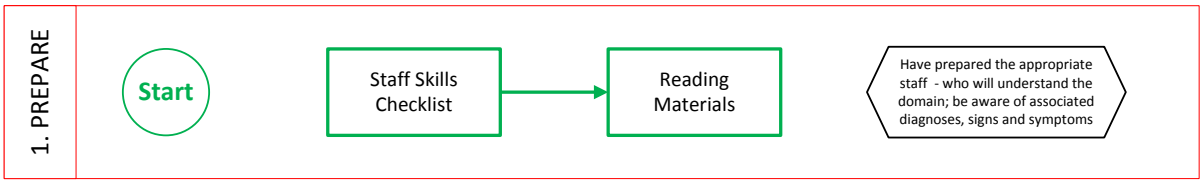
Mr. Henry Goldberg is a 72- year old retired university professor with Parkinson's disease, his wife has been his carer for the past 15 years.

Mr. Goldberg is aware that other people find his slurred speech difficult to follow and he tries to hide the constant saliva that drips from his open mouth.

Mr. Goldberg has always liked to be well dressed. Parkinson's disease has taken his clear speaking voice, so dressing well is one way he can show pride in his appearance, hopefully stopping people from dismissing him without a second glance.

The worsening tremors in his right hand are affecting many daily activities like grooming and personal care. He's been learning how to use his left hand to hold a toothbrush and comb his hair, but he is more dependent on staff with toileting activities. He copes quite well when those things are done in the privacy of his room. He wants to avoid embarrassment in the more public areas of the facility – when he is in the dining room or in other shared areas.

Preparation



There are two specific aspects to **preparing** staff for the management of resident self-care needs. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 7 provides a structure for management to identify which staff have the skills required to complete the activities within the self care process. The process includes:

- Identifying the required activities (examples provided in Table 7)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in “specialised self-care assessment”, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge, or identifying a local Allied Health Professional (i.e. Physiotherapist; Occupational Therapist) who could complete the assessment.

The introduction guide also provides further instructions for nursing management in preparation for implementing this toolkit.

Table 7: Staff Activities for the Self-care Process

Activity	Responsible for sign off	Do the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment: e.g. CHA		
Assessment: Range of Movement		
Assessment: Physical Mobility Scale		
Assessment : Grip Test		
Observational Performance Assessment		
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		

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of self-care issues in older people. It is expected that staff will have:

- A comprehensive understanding of the self-care domain and how it is impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practice associated with self-care - to assist with the development and implementation of evidence-based care plans

The background reading relevant to the self-care topic is Module 3 of the CHAOP (Comprehensive Health Assessment of the Older Person- Modules 3 and 4 are found in the Reading Pack)**.** This resource is also relevant to the other ADL topics in this workbook.

- Module 3 covers Musculoskeletal Assessment - physical examinations and assessments by nurses associated with Range of Movements (e.g., does a person have the hand dexterity or muscle flexibility to self-care?).

The BCOPE resource (Best Care for Older People Everywhere) reading for the Mobility topic is also relevant to Self-care (BCOPE pp. 61-63 and p. 68). This is summarised below along with relevant information about the role of communication (BCOPE p. 51). Please note that because BCOPE was written primarily for hospital settings with intended transferability to a range of other care settings, the language and terminology used may not always suit residential aged care.

Some Basics

What do we mean by self-care?

Self-care covers the personal care areas of dressing, bathing, toileting, grooming (which means brushing your teeth, combing your hair, putting on makeup, etc.), eating and drinking. The level of self-care is the level of personal care carried out by the person.

Why is it important?

Maintaining a person's self-care skills (and mobility) helps build the person's level of strength, balance and endurance. A person's ability to retain their participation in self-care tasks is fundamental to maximising their physical strength and their sense of security, control, personal independence and dignity. The activities of daily living provide an opportunity to interact with a resident on a social level and maximise independence and dignity, even when people reach the stage of needing physical assistance with self-care.

How Self-Care Interacts with Other Domains

Self-care can also be related to performance in a number of other health care domains. For example:

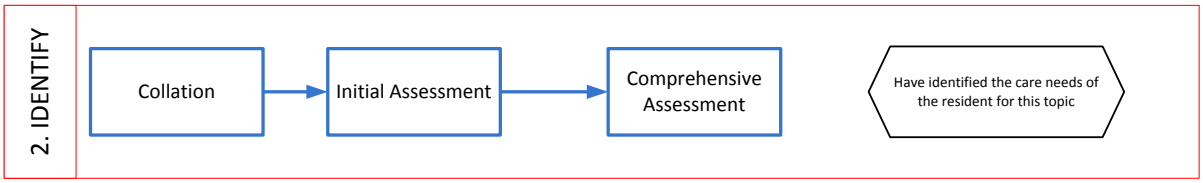
- A physical impairment such as dexterity can impact independence with nutrition (ability to hold and use utensils), mobility (ability to grip aids) and self-care (ability to hold and use grooming utensils such as tooth brushes and hair brushes)
- An older person's ability to walk to the bathroom (functional mobility) impacts on the level of independence and type of assistance required to complete self-care activities such as toileting
- The ability to carry out self-care tasks is linked to a sense of independence which in turn is likely to lift one's **mood** and self-esteem

- People who are able to dress and groom themselves tend to have more strength, balance and endurance.
- The need for higher levels of care support can also impact on behavioural issues. As frequent direct physical contact between staff and residents is required when assisting with self-care activities, the potential for triggering problematic interactions increases. Residents may not be comfortable (due to privacy or cultural preferences or cognitive impairment) being assisted with these tasks.
- It should be also noted that one's abilities related to self-care are also influenced by other potential issues, such as those related to vision, speech, hearing and cognition. These sensory impairments could limit the person's ability to see their comb or toothbrush, hear instructions, verbalise what they want, or understand once familiar activities.

As maintaining a person's ability to perform self-care activities as far as possible is important for health, general functional performance and quality of life, it is important that the nursing team have contemporary knowledge about and be competent to:

- Perform a comprehensive assessment of self-care needs and understand why the resident may have difficulties performing the tasks. Staff then need to be trained in how to support the person to be as independent as possible
- Develop an individualised care plan to promote self-care independence with input from the resident and family
- Understand how to assess and modify the environment to encourage independence
- Know where to refer for individual for support with self-care activities
- Train staff providing self-care support to residents with not only the necessary technical competencies but also to understand the importance of developing a trusted, calm and supportive approach when assisting the resident who may not be comfortable being assisted

Identification Process



The steps in the process of **identifying** are:

- Gathering the history from current documentation and information from carers, family and the consumer if possible
- Identifying a need (e.g. initial nurse assessment); and
- Completing a comprehensive assessment of the self-care needs

Gathering the History

What documents (before you start assessing) do you have which provide information on the resident you are focusing on? You will be able to build a picture of the person's relevant history through current documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, information on signs and symptoms, and previous assessments. Below is an example of the types of documents to be collated and reviewed, and the information that is being sought for self-care.

Document	Looking for
ACCR	Diagnoses, self-care status and identified needs (personal hygiene and toileting)
Medical Notes/CMA	Diagnoses, self-care status and identified needs (personal hygiene and toileting)
Allied Health Professional notes/assessment (Physiotherapist, Occupational Therapist)	Diagnoses, self-care status and identified needs (personal hygiene and toileting)

Examples of how the collated diagnoses and issues may be indicators of self-care needs are as follows:

Diagnoses/physical functioning status	**How it may impact on the care needs**
Musculoskeletal diseases e.g. Arthritis and physical deterioration	Affecting endurance and strength, and may require physical help, supervision or aides to assist with aspects of dressing, bathing, grooming, toileting. e.g. modified grooming tools e.g. setting up toiletries, taps or grooming articles e.g. fitting and removal of splints, medical braces
Diseases of the nervous system e.g. Parkinson's, Huntington's, Cerebrovascular diseases	May require aids or physical assistance with dressing, dressing, bathing, grooming, and toileting.
Falls risk	May require assistance with fitting and removal of hip protectors.
Limb deformities, amputation	May require assistance with fitting and removal of prostheses, slings, cuffs, splints, medical braces.
Physical functioning (dexterity, grip, arms, sitting upright, range of movement)	Affects self-care ability in dressing, bathing, grooming, toileting, e.g., may need setting up of or assistance with toiletries, taps or grooming articles.
Cognition (moderate to severe cognitive impairment)	Moderate or higher impairment usually requires supervision with bathing/washing and toileting due to inability of the person to understand or follow the activity process.
Communication issues of understanding others and/or communicating to others	Requiring strategies or aids to assist the resident to participate in self-care activities. For example, communication aides (language cards, picture cards).
Sensory loss- eyes, hearing	Requiring strategies or aids to assist the resident to participate in self-care activities, e.g., setting up toiletries, taps or grooming articles to assist the visually impaired
Mood issue (reduced motivation to maintain personal hygiene, loss of interest in self-care)	Requiring supervision/assistance during self-care activities or other strategies to encourage participation in self-care activities.
Behavioural issues (e.g. refusal of care)	Requiring environmental changes to the bathroom and strategies to assist the acceptance of the bathing process

Resident and Family

It is important to seek input from the resident and his or her family members.
Mr Goldberg and his wife have provided some valuable information about both his care needs and what is important for his enjoyment of life, for example:

- The importance to his dignity to be able to be as independent as possible in some self-care skills. He prefer to eat in a quiet, more secluded part of the dining area
- His worsening tremors in his right hand are affecting many daily activities like grooming and personal care and he is starting to resist staff assistance, particularly when he is tired. Staff need to be patient and not rush him when he is frustrated
- Being well dressed

Meeting the needs of a resident is a team effort and input from a variety of sources both professional and non professional will assist the understanding of the resident's needs.

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Comprehensive Health Assessment (CHA) for Older People in the Health Care System, which will help to identify needs and preferences related to self-care. Nurses (RN or EN) who have completed the Comprehensive Health Assessment of the Older Person (CHAOP) training would have the competencies to complete the Comprehensive Health Assessment questionnaire. The CHAOP manual and training covers how to assess for mobility, musculoskeletal and Range of Movement strengths and weaknesses. This information is also relevant across all ADL topics. The Comprehensive Health Assessment tool is found in the ADL Assessment Pack and is referenced in the ADL Appendix.

The Comprehensive Health Assessment (CHA) for Older People in the Health Care System items that particularly inform on self-care cover physical function, musculoskeletal, Range of Movement, oral health and foot care, are:

PHYSICAL FUNCTION: If no to any of the following items then complete the PMS assessment

Can the person walk unaided? Yes ☐ No ☐
What mobility aids does the person use?

Can the person attend to their own personal hygiene/bathing? Yes ☐ No ☐
What assistance does the person require with their personal hygiene/bathing?
Can the person dress themselves? Yes ☐ No ☐
What assistance does the person require with dressing?

Identified Issues….

MUSCULOSKELETAL: If no to any of the following then complete the PMS assessment

Posture

Is their body erect?	Yes	☐	No	☐
Is their head upright?	Yes	☐	No	☐
Normal curvature cervical/thoracic/lumbar	Yes	☐	No	☐

Gait

Is gait coordinated?	Yes	☐	No	☐
Is turning co-ordinated and easy?	Yes	☐	No	☐
Normal curvature cervical/thoracic/lumbar	Yes	☐	No	☐

Limbs

Alignment	Yes	☐	No	☐
Muscle tone	Yes	☐	No	☐

If YES to any of the two following CHA questions then complete the PMS assessment

Limbs: Deformity, contractures	Yes	☐	No	☐

The ROM section can be used to inform on many aspects of the ability to self-care i.e. ability to hold grooming tools or raise arms above the shoulder to brush the hair.

Range of Movement (ROM) items (from the CHAOP)**:** these items are a comprehensive assessment of ROM and therefore do not trigger further assessment.

Muscles: strength, tone and movement is recorded on a (0-5 scale), if less than 3 then disability is present.

Joints : assess (get older person to copy movements with your hand placed over the joint)

- Crepitus
- Heat
- Redness
- Pain
- Deformity

Joints to assess:

- temperomandibular
- neck
- shoulders
- elbows
- forearms

- wrists
- fingers and thumb
- hips
- knees
- ankles
- toes
- spine

CONTINENCE

Are they able to take themselves to the toilet?	Yes	☐	No	☐
Does the person have a stoma?	Yes	☐	No	☐

Identified Issues….

ORAL HEALTH (CHA):

Teeth	Own	☐	Dentures	☐
Are own teeth broken	Yes	☐	No	☐
Decayed (check colour)	Yes	☐	No	☐
Do dentures fit well?	Yes	☐	No	☐
Are gums, buccal mucosa, and tongue pink and moist	Yes	☐	No	☐
Any lesions on gums, buccal mucosa or tongue?	Yes	☐	No	☐
Lips – smooth and lesion free	Yes	☐	No	☐

Oropharynx

Identified Issues…

FOOT CARE

Foot care (especially for diabetics)

Identified Issues….

Oral and Dental Hygiene

There is a high incidence of oral and dental disease in older people in residential aged care facilities. Appropriate assessment and intervention can improve the dental and oral health of residents (JBI, 2008 - cited from the SCP Oral and Dental Hygiene).

The Standardised Care Process (SCP): Oral and Dental Hygiene sets out a comprehensive approach to this topic. Following the process as set out in the SCP will ensure the best care or resident's oral and dental health.

Comprehensive Assessment

In addition to an Initial Nurse Assessment (e.g. CHA), the full assessment approach for all new residents on the topic of self-care includes:

- The Physical Mobility Scale (PMS) assessment (if triggered from the initial nurse assessment);
- An objective measurement of grip strength (optional)
- Structured Observational Performance Assessment of a self-care activity; and
- An oral and dental risk assessment using the process set out in the Standardised Care Process (SCP) Oral and Dental Hygiene

These assessments are described further in the boxes below. Further information about the recommended screens and assessments (CHA, ROM, PMS, Grip Test, Observational Performance Assessment) and the SCP (Oral & Dental Hygiene) are found in the ADL Appendix, and copies of the tools are found in the ADL Assessment Pack.

Physical Mobility Scale (PMS)
The Physical Mobility Scale (PMS) was developed by Australian physiotherapists working in residential aged care to specifically show resident functional mobility and to provide information regarding each resident's need for supervision or assistance from one or two staff members and equipment during position changes, transfers, mobilising and personal care.

The PMS can be completed by the nursing staff (with the appropriate training, for example RN or EN with CHAOP or similar evidence informed training).

It has 9 items scored from 0-5 (dependent to independent scale) and produces objective data on:

- Positional changes (lying to side, lying to sit, sit to stand and reveres)
- Balance (sitting, standing)
- Transfers
- Ambulation
- Aids

A **grip assessment** could be utilised if the facility has the equipment and the trained staff. Grip strength is considered a good marker of physical performance in older people and is more feasible than short physical performance batteries (J Nutritional Health Aging 2012; 16(9): 769-74).

Further information can also be gained from a structured observation of the resident undertaking part of a self-care task. For example, a resident who has trouble putting on their own socks may be revealing a variety of related issues. They may have difficulty due to:

- Stiffness that prevents bending
- Lack of coordination and strength due to arthritis or a tremor
- Foot pain caused by an ingrown toenail
- Advanced dementia that has resulted in apraxia (an inability to carry out once familiar tasks)

Structured Observation Assessment

Note that observational assessments can be – and are likely to be – completed over time and during normal nursing practice. However, to maintain an objective and consistent approach across staff, there should be a written protocol describing the observation assessment outcomes and process.

One of the keys to that protocol should be that evaluation should be done in the context of the resident's typical daily routine. Ask a resident to perform the activity in a relaxed, normal manner, in an appropriate setting and time, such as when they are getting dressed in the morning.

Furthermore, the assessment should be done with some knowledge of the person you are assessing. This means not only knowing something about the person's life story, but about their routines and preferences.

If you know a resident (like most older adults) wakes up with stiff muscles and likes a chance to get up slowly and have a cup of tea before getting dressed, you will not test their ability to dress independently before they are ready. And if you can include a motivator (e.g., they like to dress well when family are visiting), you can include that into the activity (e.g., why you want them to demonstrate putting on a particular piece of clothing with zips or buttons etc). Therefore, you will be testing their abilities with something they are interested in.

Example of an Observation of Performance Assessment for Grooming

In this example we ask the person to set up and complete a grooming task. The activity was incorporated into the normal daily activity.

Elsa was asked to set out her hair grooming tools and to comb her hair as part of her normal morning routine. The brush, comb and mirror were in her bedside drawer.

Elsa had to be prompted a number of times to initiate the activity and set out the grooming tools, but once the task was set up she completed the activity of combing her hair.

Elsa showed outstanding dexterity in reaching over for her comb and mirror, holding the mirror in front of her while she combed her hair and in reaching over and behind her head to comb her hair. Her dexterity, range of movement for this task and coordination might be considered especially good since she was missing two fingers on her dominant hand.

Elsa was showing short-term memory loss, however she had not lost the ability to complete a well practiced activity. One would expect that Elsa will require assistance to plan activities but can then be quite independent in grooming activities and other ADLs that require primarily hand movements.

Clinical Risks

To assess the oral and dental status of resident's it is recommended that the following clinical risk tool be undertaken:

- SCORE **Standardised Care Process Oral and Dental Hygiene**

If there are oral and hygiene issues it is recommended that the Standardised Care Process (SCP) for Oral and Dental Hygiene be undertaken (found in the ADL Assessment Pack).
As we have noted earlier, self-care is intertwined with most of the other ADL topics and other domains. The gathering and review of documents should include these other domains in order to avoid missing relevant information.

Bringing the information together

As is the case with all of the EBCAT topics, the assessor should also consider the impact from other domains and care topics. These might include:

- Cognitive impairment (e.g. as identified in the Cognition domain)
- Sensory impairment (e.g. as identified in an initial nurse assessment)
- Physical impairment (e.g. as identified in an initial nurse assessment)
- Behavioural issues (e.g. as identified in the Behaviour domain)
- Psychological/Psychiatric symptoms (e.g. as identified in the Cornell Depression Scale)

Once you become familiar what you have to do (the steps) and how to do it (the process), the basics apply to all the topics and domains in this toolkit. You will however always need to know how to apply it to individuals.

Back to Mr. Goldberg's assessments:

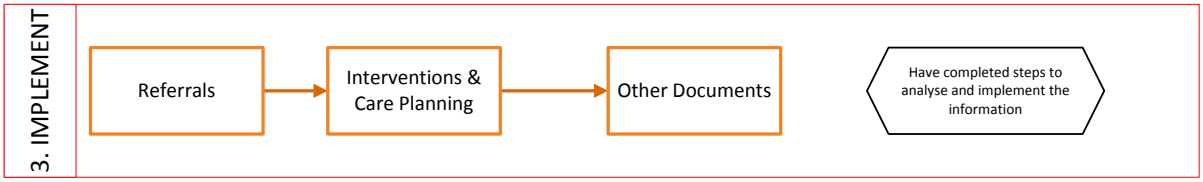
Mr Goldberg has a medical diagnosis of Parkinson's disease. Parkinson's disease is highly individualised with symptoms being as varied as each individual who has the condition

A comprehensive assessment and a physiotherapist report found:

- *An uncontrollable tremor in his right hand, particularly when he is at rest and not using the hand. He also has a tendency to unconsciously rub his thumb and forefinger back and forth (pill-rolling tremor)*
- *In terms of self-care tasks, he needs assistance, assistive devices, and/or modifications of routine related to dressing, bathing, grooming, toileting and eating*
- *A stooped posture makes it difficult to see his face when he talks, and his eyes are usually downcast. He is at risk for falls and must use a frame at all times when standing*
- *His stooped posture means he often has excessive saliva dripping from his mouth*
- *His overall movements are slowed (e.g., bradykinesia). His steps are shorter and more shuffling. It takes him longer to make his legs move, but once he gets going, it can also be hard to stop. Getting in and out of a chair can both be difficult – and because of muscle stiffness that comes with the disease – even painful*
- *His pain is being treated with a mild analgesic*
- *Mr. Goldberg's speech has become slightly slurred and slower. Now it requires a great deal of patience to listen carefully to him and understand what he is saying*

As is also common with Parkinson's disease, his writing has become small and cramped, and because of the tremor, almost impossible to decipher. That means writing out his thoughts is not an option

Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning.

The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process and the accountability systems, such as for the ACFI funding claims and quality of care aspects for accreditation

Referrals

If there is an identified need for a specific physical functioning assessment that cannot be provided on site by an allied health professional, a referral to an occupational therapist, physiotherapist or medical practitioner may be needed.

We recommend that for the self-care program, the nurse management group develops referral lists based on what your health service can provide, what is available in your local area and a list of important website contacts to find a practitioner or advice (Table 8).

Table 8: Referrals for Self-Care

Health Professional	Source	Contact
Dentist	Local	Name, contact details
Occupational Therapist	Health Service X	Name, contact details
Physiotherapist	Health Service X	Name, contact details
Clinical Nurse Specialist	Health Service X	Name, contact details
Australian Physiotherapists Association	website	http://www.physiotherapy.asn.au/

Interventions

In the identification phase the resident's healthcare and personal needs were identified. The intervention program will address these identified issues, by developing strategies to improve or maintain the resident's health status and their quality of life.

The intervention program targeting self-care should involve evidence informed strategies (refer below) that address the self-care needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident's history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Intervention Resources

BCOPE (2012, p.67) notes that in some cases residents will need retraining related to self-care, which might mean relearning old skills that have been lost or developing alternative strategies. Perhaps, a stroke has left their dominant hand paralysed and they will need to learn to brush their teeth and hair with their left hand. Other strategies might include:

- Providing aids to assist with optimal independence (such as appropriately designed seating)
- Ensuring bed and chair heights are optimal for independence
- Providing verbal encouragement and guidance to promote independence.

BCOPE (2012, p. 52-53) also emphasises the role of families and all carers in improving communication when vision, hearing and/or speech impairments are present. This is relevant for all activities of daily living. For example, families and carers:

- Often have useful strategies for enhancing communication with older persons and they should be encouraged to share their knowledge with the staff
- Can help to make sure older persons have their appropriate communication aids and that they are working and encourage older persons to use their prescribed

communication aids. Many older people are reluctant to wear their prescribed hearing aids because it takes time for them to adjust to sound qualities and background noise

- Can participate in training and education to understand how to improve communication. It may be important to explain to families and carers that vision, hearing and/or speech impairments are causing the older persons communication difficulties. For example, people with hearing difficulties are sometimes thought to have dementia when they respond inappropriately or not at all to directions. Older adults with a vision, hearing and/or speech impairment are susceptible to social isolation, which can also lead to the development of depressive symptoms and/or anxious behaviours. It is important to consider strategies to help maintain their psychosocial wellbeing.

Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

Facilities may have their own care plan or the NATFRAME Care Profile could be used as a starting point as a summary care plan. Although the NATFRAME Care Profile will probably not record enough details for your home, it is an example of how to start to collect and document information in a systematic, professional and accountable manner.

Goal Setting

Moving beyond compliance, the care planning should also address setting goals based on clinical outcomes and the resident's perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations).

SMART Goals are an example of a standardised approach to goal setting with measureable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

- **Specific**, that is, they provide clarity, focus and direction.
- **Measurable -** Objective measures can demonstrate the effectiveness of the goals.
- **Action-oriented**, that is, they provide a strategy for achieving them.
- **Realistic** – because if they're not, we're just setting up for almost certain failure that will then impact on the residents motivation, interest and involvement; and
- **Time-based**, meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis.

Role of documentation

Documentation of care is essential because members of the care 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 also 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. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the nursing process which drives the care. It should incorporate evidence informed assessments and interventions, utilise staff skills and drive a quality care approach.

The documentation process should provide a documentation trail that provides robust and accountable information, leaving your facility audit ready. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This process supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required.

- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate)
- Record the evaluation of the care provided and the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes
- Incident forms should be completed when appropriate. The analysis of such incidents should take into consideration the resident's right to take risks. This would be documented in the resident's goals and care plan

Linking the evidence

This is about showing the link between the evidence (what has been collected in the background and assessment information) and the care that has been provided to address the identified care needs.

The linking the evidence steps are:

- Begin by looking at and noting any underlying issues (e.g. diagnosis) or symptoms (e.g. restricted range of joints and painful joints). From the identification step it will be apparent what body structures and functions (e.g. self-care, mood) are impacted
- Describe the activity limitations (e.g. personal hygiene). It's important to look at remaining strengths (e.g. motivated by carer feedback and family contact)
- Determine what strategies and interventions will be put into the Care Plan to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. exercises for joints, pain treatment)
- Finally, define the care goals (e.g. maintain movement of joints) and resident goals (e.g. enjoyment of life) that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes.

Below is an example of demonstrating the evidence from the case study of Mr Goldberg:

- There was a diagnosis of Parkinsons' Disease
- From the identification process, we identified Mr. Goldberg's symptoms of speech (slurred) and hand (tremor) issues, and that he was at risk of falls.
- Mr. Goldberg had reduced self-care and mobility ability.

- His remaining strengths included that he was still a bright and active thinker, and remains fairly independent with walking using a frame and completing some hygiene tasks – i.e. shaving, washing body)
- Strategies were developed to address the impaired activities such as simplifying clothes to enable self management and for retaining dignity
- The care plan strategies will be defined as goals. Goals give purpose to the care and provide a measurement for evaluating our success

Mr. Goldberg's care plan and goals:
The physiotherapist, occupational therapist and speech pathologist have all consulted with care staff and Mr. and Mrs. Goldberg. Along with the care staff they have come up with some specific additions to the care plan.

The goal is to maintain self-care activities, as long as possible, for example:

- Grooming: The physiotherapist is working on increasing Mr Goldberg's use of his left hand to improve his muscle strength and independence.
- Grooming tools have been selected to improve independence - an electric toothbrush and electric shaver, and stand by to provide assistance as required
- Dressing: Clothing has been selected to assist self-dressing and to meet Mr. Goldberg's personal preferences e.g., pull-on pants, and slip on shoes.
- Balance and muscle strength: Mr. Goldberg will attend Tai Chi, have stretching exercises, and the physiotherapist has trained the care staff on how to guide him through a series of in-bed stretches before getting up each morning. Also for the next month, the physiotherapist will do a series of weight-lifting exercises with him three times a week

Completing the ACFI documentation

The data collected to this point can now be used to complete the **ACFI 3 and 4 checklists** as described in Tables 9 and 10.

Table 9: ACFI Question 3 Checklists

ACFI 3 Checklist: Personal Hygiene	Where to find the information
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.	ACCR or Medical Practitioner notes OT or Physiotherapist notes Documented impairments- physical, sensory, cognitive, behavioural CHA Physical Function questions (can they dress themselves? can they stand from a sitting position?) CHA, ROM Assessment & Grip test (e.g. dexterity and wrist, elbow joint, forearm, fingers and thumbs, hips, knee flexion, can elevate foot to tie shoes) Observational Assessment (e.g. selecting clothes, dressing upper body e.g. buttoning cardigan, dressing lower body e.g. putting on socks and shoes)
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.	ACCR or Medical Practitioner notes OT or Physiotherapist notes Documented impairments- physical, sensory, cognitive, behavioural CHA Physical Function questions (can the person attend to their own personal hygiene/bathing? what assistance do they require with personal hygiene/bathing? can they stand from a sitting position?)

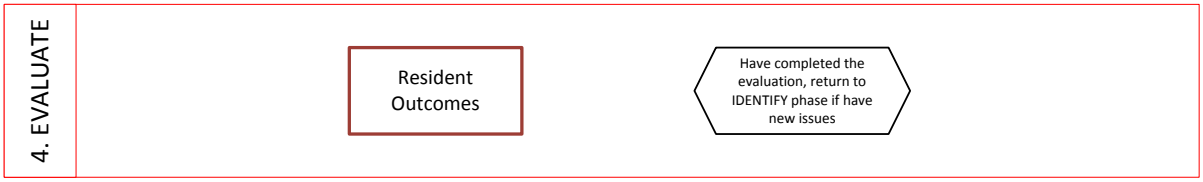
ACFI 3 Checklist: Personal Hygiene	Where to find the information
	CHA, ROM Assessment & Grip test (e.g. dexterity and wrist, elbow joint, forearm, fingers and thumbs, hips, knee flexion, can elevate foot to dry feet)
Grooming Supervision is: • setting up articles for grooming OR • standing by to provide assistance (verbal and/or physical). One-to-one physical assistance is required for: • dental care OR hair care OR shaving.	ACCR or Medical Practitioner notes OT or Physiotherapist notes Documented impairments- physical, sensory, cognitive, behavioural CHA Physical Function questions CHA, ROM Assessment & Grip test (dexterity, wrist, elbow joint, forearm, fingers and thumbs) Observational Assessment (grooming)

Table 10: ACFI Question 4 Checklists

ACFI 4 Checklist: Toileting	Where to find the information
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	ACCR or Medical Practitioner notes OT or Physiotherapist notes Documented impairments- physical, sensory, cognitive, behavioural CHA Continence questions (Does the person have a stoma? Informs on 'ostomy articles'; identified toileting issues) CHA, ROM Assessment & Grip test (e.g. dexterity and wrist, elbow joint, forearm, fingers and thumbs, hips, knee flexion)
Toilet completion Supervision is: • standing by while the resident toilets to provide assistance (verbal and/ or physical)	ACCR or Medical Practitioner notes OT or Physiotherapist notes

ACFI 4 Checklist: Toileting	Where to find the information
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.	Documented impairments- physical, sensory, cognitive, behavioural CHA Physical Function questions (e.g. can they stand from a sitting position?) CHA Continence questions (Does the person have a catheter or condom drainage? informs on 'emptying drainage bags'); CHA, ROM Assessment & Grip test (e.g. dexterity and wrist, elbow joint, forearm, fingers and thumbs, hips, knee flexion)

Evaluation Process



Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting provides the criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention to guide further improvements.

Evaluation forms the basis of the interactive cycle of continuously improving the quality of the care provided. The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways (e.g. happier, healthier)? What might have produced this outcome (e.g. family meals)? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and family.

- Resident Care Outcomes

  With regard to self-care, for example, has the intervention maintained muscle strength and independence? This could be determined by task observation.

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Outcomes

Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative.

The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

An evaluation of Mr. Goldberg's care has shown that he has maintained his level of functioning and the interventions have likely assisted this outcome. Mr. Goldberg and his family met with the members of the care planning staff to evaluate how far they have come and discuss any changes that needed to be made. They reviewed the progress notes and the notes made by Mr. Goldberg's doctor, nursing staff and physiotherapist. They also assessed the outcomes against the goals included in his care plan. They found:

- Mr. Goldberg is happy with his progress, and is maintaining his level of performance with grooming activities
- Mr. Goldberg still needs assistance with socks and putting on shirts, and he hasn't managed to independently put on his underwear, but he wants to keep trying
- He is managing his modified clothes and slip on shoes
- He enjoys his morning stretches and staff use the time to have a chat about things that interest Mr. Goldberg. He reported that the stretching classes and exercises make him feel good but that the Tai Chi was too complicated

Evaluation will show care staff what is or is not working and provide the basis for reviewing the interventions being used to achieve the goals. The evaluation can provide the proof that interventions are working.

Summary: Steps and Information Flow

Figure 6 below shows the self-care topic phases and steps in the process. It involves:

The identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment (including Physical Functioning, Musculoskeletal System and ROM)
- Completing the Comprehensive Assessment (Physical Mobility Scale, Grip Test, Structured Observation and completing Standardised Care processes to address any clinical risks)

The implementation phase which comprises:

- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

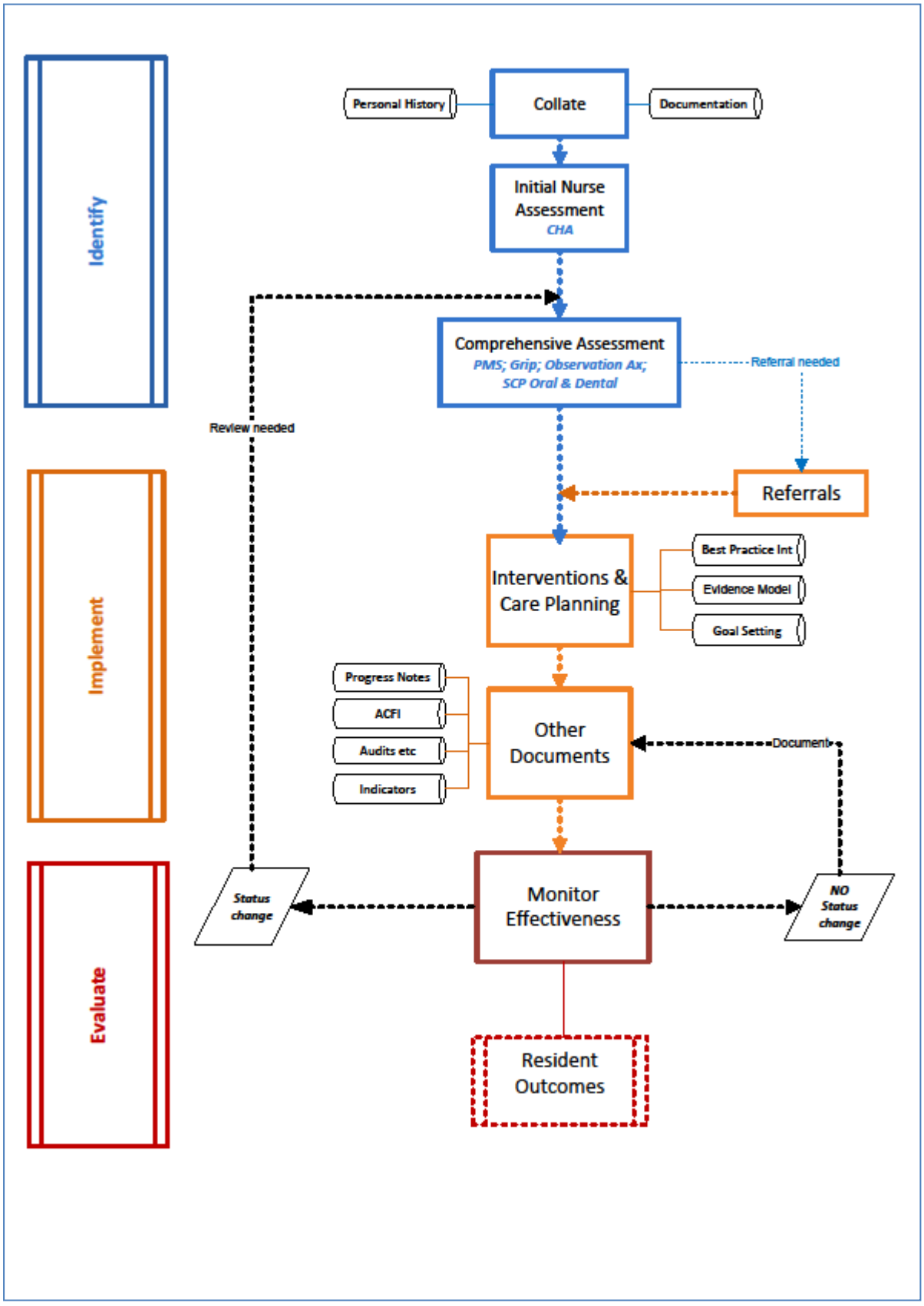
The evaluation phase which comprises:

- A review of the effectiveness of the interventions
  Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the comprehensive assessment step and the associated steps

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives us a reason to follow a particular plan toward improved health.

Prepare | Identify | Implement | Evaluate

Figure 6: Self-Care Summary: Steps and information flow



ADL Resources

The recommended resources are listed below and information on where they are found in the toolkit (Table 11).

Table 11: ADL Workbook Resources

Resource Type	Details	Document
Background Reading	CHAOP Modules 3 & 4	Reading Pack
Background Reading	BCOPE Nutrition pp.77-109; Mobility/Self-care pp.61-71	Reading Pack (facility to download)
Assessments	Initial Nurse Assessment (e.g. CHA)	ADL Assessment Pack
Assessments	Range of Movement (CHA)	ADL Assessment Pack
Assessments	Resident Nutrition Data Card	ADL Assessment Pack
Assessments	Physical Mobility Scale	ADL Assessment Pack
Assessments	Grip Test	ADL Assessment Pack
Assessments	Observational Performance	ADL Assessment Pack
Goal setting	Quality Of Life Questionnaire	Reading Pack
Assessment	FRAT	ADL Assessment Pack
Standardised Care Processes (SCP) for Nutrition	Choking; Dehydration; Oral and dental hygiene; Unplanned weight loss	ADL Assessment Pack
Standardised Care Processes (SCP) for Mobility	Physical Restraint	ADL Assessment Pack
Standardised Care Processes (SCP) for Self-care	Oral and dental hygiene;	ADL Assessment Pack

ADL References

The recommended resources are listed below and references are provided (Table 12).

Table 12: References for the ADL Workbook

Document name	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 (CHA) for Older People in the Health Care System	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria The CHA is an example of an initial nurse assessment, it is based on the CHAOP resource.
Comprehensive Health Assessment of Older Person (CHAOP)	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria Resource developed for comprehensive health assessment training for PSRACS (2013).
Falls Risk Assessment Tool (FRAT)	Freeman-Smith C; Bull K; Hough P; Greenwood K; Goldie P; Peninsula Health Falls prevention service; Rehabilitation, Aged and Palliative Care Services. Sourced from NATFRAME
Grip Assessment	J Nutritional Health Aging 2012; 16(9): 769-74)
Minimising the Risk of Falls & Fall-related injuries: guidelines for Acute, Sub-acute and Residential care settings.	Victorian Quality Council (July 2004) Published by the Metropolitan Health and Aged Care Services Division Victorian Government Department of Human Services, Melbourne Victoria. July 2004 Sourced at: http://www.health.vic.gov.au/qualitycouncil/downloads/falls/guidelines.pdf
NATFRAME Care profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource 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
Physical Mobility Scale (PMS)	The Gerontology Group of the Australian Physiotherapy Association. Sourced from NATFRAME 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
Observational	AACS training material was reviewed for describing an

Document name	Reference
Performance Assessment	"Observational Performance Assessment".
Range of Movement (ROM)	Refer to CHA
Resident Nutrition Data Card (RNDC)	Best Practice Food and Nutrition Manual for Aged Care Facilities, Bunney, C. & Bartl, R Central Coast Health, NSW. sourced from the NATFRAME @ 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
Standardised Care Processes (SCP)	Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Authors: La Trobe University ACEBAC Choking: http://www.health.vic.gov.au/agedcare/downloads/score/choking_scp.pdf Constipation: http://www.health.vic.gov.au/agedcare/downloads/score/constipation_scp.pdf Dehydration: http://www.health.vic.gov.au/agedcare/downloads/score/dehydration_scp.pdf Oral and Dental Hygiene: http://www.health.vic.gov.au/agedcare/downloads/score/oraldental_hygiene_scp.pdf Physical Restraint: http://www.health.vic.gov.au/agedcare/downloads/score/restraint_scp.pdf Unplanned Weight Loss: http://www.health.vic.gov.au/agedcare/downloads/score/weightloss_scp.pdf

ADL Workbook Exercises

Now that you have worked through at least one ADL topic, you are ready to complete a small case study. You may choose to do this by yourself or as a group discussion.

Facility to insert a case study relevant to ACFI 3 or 4

What clinical history is relevant?

What personal history is relevant?

Start to link the evidence together from the case study

Diagnoses

……

Body structure/function that is affected

……

What activities have been restricted

……

Would you recommend a referral? If yes,

What advice or assessment is missing

……

Who would the referral be sent to

……

What information would you prepare for the Health Professional?

……

What information would you expect from the Health Professional?

……

Develop two goals with the following aspects:

- Has a single issue focus
- Measurable
- Action orientated strategy
- Realistic and achievable
- Can be evaluated

Resident QoL goal

……..

Clinical Care goal

……..

What documents do you have, and where are they stored (i.e. documentation trail)

Document Name (insert)	**Location**	**Date**
Resident /family Interview		
ACCR		
CMA/ other medical notes		
Screen/ Initial Assessment		
Assessment Tool (Nutrition)		
Assessment Tool (Mobility)		
Assessment Tool (Self-Care)		
Other		

Complete the following ACFI 3 and ACFI 4 Checklists and note the evidence for that claim.

	ACFI 3 Personal Hygiene Checklists	Describe the evidence and note the documents that support the claim
	Dressing and undressing	
☐	Independent (0)	
☐	Supervision (1) o choosing and laying out appropriate garments OR o undoing and doing up zips, buttons or other fasteners including velcro OR o standing by to provide assistance	
☐	Physical assistance (2) o dressing AND undressing i.e. putting on or taking off clothing AND footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings) OR o fitting and removing of hip protectors, slings, cuffs, splints, medical braces and prostheses other than for the lower limb.	
	Washing and drying	
☐	Independent (0)	
☐	Supervision (1) o setting up toiletries, or turning on and adjusting taps, OR o standing by to provide assistance	
☐	Physical assistance (2) o washing and/ or drying the body.	
	Grooming	
☐	Independent (0)	
☐	Supervision (1) o setting up articles for grooming, OR o standing by to provide assistance	
☐	Physical assistance (2) o dental care OR hair care OR shaving	

	ACFI 4 Toileting Checklists	Describe the evidence and note the documents that support the claim
	Use of toilet	
☐	Independent (0)	
☐	Supervision (1) o setting up toilet aids, or handing the resident the bedpan or urinal, or placing ostomy articles in reach, OR o stand by to provide assistance with setting up activities (verbal and/ or physical)	
☐	Physical assistance (2) o positioning resident for use of toilet or commode or bedpan or urinal	
	Toilet completion	
☐	Independent (0)	
☐	Supervision (1) o standing by while the resident toilets to provide assistance (verbal and/ or physical) with adjusting clothing or peri-anal hygiene, OR o emptying drainage bags, urinals, bed pans or commode bowls	
☐	Physical assistance (2) o adjusting clothing AND o wiping the peri-anal area.	