Evidence-Based Clinical Assessment Toolkit (EBCAT)

Complex Health Workbook

COPYRIGHT

DISCLAIMER

Applied Aged Care Solutions Pty Ltd (**AACS**) and its authors are not responsible for the results of any action taken on the basis of any information in this publication or for any error in or omission from this publication.

This publication contains information of a general nature that may not be suitable to your own circumstances. It is your responsibility to satisfy yourself as to its suitability for your circumstances.

The publication has been compiled from information provided by third parties and other sources. There may be technical inaccuracies, typographical errors or unsuitable material for you. If you have any concerns about such third party content, you should refer to those sources for more specialist information and advice. Attribution to such sources appears in the text of this publication.

To the fullest extent permitted by law, AACS and its authors will be under no liability to any person in respect of any loss or damage (including consequential loss or damage) which may be suffered or incurred or which may arise directly or indirectly from or in connection with any use of this publication or the information contained in it.

To the fullest extent permitted by law, all express or implied warranties are hereby excluded. Warranties or guarantees implied by statute which cannot be excluded will apply, however the liability of AACS and its authors for a breach of such implied terms will be limited, at the option of AACS, to any one or more of the following:

- replacement of the product supplied or supply of an equivalent product;
- payment of the cost of replacing the product or of acquiring an equivalent product;
- payment of the cost of having the product rectified;
- and in no circumstances extends to consequential, indirect or special loss or damage.

Acknowledgements

Barwon Health was funded by the Department of Health Victoria to develop an evidence based Aged Care Funding Instrument (ACFI) toolkit and associated process guidelines for public sector residential aged care services (PSRACS). Barwon Health engaged Applied Aged Care Solutions (AACS), developers of the original ACFI to conduct the project and develop the toolkit. AACS has extensive experience in designing assessment models and evidence-based tools for residential aged care.

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

La Trobe University

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

Monash University

Professor Daniel O'Connor (Professor of Old Age Psychiatry, Faculty of Medicine, Nursing & Health Sciences, and Head of the Aged Mental Health Research Unit Monash University) provided feedback on the framework and the process content of the Cognitive and Behavioural Expressions Workbooks.

PRACS Leadership Group

AACS acknowledges the comments of the PSRACS Nurse Leadership Group and feedback and comment provided at the workshops for PSRACS staff hosted by the Department of Health Victoria.

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

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.

	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 Complex Health Workbook

The Complex Health Workbook is one of six workbooks of the Evidence Based Clinical Assessment Toolkit (EBCAT). The Complex Health Workbook covers the topics of Pain, Swallowing, and combined Skin and Wound Care. This workbook is one of four resources relevant to the Complex Health domain which comprise:

- Reading Pack
- Complex Health Workbook
- Complex Health Quick Guide
- Complex Health 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), introducing more stringent penalties from 1st July 2013 for providers with inaccurate or misleading ACFI appraisals from 1 July 2013, highlighting the importance of robust documentation and evidence.

While the ACFI User Guide advises there are to be assessments for Pain, Swallowing, Skin and Wounds, there are no mandated assessments. This Complex Health Workbook will assist a service to meet ACFI evidence requirements including the:

- ACFI User Guide
- An initial Nurse Assessment, e.g. 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
- Joanna Briggs Institute (JBI) resources
- PMG Kit for Aged Care in conjunction with the Australian Pain Society's *Pain in Residential Aged Care Facilities: Management Strategies*

Topic 8: Pain

The Pain Topic

This topic focuses on pain and it represents one of the three topics within the Complex Health Workbook.

Understanding the impact of pain in older people and the ways of assessing for pain are fundamental to good care. Pain can be unrecognised or poorly managed and this may result in an unnecessary and serious decline in the person's quality of life. Pain is not a normal part of the ageing process although its prevalence does increase with age and illness.

Because pain affects most domains covered in the EBCAT series, its importance cannot be over-estimated. It will impair a person's ability to function independently in performing everyday activities of living. Its presence may be demonstrated by behavioural expressions (including mood symptoms), and it has the potential to increase the severity of other impairments if left untreated.

Investigating Pain

The following four process steps should be followed when investigating pain (consistent across all topics). 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:
   - The Australian Department of Health's PMG Kit for Aged Care (2007)
   - The Australian Pain Society 'Pain in Residential Aged Care Facilities: Management Strategies' (2005).
   - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

The references for these resources can be found in the Pain 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 also essential that pain assessment is undertaken during movement and normal functions of the person. A comprehensive approach will include:

File Notes Review:

- Aged Care Client Record (ACCR) – This may contain Allied Health and Therapy notes, diagnoses and other comments to confirm the presence of pain or impairments that may lead to or cause pain.

- Comprehensive Medical Assessment (CMA) – may have information on acute or chronic pain, medications and other impairments which may lead to pain.

Screen:

- Initial nurse assessment e.g. the CHA is an initial nurse assessment based on the 'Comprehensive Health Assessment of the Older Person' resource) records information about the resident's pain status, in particular it investigates seven aspects of pain named COLDSPA. The seven aspects are:
  - Character (type of pain)
  - Onset
  - Location
  - Duration
  - Severity
  - Pattern, and
  - Associated factors

The reference for the CHA can be found in the Complex health Appendix and a copy is found in the Complex health Assessment Pack.

Further Assessment:

The following assessment tools (found in the Complex Health Assessment Pack) are recommended for comprehensively assessing pain. A comprehensive assessment approach should include options for interview based and observation based pain assessments.

- The Abbey Pain Scale or the Pain Assessment in Advanced Dementia (PAINAD) for residents that **cannot** be interviewed. These tools are based on observation of the person.
- The Modified Resident Verbal Brief Pain Inventory (M-RVBPI) as the comprehensive assessment tool for residents that **can** be interviewed.
- A pain intensity tool for the ongoing evaluation of pain intensity and response to treatments such as (i) a Verbal Descriptor Scale (VDS) or (ii) a numeric rating scale or (iii) a visual analogue scale or (iv) a pictorial pain scale. These tools are suitable for residents that may have a language or cognitive impairment but **can** still indicate a meaningful response.

These tools are found in the Complex Health Assessment Pack and are referenced in the Pain Appendix.

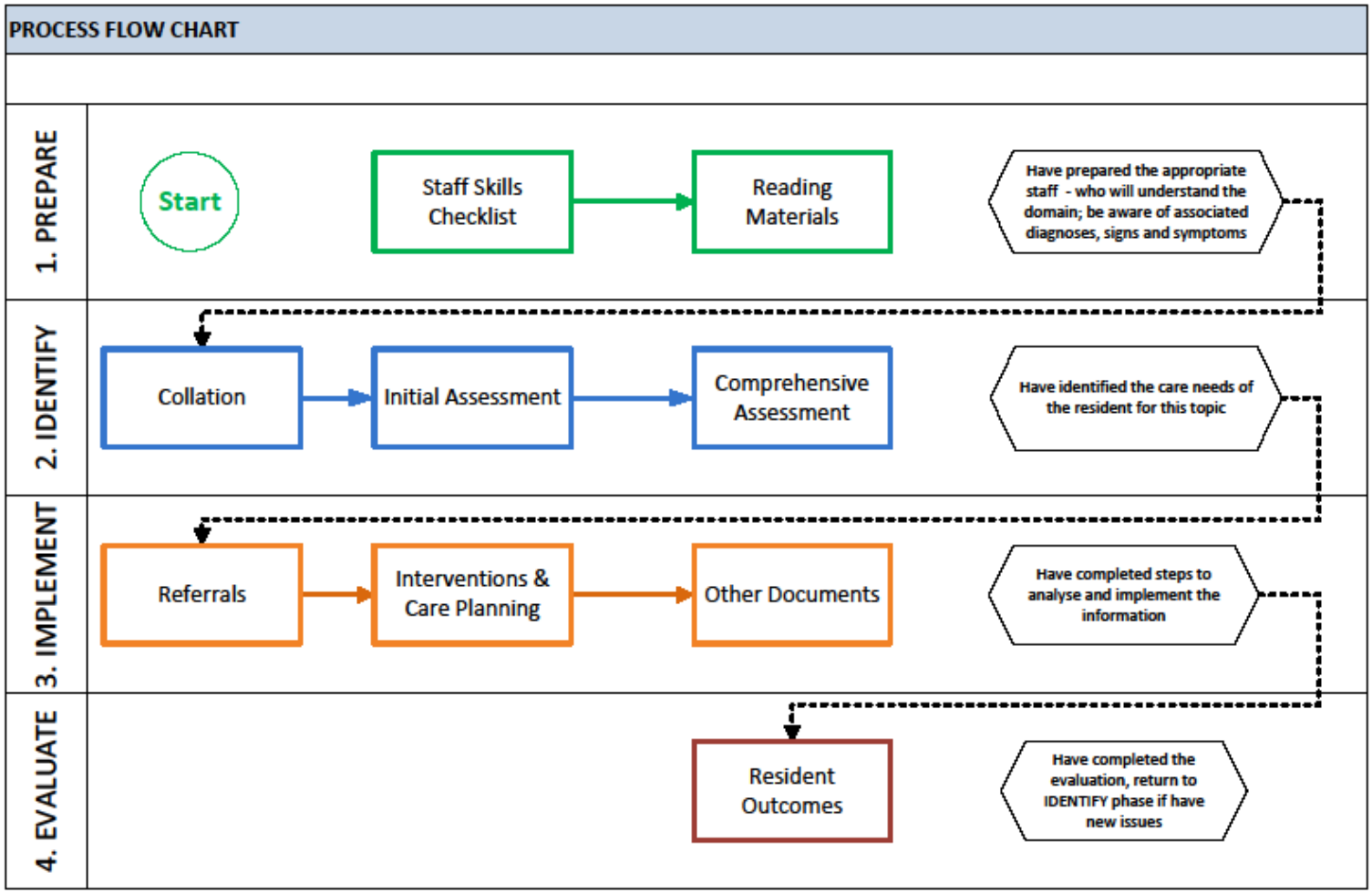
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

    - Undertaking referral options to complete gaps or seek specialist advice
    - Planning evidence informed care strategies to manage the pain and 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 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 workbooks 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: Pain Process



Getting Started with a Pain Example

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

We return to Mr. George Teal from the Mobility Topic. He 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 has an impaired gait and a potential for falls. George also had some symptoms of mild dementia that included loss of proprioception (recognising the position of his body in space and how he needs to move it to get from place to place).

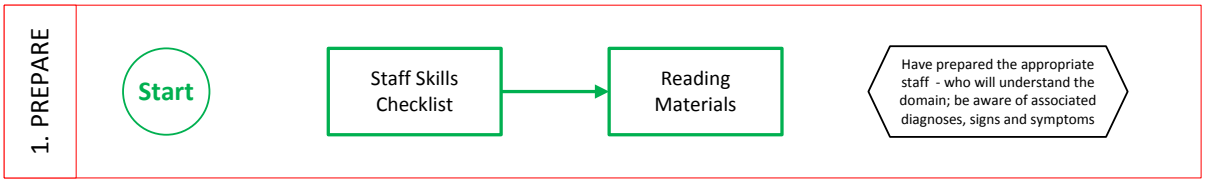
In spite of his falls risk, George, his family, and the staff wanted to keep him as mobile as possible, because 1) even weighing the risks of falling, remaining mobile was good for his health, and 2) it was considered an essential element in his quality of life, especially the opportunity to be outdoors regularly.

Through the course of the Mobility topic, we talked about the ways in which he was supported on the clinical level to become a safer walker, and on the quality of life level to pursue his lifelong interests in bird watching and gardening.

Now, six months have passed. Even with the best strategies in place, Mr. Teal has had two falls, no broken bones but he requires regular analgesia for pain and is working with the physiotherapist on a regime of gentle exercises. While he is physically improving, he shows little interest in moving about and his body language indicates he is afraid of falling. He has been spending most of his days in his bed or chair.

His family and staff are trying to encourage him to safely return to enjoying his personal hobbies of bird watching and being in the garden.

Preparation



There are two specific aspects to **preparing** staff for the management of pain 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 provides a structure for management to identify which staff have the skills required to complete activities within the pain 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 pain process can be completed effectively. For example, if there is a gap found in the pain 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. Physiotherapist) 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 Pain Management Process

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment: e.g. CHA		
Observational Assessment: Abbey Pain Scale		

Activity	Responsible for sign off	Does the activity
or PAINAID		
Pain Intensity Tools		
Interview Assessment: M-RVBPI		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and Strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		

Background Reading

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

- A comprehensive understanding of the pain topic 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 pain - to assist with the development and implementation of evidence-based care plans

The background reading relevant to the pain topic is:

- The Australian Department of Health's PMG Kit for Aged Care (2007). The PMG Kit for Aged Care was developed to assist Residential Aged Care Facilities to better manage residents' pain. The resource is based on 24 guidelines that address pain identification/assessment, treatment and organisational issues surrounding pain management. The pain assessments recommended for use in this workbook are taken directly from the PMG Kit or its associated document from the Australian Pain Society. The reference for this resource can be found in the Pain Appendix.

- The Australian Pain Society 'Pain in Residential Aged Care Facilities: Management Strategies' (2005). The 'Pain in Residential Aged Care Facilities: Management Strategies' underpins the PMG Kit and outlines in more depth the good practice principles to successfully identify, assess and manage pain in residential aged care. The resource provides more background detail to the assessment tools, treatment approaches and quality of care issues associated with pain management. The reference for this resource can be found in the Pain Appendix.
- BCOPE (Best Care for Older People Everywhere) which is summarised below, covering pages 225-244. The BCOPE outlines keys facts about pain and the different types, signs and symptoms; the impact of pain on other care domains; ways of assessing pain; and useful care management principles. The reference from the BCOPE is found in the Pain 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 pain?

Pain is a subjective experience that is unique to the person experiencing it. It occurs *wherever and in whatever form the person says it does*, as it can be both a sensory and emotional experience. It should not be ignored or under treated.

Pain can be described as:

- A sensory experience (based on its intensity, nature and location);
- An emotional response (based on its unpleasantness or the fear, frustration or anxiety attached); or
- In terms of its impact on physical, psychosocial and functional aspects of daily life.

Pain can be acute or chronic:

- Acute Pain - short-term episode following tissue damage that typically ceases following a period of healing
- Chronic Pain - pain that lasts beyond normal healing time (usually 3months+) or is as a consequence of disease where no healing will occur.

(BCOPE, 2012. p.225)

Why is pain important?

"Chronic pain is prevalent in Australia with 1 in 20 people experiencing it. Chronic pain of non-malignant origin is common among older people (both in the community and in

residential care). …Consequences of untreated pain include unnecessary suffering, physical and psychosocial dysfunction, impaired recovery from acute illness and surgery, immuno-suppression, and sleep disturbance." (CHAOP Module 7 p.13)

There are five key facts about pain that all staff providing care should understand (BCOPE p.225). These include:

1. Pain observed in older people **can be treated** and is **not an inevitable part of ageing.**
2. All health care staff should be aware of pain among older people, as it can be underreported and unacknowledged even by the person themselves.
3. Untreated pain detrimentally impacts on quality of life (QoL) and participation in functional activities of daily living. Effective treatment of pain is essential for improving QoL and preventing chronic pain or long-term disability.
4. Resident self-reporting remains the most reliable source of pain information. There are observation based tools designed for pain assessment among persons with severe cognitive impairment or communication issues. Cognition and communication impairment may impact on the assessment process if based on resident verbal or visual self-report.
5. It is vital to address the pain and to treat its cause. Failure to treat the cause of pain may increase the effect of injury or disease and increase the likelihood that the pain could become chronic.

The assessment of pain should be a formal process, using an appropriate tool (suitable to the person's cognition, using meaningful language, and ease of use for the older person). Treatment of pain will vary but it is usually a combination of pharmacological and non-pharmacological approaches. In acute care, older adults receive fewer pain-relievers than younger people. While drug metabolism is affected by age and it is therefore appropriate to start on lower dosages, the treatment should be monitored. If pain persists, a higher dose or a different medication should be considered (CHAOP Module 7, p.13).

Whilst pain can present itself as a symptom to be treated, identification of the underlying cause is paramount to pain management, as failure to address the underlying trigger for pain can lead to chronic and long-term pain injury.

The PMG Kit (p.10) and BCOPE (p.225-226) provide clear descriptions of the following types of pain:

- **Nociceptive pain:** *somatic or visceral*
  Somatic pain is described as sharp, aching or gnawing sensation and can usually be clearly localised. Somatic pain receptors are located within the skin, muscles and bone. This type of pain is common with skin ulcers, musculoskeletal conditions or arthritis.

Visceral pain is described as a dull ache, deep or squeezing sensation that is less easily localised. Visceral pain is associated with organs such as the liver, heart and gut.

- **Neuropathic pain**
  Pain related to the nervous system (due to a primary lesion or dysfunction) and it is described as a burning, shooting or tingling sensation. Neuropathic pain is associated with conditions such as postherpetic neuralgia, phantom limb pain (following amputation), diabetic neuropathy, sciatica or stroke.
- **Cancer pain**
  Can be due to cancer treatment or the disease itself, and is either nociceptive or neuropathic in nature.
- **Pain related to psychological/psychiatric factors**
  This relates to pain that results from, or has an increased severity due to, underlying psychological and/or psychiatric factors. The psychological/psychiatric factors contributing to the pain need to be considered in order to reduce or overcome the associated pain experiences. Often these factors do not cause the pain, but influence the way it is reported and perceived by the individual.
- **Mixed or unspecified pain**
  This refers to pain that has an unknown mechanism and may be recurrent (i.e. headaches or fibromyalgia) with no obvious associated pathology.

Observational signs of pain

Cognitive and communication impairments and cultural differences are common in residential aged care, as is the presence of pain among older people. As a result, there are certain factors which can interfere with accurate pain identification (BCOPE p. 232), such as:

- Differences in the terminology used by health professionals and the older person/their family
- Individual misconceptions or fear regarding pain
- Language and cultural differences
- Literacy and numeracy skills involved with some assessment tools
- Communication and cognitive impairments
- Sensory impairments, such as poor sight and hearing when answering questions or reading information.

Observational identification of pain is therefore critical in residential aged care settings, as non-verbal indicators of pain may be the only indication of discomfort. It is important to be aware of the signs and symptoms of pain.

The following is a summary list of these signs and symptoms of pain (BCOPE p.231):

Facial Expression

- Frowning, sad or frightened face
- Grimacing, wincing, eye tightening or closing
- Distorted facial expressions - brow raising/lowering, cheek raising, nose wrinkling, lip corner pulling
- Rapid blinking

Vocalisation

- Sighing, groaning, moaning
- Grunting, screaming, calling out
- Aggressive/offensive speech
- Noisy breathing
- Asking for assistance

Body Movement

- Tense posture, guarding, rigid
- Fidgeting
- Pacing, rocking or repetitive movements
- Reduced or restricted movement
- Altered gait

Changes in Social Interaction

- Aggressive or disruptive behaviour
- Socially inappropriate behaviour
- Decreased social interactions
- Withdrawn

Changes in Activities

- Appetite change, refusing food
- Increase in rest periods
- Sleep or rest pattern changes
- Increased wandering

Changes in Mental Status

- Cognitive decline, increased confusion
- Crying/tears
- Irritability or distress

Autonomic

- Pallor, sweating, tachypnoea, altered breathing, tachycardia, hypertension

Whilst observational signs may be crucial for the identification of pain among some older people, it is important to remember that autonomic signs of pain such as pallor, sweating and rapid heartbeat are only observable during a severe acute pain episode.
The presence of autonomic behaviours could be linked to either pain or activities the person does not enjoy or has had previous negative experiences with. In this instance, pain may be absent but some evidence of sweating or altered breathing may be visible. Therefore, clinical judgement, familiarity with the person and discussions with family/carers, and regular observation of the person's behaviours is crucial.

How Pain Interacts with Other Domains

Pain can also affect performance in a number of other health care domains, recognising and treating pain early is critical due to its negative impact on other care domains (BCOPE p. 227-228).

Pain can be associated with the following outcomes:

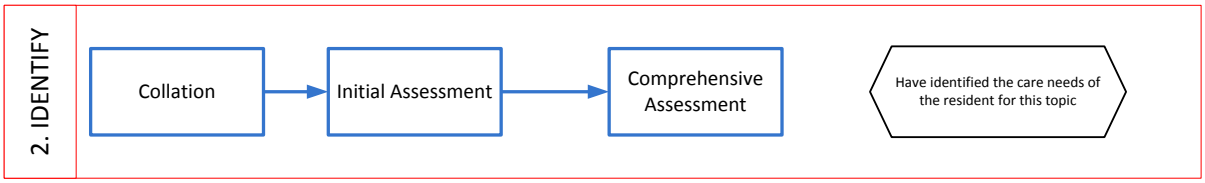
- Impaired mobility or immobility leading to muscle wastage
- Depression, anxiety and social isolation
- Sleep disturbance
- Reduced participation in activities of daily living
- Fatigue and pulmonary complications
- Delayed healing and recovery
- Increased healthcare costs and use of services
- Increased mortality

Pain is also suggested to worsen:

- Gait disturbances
- Polypharmacy
- Physical deconditioning
- Falls episodes
- Cognitive dysfunction
- Malnutrition
- Rehabilitation

Clearly, the presence of pain in older people can impact on a wide variety of other health domains, at both the physical and psychological level. To comprehensively identify and treat pain, you need to recognise its wider impact on the person and how this may lead to further issues.

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 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, documented 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 pain.

Document	**Look for**
ACCR	Diagnoses in Part 4 Q28 Comments on pain may be found in the Notes in Part 5 Allied Health/Therapy notes may inform on pain issues/treatment in Part 5 Q40
Medical Notes/CMA	Relevant diagnoses, pain status may be mentioned
Allied Health Professional notes/assessment (e.g. Physiotherapist, Occupational Therapist)	Pain status, treatment/intervention needs, aids and assistance

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

Diagnoses/impairments/strengths	**Impact**
Diagnoses of Osteoarthritis / Rheumatoid arthritis	Pain associated with movement, requires assistance with mobility and personal hygiene tasks.
Cancer and terminal illnesses	Usually accompanied by pain, also may require palliative care. Pain can impact on many aspects including activities of daily living, mobility, falls risk, cognition, mood, fatigue, sleep disturbance, nutrition, social interaction, skin integrity etc.
Wounds	Wound pain may be reported, pain is associated with delayed healing and recovery.
Behavioural Expressions e.g. wandering, verbal disruption, physical behaviour, depression	May be impacted on (worsened) by pain or be an expression of pain. Excessive wandering and physical self harm can cause pain or be the result of untreated pain.
Cognitive Impairment	Reduced ability to communicate the pain, this requires observation and patience to identify pain, assess pain and monitor the effectiveness of treatments.
Communication issues - understanding others and/or communicating to others due to for example, stroke or cultural diversity	May require strategies or aids to assist the person to communicate their level of pain and to help them to understand the pain management strategy. For example, communication aides (language cards, picture cards) to assist the resident to communicate. For example, interpreters to explain the pain management strategy.

Resident and Family

Involving the older person and their family/carer in the identification, treatment and care planning process is fundamental to ensuring they have an active and participatory role in their pain management. Residential care staff should encourage residents to regularly report on (BCOPE p.238):

- The pain they experience
- Where it is located
- How intense the pain is
- A description of the pain (i.e. aching, throbbing)
- Activities that improve or worsen the pain
- How the pain interferes with their daily activities (i.e. sleeping, eating)
- What strategies for pain have or have not worked
- What would most improve or maintain their enjoyment of life

Getting Back to Mr. Teal

While a person with dementia may not verbally complain of pain, perhaps because they cannot find the words or cannot express themselves with language, their actions, body language and behaviours can be informative.

George is showing no interest in participating in activities that he once enjoyed and staff have observed from his facial expressions and body stiffness that he is possibly frightened or may even be in pain, when asked to walk with his frame. The family has also noticed that George looks frightened and grimaces when asked to walk. He needs motivation to overcome his fear, because if he doesn't start moving again, he will very likely deteriorate.

The staff and family agreed that he needs to gain confidence walking again and George agreed to start exercises with the physiotherapist to strengthen his arms and legs. The physiotherapist was also able to undertake an assessment for pain and provide insights into George's pain issues and where it was hurting when he walked. They also discussed with the family what pleasant events might motivate him.

Initial 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. In particular for pain, the Comprehensive Health Assessment identifies whether the pain is acute or chronic, and follows the COLDSPA criteria for pain identification.

Note that a validated pain assessment tools is recommended in the CHA. Validated pain tools are also discussed in the comprehensive approach section.

The relevant items from the CHA for pain are listed below; it is recommended that a positive screen from any one of the indicated items should trigger further assessment.

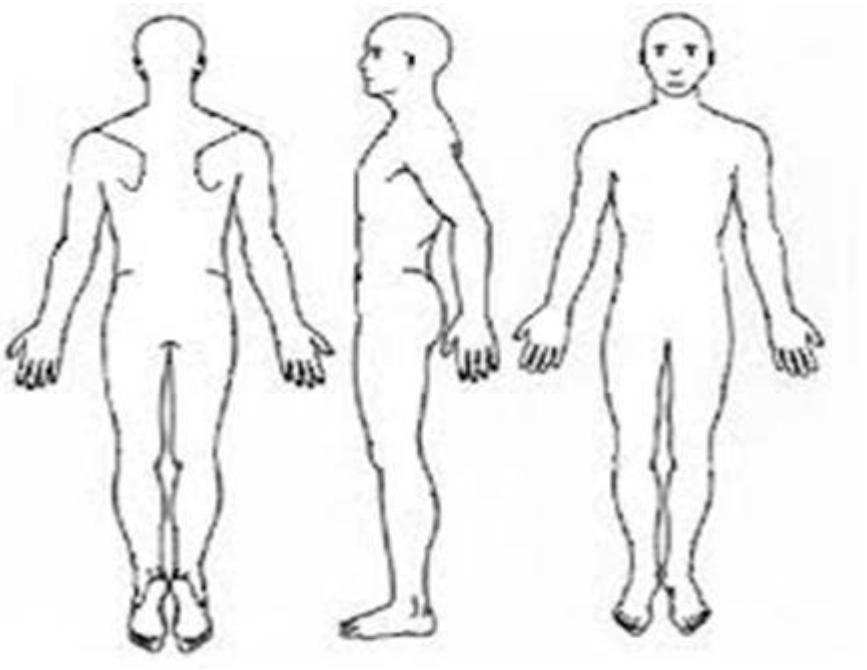
Pain

Acute	Yes	☐	No	☐
Chronic	Yes	☐	No	☐

What does the person perceive to be the cause of the pain?

If pain present assess this using validated pain assessment tool both at rest and on movement.

Identify location of pain on diagram below



C - character

O - onset

L - location

D - duration

S - severity

P - pattern

A – associated factors

What relieves the person's pain?.....

Identified issues .....

Comprehensive Approach

It is recommended that all **new** residents have a comprehensive assessment for pain which will further identify the person's pain issues.

In addition to the completing CHA, the comprehensive approach includes:

- An interview based pain assessment if suitable (Modified Resident's Verbal Brief Pain Inventory (M-RVBPI) OR
- An observational pain assessment (Abbey Pain Scale OR Pain Assessment in Advanced Dementia) when it is not appropriate to interview the resident
- A pain intensity assessment for on-going monitoring (Verbal Descriptor Scale OR a numeric rating scale OR visual analogue scale or pictorial pain scale)

The PMG Kit (in conjunction with the Australian Pain Society Management Strategy document) recommends all of the assessment tools recommended in this workbook (references are provided in the Pain Appendix and copies are found in the Complex Health Assessment Pack).

The PMG Kit (p. 9) lists six guidelines to guide the identification and assessment of pain. More detailed information on the strategies from the PMG Kit can also be found on pages 7-20 of the 'Pain in Residential Aged Care Facilities: Management Strategies' resource.

The six guidelines for identification highlight:

- Pain assessment is an ongoing process - it should occur at admission, when there are significant changes, when pain is suspected, at least every three months;
- Combined use of observational and self reports of pain is recommended;
- Diagnosis is vital for effective management;

- A multi-faceted investigation approach should be taken (record general and pain history, physical examination, impact of pain physically and socially, psychosocial factors, review medications, assess pain severity and intensity);
- The selection of an appropriate structured pain assessment;
- Pain intensity scales are useful for ongoing evaluation

Due to the complexities involved in identifying pain amongst older people, in particular among those who may have difficulties verbally expressing their pain, combined observation and verbal techniques should be used if appropriate. It is important to select the appropriate screening tool for the resident based on their profile (e.g., if they have cognitive or communication impairments, an observation based tool may be more suitable).

For residents who **DO** have a cognitive or communication impairment, and are best assessed using only observation-based assessment, the recommended *observation* assessments are either of the following:

- Abbey Pain Scale
- Pain Assessment in Advanced Dementia (PAINAD)

This information should be combined with any additional evidence collected from the CHA pain assessment criteria, such as COLDSPA, which focuses on the type and characteristics of the pain as opposed to solely whether pain exists or not.

For residents who are unable to verbally describe their pain, it may be more difficult to address each element of the COLDSPA criteria; however, every effort should be made to establish as much of the COLDSPA criteria as is possible, based on the Abbey Pain Scale/PAINAD outcomes and continuous monitoring of the person.

For residents who **DO NOT** have a cognitive or communication impairment, and can respond to interview questions, the recommended assessment is the

- Modified Resident's Verbal Brief Pain Inventory (M-RVBPI)

The Modified Residents Verbal Brief Pain Inventory (M-RVBPI) is as the name suggests a modified version of the Brief Pain Inventory that was developed specifically for use in residential aged care facilities. The M-RVBPI asks the resident about several aspects of their pain, including pain intensity and its impact on their quality of life.

Evidence collected from the M-RVBPI should be combined with information collected from the CHA pain assessment criteria, such as COLDSPA.

The *PMG Kit for Aged Care and the Pain in Residential Aged Care Facilities: Management Strategies (2005)* provides further guidance on how to complete all parts of the assessment tools.

For residents who **have no** or only a mild cognitive or communication impairment, and can respond to scales based on numbers or pictures, the following uni-dimensional scales are appropriate for identifying the intensity of the pain (initially and after treatments).

- E.g. Verbal Descriptor Scale (VDS) OR a numeric rating scale OR visual analogue scale or pictorial pain scale.

References for the pain assessment tools are found in the Pain Appendix and copies are found in the Complex Health Assessment Pack.

Bringing the information together

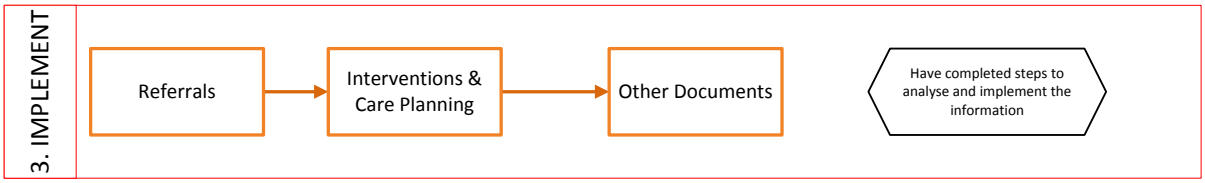
A multi-faceted investigation approach will ensure you have considered the clinical risks related to pain. This would include (i) recording both general history and pain history, (ii) ensuring a physical examination has been undertaken, (iii) investigating the impact of pain both physically and socially, (iv) considering psychosocial factors such as mood or behaviours that could worsen the pain, and (v) reviewing medications.

Pain is intertwined with most of the other healthcare domains. 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)
- Skin and wound issues (e.g. as identified in a later topic of this workbook)
- Diagnoses (e.g. as identified in collated documents, associated with pain issues e.g., arthritis)

Once it is understood 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.

There are three specific aspects to implement care of the resident's identified needs

- Undertake **referrals as required** to gather further required 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 issue with pain that is ongoing, a referral to a physiotherapist (for a pain intervention using exercise or movement), GP (for medication), psychologist (for Cognitive Behavioural Therapy or counselling) or to a more specialist pain clinic could be considered. More remote geographical areas may not have ease of access to specialists, however, there is increasing availability of telehealth and the local availability of this option could be investigated.

Based on the type of pain identified during assessment, the cognitive and communicative capabilities of the person and their preferences in pain management, a variety of different treatment options and referral routes should be considered.

We recommend that nursing management develops comprehensive 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, for example (Table 2):

Table 2: Referrals for Pain

Health Professional	Source	Contact
Medical Practitioner	Health Service	Name, contact details
Psychologist	Health Service	Name, contact details
Physiotherapist	Health Service	Name, contact details
Occupational Therapist	Health Service	Name, contact details
Pain Clinic/Pain Specialist	Health Service	Name, contact details
Consultant Nurse (Pain) Specialist	Health Service	Name, contact details
Australian Pain Society	website	https://www.apsoc.org.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 residen's health status and their quality of life.

The intervention program targeting pain should involve evidence informed strategies (refer following) that address the pain 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 PMG Kit lists 15 strategies (p.13-17) to support the treatment of the older person with pain and it is recommended that readers refer to this document and the supporting resource 'Pain in Residential Aged Care Facilities: Management Strategies' pages 18-50 for more detailed description of these techniques. Below is a summary of the management strategies discussed (a reference for this resource is found in the Complex Health Appendix).

Comprehensive management approach

- Developing a treatment plan that incorporates both pharmacological and non-pharmacological therapies is advocated, as there is an increased chance of relieving pain through combined approaches rather than through one strategy alone.
- Treatment of persistent pain is always more effective when combined with non-drug approaches. Persistent pain that includes sensory and emotional components requires a more comprehensive approach to pain management, which will involve using non-pharmacological treatments.
- Non-drug treatments may be particularly suitable for residential aged care facilities as they promote the older person's involvement in pain management and sense of control over their pain.
- Combining approaches may allow for lower drug doses to be used, potentially reducing side effects.
- Symptoms other than pain (e.g., sleep disturbance) need to be treated as part of the pain management process.
- Multidisciplinary collaboration (family included) enhances pain management.

Care Plans/Referrals

- The resident (or their advocate if the person is unable to provide informed consent) needs to be informed, understand the purpose of and provide consent for all treatments.
- Pain management plans need clearly established goals, such as to achieve full pain relief or to decrease pain to bearable levels.
- Pain on movement, or during dressings and other care interventions can be minimised by using appropriate manual handling techniques and equipment, and giving analgesia at an appropriate time before movement.
- Residents who fail to respond to pharmacological and non-pharmacological treatment and continue to be distressed by their pain should be referred to a pain specialist or pain clinic.

Pharmacological treatments

- Pharmacological treatments require a diagnosis where possible and a co-existing medical condition must be considered.
- Consideration of age-related changes in drug sensitivity, metabolism and side effects must be considered.
- A pharmacological approach to pain relief must consider the interactions of other medications and the potential side effects (as it is common for older people to be prescribed multiple medications).
- Analgesia

- Analgesia that is tailored for a specific pain diagnosis is most likely to be effective in relieving pain.
- Side effects can often be anticipated and treated or avoided.
- Regular (around the clock) administration of analgesia is the most effective treatment for persistent pain**.**
- The need for short-acting analgesia for breakthrough pain should be anticipated and prescribed on an as-needed (PRN) basis. Short acting analgesia given prior to an activity can be effective at reducing predictable (incident) pain. This is especially important to recognise because people with dementia can seldom provide requests as needed.

Psychological-Educational approaches

- Cognitive behavioural therapies (CBT) can be beneficial for the management of persistent pain but are only suitable for those residents who are cognitively able (and willing) to participate.
- The benefits of CBT can include improved coping skills, increased participation in social activities, and/or an overall improvement in the person's quality of life.

Physical therapies

- Physical therapies need to be selected based on the person's cognitive, communicative and physical abilities.
- Therapeutic exercise can decrease pain. Strengthening, stretching and aerobic exercises can be beneficial in increasing function and improving mood, as well as reducing pain intensity.
- Physical therapies, such as superficial heat and Transcutaneous Electrical Nerve Stimulation (TENS), can be helpful in reducing pain intensity in the short term, for residents who are able to provide feedback on their experience.

Complementary and alternative medicine (CAM) therapies

- Use of Complementary and Alternative Medicine (CAM) therapies may be helpful and can complement other pain management strategies.
- The older person or their family/carer should be fully informed about the safety and effectiveness of any CAM treatment.
- It is important to note that while there is a diversity of CAM therapies available more research is needed into their safety and effectiveness to inform prospective users of the benefits of these therapies.

Back to Mr. Teal

The staff were patient with George following his fall as they knew he was in pain from his bruises, body language when standing, his grimaces when he moved, and from his disinterest in the activities he had previously enjoyed. The GP ordered regular analgesic, the staff checked on him regularly, and when he wanted to stay in bed, they let him be.

After a week, his bruises were healing, but without daily movement, he was getting stiffer and weaker. Now the staff tried to interest him in meals in the dining room. While he was very nervous while he was on his feet, and always anxious to sit down, the dining room was very close to his room. With a staff member assisting him to use his frame he was able to safely walk to the dining room.

Staff noticed he couldn't cut his meat because of the pain in his left arm, and his menu was adapted to casseroles and meals that could be eaten with just a fork; that helped maintain his nutritional health and self-care skills.

The physiotherapist started him again on a series of strengthening exercises and the staff also introduced these exercises after the physiotherapist educated the staff on the correct way to assist George. His family also increased their visits with the aim of lifting his mood.

George saw the physiotherapist regularly, and with her encouragement, started breathing and stretching exercises. She suggested he to do the stretching exercises outdoors; and that encouraged and motivated him to return to his bird watching hobby.

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 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** – 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

For example, one specific goal for Mr. Teal could be to reduce his pain over the next 2 weeks. This goal will be:

- Measurable by assessing his pain intensity at baseline, and pre/post treatment, and after 2 weeks interview the resident and family for their feedback
- Describing the actions that are being done to achieve the goal, e.g., administering regular analgesic
- Realistic as it fits into the normal practices, and it is affordable
- Time-based as it is to be reviewed after 2 weeks

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 where relevant. The analysis of such incidents should take into consideration the resident's right to take risks and personal preferences. 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. recent fall) or symptoms (e.g. facial grimacing), connect the link to the body structures and/or functions that are impacted (e.g. limited mobility, pain)
- Describe the associated activity limitations (e.g. reduced independence in mobility,). It's important to look at remaining strengths (e.g. personal interests)
- 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. pain management to reduce pain, exercises to improve muscle strength)
- Finally, define the care goals (to reduce pain, improve muscle strength) 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 in regards to pain:

- There was a diagnosis of arthritis, a recent fall and dementia (Medical Notes/ACCR/progress notes).
- From the identification process, we identified the body structures/ functions that were affected. The arthritis affected the lower right limb, and recent fall had associated pain and impacted on mobility (ROM assessment, file notes).
- These issues resulted in loss of his confidence to safely move around, and loss of interest in previous enjoyable activities.
- Strategies and subsequent interventions were developed to address the limitations by reducing the pain intensity, improving his muscle strength by exercising, encouraging participation in communal meals and returning to pleasurable activities such as bird watching. It is important to look at remaining strengths and motivations, such as personal interests, that can be used to support the person's participation in everyday activities.

- The aims of the care plan were defined as goals (e.g. provide regular analgesia for pain management, improve muscle strength with exercises, provide more staff assistance to encourage safe mobility to the dining room, encourage George to return to personal hobbies) that can be evaluated.

Completing the ACFI documentation

The data collected can now be used to complete the **ACFI 12 .3, 12.4a and 12.4b evidence requirements.** Table3 presents the evidence requirements for simple pain and Table 4 for complex pain. Sample directives for ACFI questions 12.3, 12.4a, and 12.4b are also provided.

Note that the pain assessment can be utilised in 12.18 however, the Palliative Care claim is not discussed in this topic).

Diagnoses of pain combined with information about the location, severity and type of pain are particularly informative to identify the type of treatment and care planning procedures required.

To support claims for ACFI 12.3, 12.4a and 12.4b an

- Assessment using an evidenced based pain tool is required (these have been discussed in this workbook)
- A directive specifying the treatment including duration and frequency (examples are provided below); and
- A record of treatment should be kept (and presented if requested). The resource "The PMG Kit for Aged Care (2007)" provides an example of a pain chart for recording pain treatments. Note, these examples would require modifications to include staff signatures (the reference is found in the Pain Appendix).

Document where the required and supporting documents are stored (e.g. Resident Progress Notes, ACFI Folder) to assist in (internal/external) audit preparation and completion and to maintain the documentation trail.

Table 3: ACFI Question 12.3 (Simple Pain) Evidence Requirements

ACFI 12.3 - Requirements	How to meet the requirements
12.3 Pain management involving therapeutic massage or application of heat packs AND Frequency at least weekly AND Involving at least 20 minutes of staff time in total	Provide 1. Directive [by a Registered Nurse Div 1 or Medical Practitioner or appropriate Allied Health Professional] AND 2. Evidence based pain assessment AND on request: Record of Treatment

Below is an example of a pain directive that will meet ACFI requirements for ACFI 12.3, and provide enough details to ensure the 'pain treatment' is clearly described, documented and accountable for all stakeholders (resident, family, staff, internal auditors, external auditors).

ACFI 12.3. SIMPLE PAIN DIRECTIVE

This is therapeutic massage or heat packs by any care staff, for a total of 20 mins/week. This directive informs on Assessment, Treatment, Treatment days/times/length, by Staff type, Staff training requirements

Resident name/room: ……..

Assessment tool/date: ……

Treatment: ☐ Therapeutic massage ☐ Application of heat packs

Treatment to occur on the following days every week (tick days):

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Treatment time: ___:____AM/PM **Treatment length**: _____mins per session

By staff type (tick) ☐ Care staff ☐ …… **Is staff training required**? ☐ YES ☐ NO

Provide a detailed description of the treatment (preparation, body part, equipment, goal of treatment)

Name: …… Profession: ☐ RN ☐ MP ☐ AHP (state type)

Signature: …….. Date: ……

Table 4: ACFI Question 12.4a OR 12.4b (Complex Pain) Evidence Requirements

ACFI 12.4a OR 12.4b – Requirements You can only claim one item either 4a or 4b.	**How to meet the requirements**
12.4a Complex pain management and practice undertaken by an allied health professional or registered nurse. This will involve therapeutic massage and/ or pain management involving *technical equipment specifically designed for pain management AND Frequency at least weekly AND Involving at least 20 minutes of staff time in total.	Provide 1. Directive [by a Registered Nurse Div 1 or Medical Practitioner or appropriate Allied Health Professional] AND 2. Evidence based pain assessment AND on request: Record of treatment o Under item 4a, an RN or an Allied Health Professional may provide the complex pain treatment.
12.4b Complex pain management and practice undertaken by an allied health professional. This will involve therapeutic massage and/ or pain management involving technical equipment specifically designed for pain management AND Ongoing treatment as required by the resident, at least 4 days per week	1. Directive [Medical Practitioner or appropriate Allied Health Professional] AND 2. Evidence based pain assessment AND on request: record of treatment

Information sourced from the ACFI User Guide (2013)

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

Below is an example of a pain directive that will meet ACFI requirements for ACFI 12.4a and 12.4b, and provide enough details to ensure the 'pain treatment' is clearly described, documented and accountable for all stakeholders (resident, family, staff, internal auditors, external auditors).

ACFI 12.4a COMPLEX PAIN DIRECTIVE

This is therapeutic massage or pain management by any RN or AHP, for a total of 20 mins/week

Assessment, Treatment, Treatment days/times/length, by Staff type, Staff training requirements

Resident name/room: ……

Assessment tool/date: ……

Treatment ☐ Therapeutic massage ☐ Pain management using (state technical equipment)

Treatment to occur on the following days every week (tick days):

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Treatment time: ___:____AM/PM **Treatment length**: _____mins per session

By staff type (tick): ☐ RN ☐ AHP **Is staff training required**? ☐ YES ☐ NO

ACFI 12.4b COMPLEX PAIN DIRECTIVE

This is therapeutic massage or pain management by AHP, minimum of 4 days in a week

Assessment, Treatment, Treatment days/times/length, by Staff type, Staff training requirements

Resident name/room: ……..

Assessment tool/date: ……

Treatment ☐ Therapeutic massage ☐ Pain management using (state technical equipment)

Treatment to occur on the following days every week (tick days):

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Treatment time: ___:____AM/PM **Treatment length**: _____mins per session

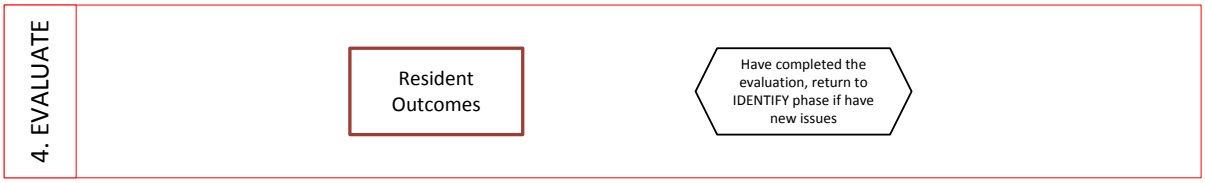
By staff type (tick): ☐ AHP

Provide a detailed description of the treatment (preparation, body part, equipment, goal of treatment)

Name: …… Profession: ☐ RN ☐ MP ☐ AHP (state type)

Signature: …….. Date: ……

Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

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

- Resident Care Outcomes

  With regard to pain, for example, has the intervention reduced the pain intensity? This could be determined by regular monitoring of the pain intensity after each intervention for a set time, for the purposes of evaluating the appropriateness and effectiveness of the treatment.

- Further improvements

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

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.

Outcomes

An evaluation of Mr. Teal's care has shown that the interventions are working as the pain has improved, he is mobilising again, and he has re-engaged with his personal interests.. George 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 his doctor and physiotherapist. They also assessed the outcomes against the goals included in the care plan. They found:

- George is improving physically – he does not indicate he is afraid of falling when walking, because he is a falls risk staff continue to supervise his mobility.
- The intensity of the pain intensity experienced after the fall has decreased, however the arthritis will continue ongoing pain treatment.
- He has also returned to bird watching and sitting in the garden, and reports he feels happier.

The evaluation provides the proof that what they had put in place to assist Mr. Teal had worked and improved his quality of life. New actions will also come out of the evaluation review, along with new goals.

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, and how important they are to achieving positive outcomes for their residents. The literature informs that at a minimum, the pain status should be reviewed every 3 months.

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 (Abbey Pain Scale or PAINAID for observation based assessment, M-RVBPI interview, Pain Intensity tools)

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

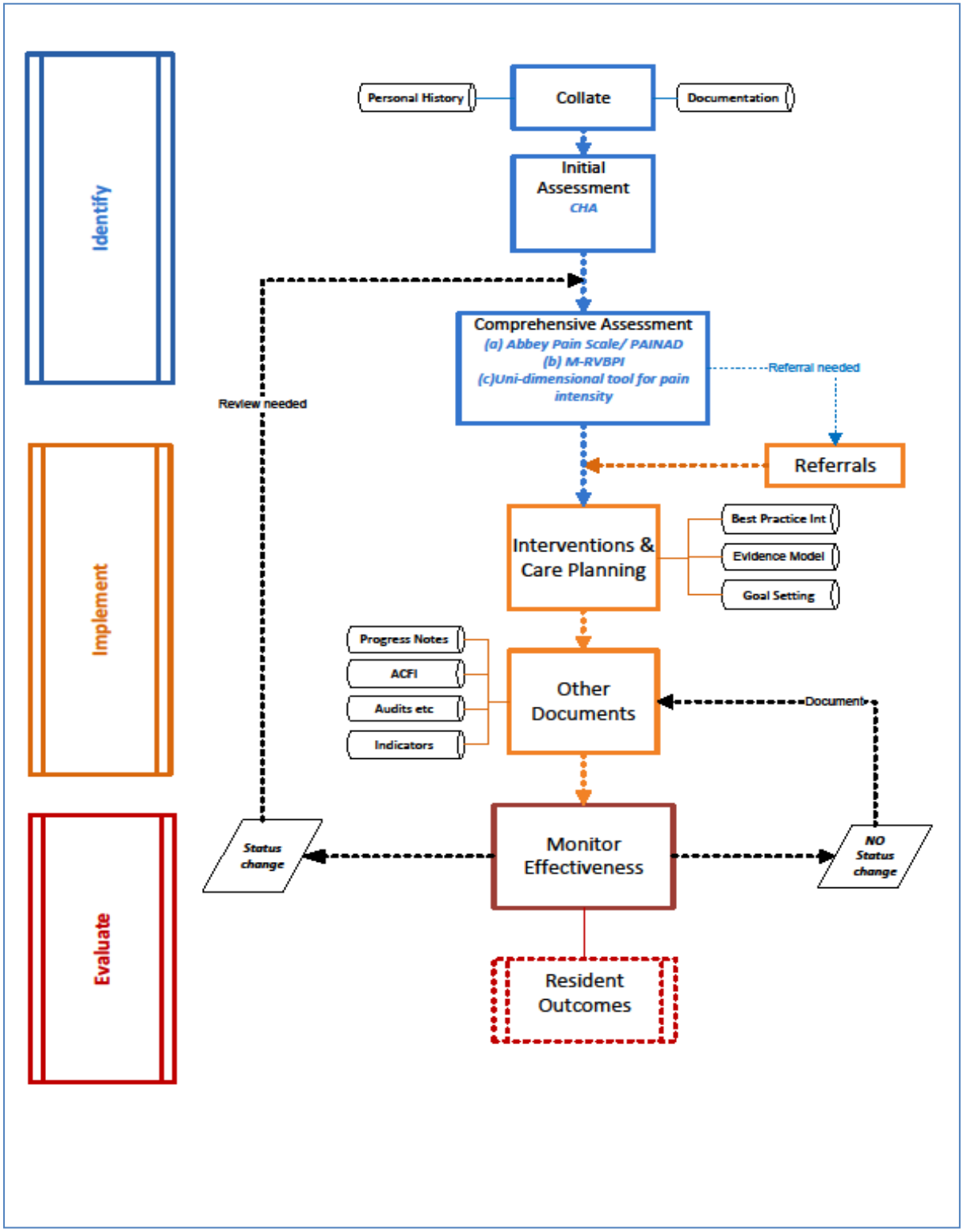
The evaluation phase which comprises:

- 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: Pain Summary: Steps and Information Flow



Pain Resources

The recommended resources are listed below with information on where they are found in the toolkit (Table 5).

Table 5: Pain Topic Resources

Resource Type	Details	Document
Background Reading	The Australian Department of Health's PMG Kit for Aged Care (2007) The Australian Pain Society 'Pain in Residential Aged Care Facilities: Management Strategies' (2005).	Pain References (facility to download)
Background Reading	BCOPE. The Toolkit (2012) pp.225-231	Pain References (facility to download if required)
Initial Assessment	Initial Nurse Assessment (e.g. CHA)	Complex Health Assessment Pack
Pain Assessments	Abbey Pain Scale OR PAINAID	Complex Health Assessment Pack
Pain Intensity Tools	Verbal Descriptor Scale (VDS) or a numeric rating scale or visual analogue scale or pictorial pain scale	Pain References (facility to download)
Pain Assessment	Modified Resident Verbal Brief Pain Inventory	Complex Health Assessment Pack
Skin Risk Assessments	Waterlow OR Braden OR Norton	Complex Health Assessment Pack
Skin Integrity Assessment	Residential Care Services Skin Integrity Assessment	Complex Health Assessment Pack
Wound Assessment	Residential Care Services Wound Assessment and Progress Chart	Complex Health Assessment Pack
Self-Care Assessment	Observational Performance	Complex Health Assessment Pack
Goal setting	Quality Of Life Questionnaire	Reading Pack
Standardised Care Processes (SCP) for Swallowing	Choking; Dehydration; Oral and dental hygiene; Unplanned weight loss	Complex Health Assessment Pack
Standardised Care Processes (SCP) for Skin & Wounds	Dehydration; Unplanned weight loss	Complex Health Assessment Pack

Pain References

The recommended resources are listed below and references are provided (Table 6).

Table 6: References for the Pain Topic

Document name	Reference
Abbey Pain Scale	Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002. Sourced from NATFRAME: The Department of Health PMG Kit for Aged Care (2007). 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
Best care for older people everywhere (BCOPE). The toolkit	Department of Health Victoria (2012) Sourced from: 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 the 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).
Modified Resident's Verbal Brief Pain Inventory (M-RVBPI)	Adapted from Cleeland, C. S. (1989). Measurement of pain by subjective report. In C. R. Chapman & J. D. Loeser (Eds.), *Advances in pain research and therapy: Vol 12. Issues in pain management* (pp 391-403). New York: Raven Press, by the Australian Pain Society, 2005, & Toye et al., 2005. Sourced from NATFRAME: The Department of Health PMG Kit for Aged Care (2007) 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
National Framework for Documenting Care in Residential Aged Care Services (NATFRAME) Care Profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource. Sourced from: 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
Numeric Pain Rating Scale (NRS)	Pain in Residential Aged Care Facilities: Management Strategies (2005) Sourced from: The Department of Health PMG Kit for Aged Care (2007) 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
Pain Assessment in Advanced Dementia	Warden V, Hurley A, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. Journal of

Document name	Reference
(PAINAD)	the American Medical Directors Association. 2003; 4: 9–15. Sourced from: The Department of Health PMG Kit for Aged Care (2007) 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
Pain in Residential Aged Care Facilities: Management Strategies (2005)	The Australian Pain Society (2005). Sourced from http://www.apsoc.org.au/publications http://www.apsoc.org.au/PDF/Publications/Pain_in_Residential_Aged_Care_Facilities_Management_Strategies.pdf
The PMG Kit for Aged Care (2007)	Funded by the Australian Government, Department of Health and Ageing, under the National Palliative Care Program. This work is covered by copyright. Kit may download in PDF format: http://www.health.gov.au/internet/main/publishing.nsf/Content/ageingpublicat-pain-management.htm There is also a CD available.
Pain Intensity Tools	Sourced from: Pain in Residential Aged Care Facilities: Management Strategies (2005) Appendix 5: Present Pain Inventory Appendix 6: Pain Thermometer Appendix 8 :Visual Analogue Scale Appendix 9: Pictorial or Faces Pain Scales Sourced from NATFRAME Pain Thermometer Pictorial Pain Scale 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

Topic 9: Swallowing

The Swallowing Topic

This topic focuses on swallowing and it represents one of the three topics within the Complex Health Workbook.

The early identification of swallowing impairments among older people is critical because it is associated with the clinical risks of choking and aspiration pneumonia.

The commonly used term for a swallowing impairment is 'dysphagia'. The prevalence of dysphagia increases with age and it is becoming more frequently identified in older people. It is estimated that 40 – 50% (and some estimates put it as high as 80%) of all older people in residential care have dysphagia (BCOPE, 2012 p.113).

Investigating Swallowing

The following four process steps should be followed when investigating pain (consistent across all topics). 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:
    - JBI Best Practice Volume 4, Issue 2, (2000) Identification and Nursing Management of Dysphagia in Adults with Neurological Impairment and the latest update by Hines et al (2011)
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012).

The references for these resources can be found in the Swallowing 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. A comprehensive approach will include:

File Notes Review:

- Aged Care Client Record (ACCR) – This may contain Allied Health and Therapy notes, diagnoses and other comments to confirm the presence of a swallowing impairment
- Comprehensive Medical Assessment (CMA) – which (if available) may have related diagnoses and sections on swallowing impairments

Screening:

- Initial nurse assessment e.g. Comprehensive Health Assessment (the CHA is an initial nurse assessment based on the 'Comprehensive Health Assessment of the Older Person' resource), this provides a short initial nurse screen of swallowing. This tool is found in the Complex Health Assessment Pack and is referenced in the Swallowing Appendix.

Further Assessment:

- A comprehensive assessment of swallowing should be undertaken by a Speech Pathologist or Medical Practitioner. It is recommended that all new residents have an initial assessment of swallowing, followed by referral to a Speech Pathologist or Medical Practitioner for a more detailed swallowing assessment if any issues are identified.

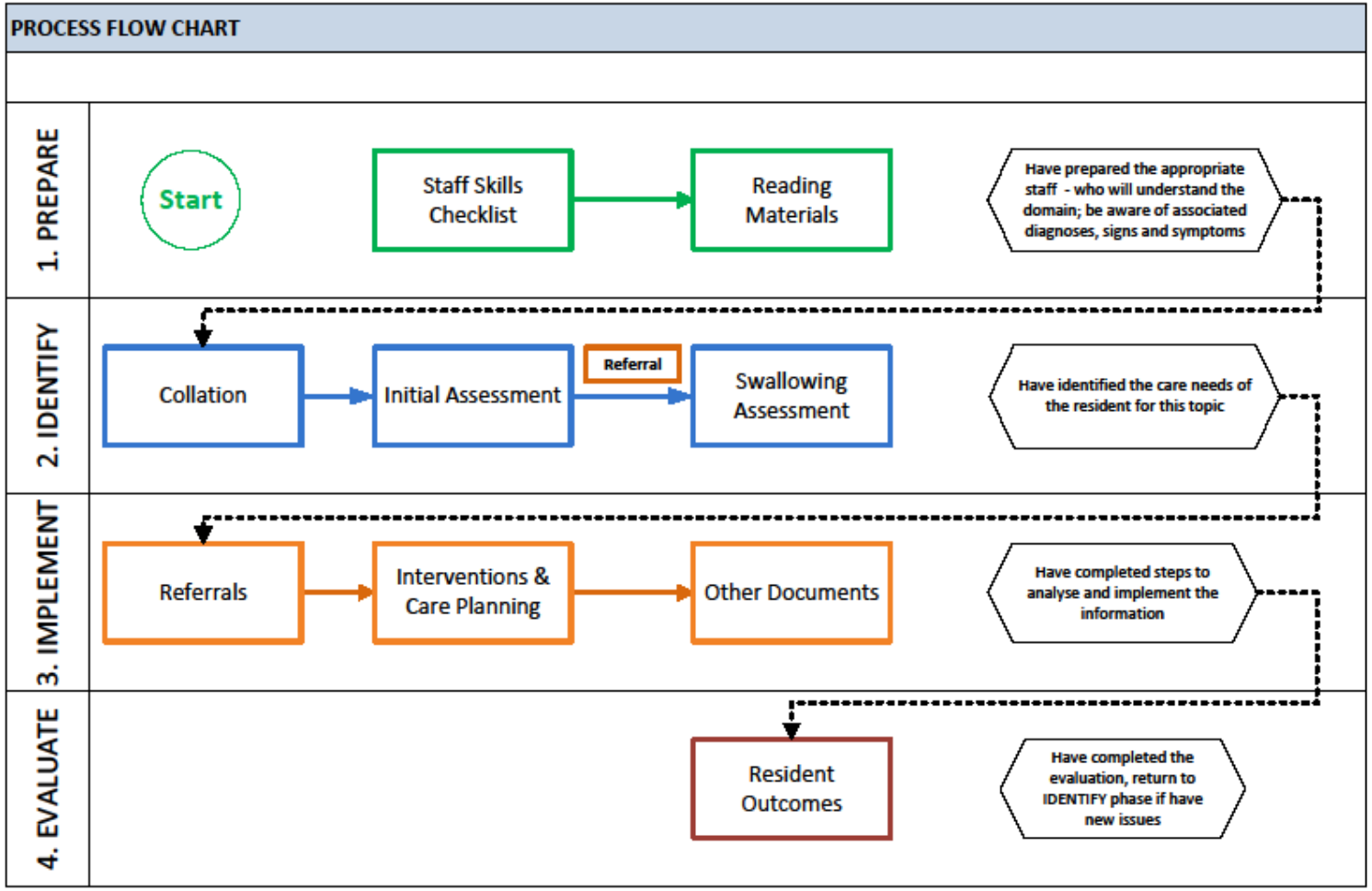
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

   - Undertaking referral options to complete a comprehensive assessment as required
   - Planning evidence informed care strategies to manage the dysphagia and 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 the resident.

The overall 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 workbooks 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: Swallowing Process



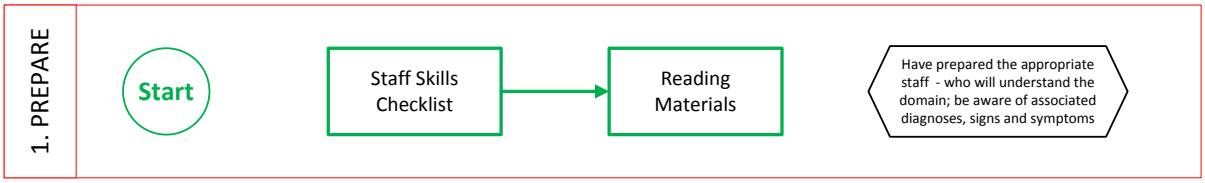
Getting Started with a Swallowing Example

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

In the nutrition topic we met Mrs. Green, an 83 year old woman in the Sunset Home who was diagnosed with dysphagia following a stroke. She had recently returned from hospital where she was treated for pneumonia, she had been assessed by the Speech Pathologist, and put on a modified textured diet of thickened fluids and soft food. The Speech Pathologist introduced exercises to improve her throat muscle movement, and the physiotherapist was providing treatment sessions to improve her range of motion and hand dexterity. The staff and family received education sessions on safe swallowing practices, to minimise the risk of choking. She had a range of other strategies in place to improve the meal time experiences.

Six months later, after making good progress, Mrs. Green has had another stroke. She is now immobile, her speech is affected (she still understands what is said to her) and her swallowing has deteriorated. . The main focus for Mrs Green and her family is now on maintaining a good quality of life.

Preparation



There are two specific aspects to **preparing** staff for the management of swallowing 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 help identify which staff have the skills required to complete activities within the swallowing process. This will assist nursing management to determine the roles of staff to ensure the process can be completed effectively (e.g. identify required activities, assess competencies, determine gaps).

For example, the Joanna Briggs Institute resource (Best Practice Information Sheet for Health Professionals, Vol 4 Issue 2, 2000) supports that qualified nurses may be educated to perform a screening assessment. However, the at-risk individual will still require a more comprehensive assessment by an appropriate health professional (e.g., Speech Pathologist or Medical Practitioner). It is therefore important that the facility identify the referral pathways available i.e. will you refer to a Speech Pathologist or Medical Practitioner for further assessment of swallowing.

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

Table 7: Staff Activities for the Swallowing Process

Activity	Responsible for sign off	Who does the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment (e.g. CHA screen)/ or other Screen		

Activity	Responsible for sign off	Who does the activity
Specialised Swallowing 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 recommended pre-reading or be able to demonstrate that they have adequate experience and knowledge of swallowing issues in older people. It is expected that staff will have:

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

The background reading relevant for this topic is:

- **CHAOP** (Comprehensive Health Assessment of the Older Person- Modules 4 and 7 are found in the Reading Pack)**.** This resource is also relevant to the other Complex Health topics in this workbook.

- Module 4 for an overview of the upper gastrointestinal system, nutritional assessment, oral examination procedures (by nurses). Also other topics associated to swallowing difficulties, such as skin integrity, malnutrition and dehydration.
- Module 7 for an overview of the nerves associated with swallowing and assessing dysphagia.

- The **BCOPE** (Best Care for Older People Everywhere- reference for the resource is found in the Swallowing Appendix) resource covers aspects of the swallowing topic (pp. 113-122) including why it's important to consider swallowing issues in older people and the management strategies to employ. The BCOPE (2012) content is summarised in the following section. Please note, 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.

- The Joanna Briggs Institute (JBI) evidence-based summary of best practice information sheet - '**Identification and Nursing Management of Dysphagia in Adults with Neurological Impairment**' (reference for the resource is found in the Swallowing Appendix). This short information sheet covers the signs and symptoms of dysphagia, the associated risk factors and practice recommendations. Note: There has been an update to this resource[1] without any major changes to the initial information, and another update is currently in progress.

Some Basics

What is dysphagia and why is it important?

The literature[2] highlights the importance of identifying dysphagia as it is a serious and life threatening condition, and is a common risk for persons with a neurological impairment or stroke history. Dysphagia is associated with the risks of choking, aspiration, pneumonia and with malnutrition. The literature recommends that healthcare facilities should have a protocol in place for the early identification and management of dysphagia. The commonly used term for a swallowing impairment is 'dysphagia'. The prevalence of dysphagia increases with age and it is becoming more frequently identified in older people. It is

[1] Hines et al 2011
[2] Miller 7 Patterson (2014); Rofes (2014); Sato et al (2014); Donovan et al (2013); Daniels et al (2012); Hines et al (2011)

estimated that 40 – 50% (and some estimates put it as high as 80%) of all older people in residential care have dysphagia[3].

Individuals with swallowing difficulties may have difficulty communicating, or not recognise the severity of the problem, making observational assessment paramount. It is therefore critical that nurses in residential care are trained to recognise the risk factors and early signs of dysphagia.

The nursing aim is to reduce the risks and maintain nutrition and hydration through safe oral feeding (non-oral feeding methods are not discussed in this topic).

These three background references (CHAOP, BCOPE & JBI) are summarised in the following discussions.

Signs and Symptoms

The general signs and symptoms of dysphagia include:

- Difficulty managing oral secretions or drooling
- Absence or weakness of a voluntary cough or swallow
- Changes in voice quality/tone (hoarseness/moist sounding)
- Decreased mouth and tongue movements
- Tongue thrust/primitive oral reflexes
- Frequent throat clearing
- Poor oral hygiene
- Changes in eating patterns
- Raised temperature
- Weight loss and/or dehydration
- Frequent chest infections

In particular, **during the eating or drinking processes**, you may observe symptoms such as:

- Slowness to initiate a swallow and/or delay in swallow (over five seconds)
- Uncoordinated chewing or swallowing
- Multiple swallows for each mouthful
- Pocketing of food in the cheeks
- Oral or nasal regurgitation of food/fluids

[3] References from BCOPE p.113: Australian and New Zealand Society for Geriatric Medicine 2011, 'Position statement: dysphagia and aspiration in older people', *Australasian Journal on Ageing*, vol. 30, no. 2, pp. 98–103.
Bloem BR et al. 1990, 'Prevalence of subjective dysphagia in community residents aged over 87', *British Medical Journal,* vol. 300, pp. 727–722.
Sitoh YY et al. 2000, 'Bedside assessment of swallowing: A useful screening tool for dysphagia in an acute geriatric ward', *Singapore Medical Journal*, vol. 41, no. 8, pp. 376–381.

- Extended time to eat/drink
- Coughing or sneezing during/following eating

After the consumption of food or drink, the following may be observed:

- A wet or hoarse sounding voice
- Fatigue
- Changes in respiratory pattern

Risk Factors

Dysphagia is associated with the following risk factors:

- Neurological conditions that are commonly seen in residential care, e.g., traumatic brain injury, stroke, Parkinson's disease, dementia, multiple sclerosis and motor neurone disease
- It may also occur in healthy adults associated with ageing changes to the oropharynx
- Older persons who are severely ill or have a disability are at increased risk of developing a swallowing impairment
- Altered level of consciousness, decreased alertness and attention span
- Cerebral anoxia (absence of oxygen supply)
- Increased agitation
- Some medications (e.g., anti-depressants, anti-psychotics, anti-epileptics, sedatives)
- Hyper-extended neck or contractures
- Long term intubation
- Speech problems
- Persons with a swallowing impairment and poor oral hygiene are at increased risk of developing pneumonia (from bacteria)
- Older persons with swallowing impairments are at high risk of choking, under-nutrition, dehydration and developing aspiration pneumonia

Aspiration

Aspiration is the inhalation of material into the larynx and lungs, the most common syndromes of this include pneumonitis and aspiration pneumonia. Aspiration pneumonia is an infectious process caused by inhaling secretions or food that have been colonised by bacteria, and is the most common cause of death among older people with dysphagia due

to neurological impairments[4]. Aspiration pneumonitis and aspiration pneumonia have overlapping clinical features that may include the following[5]:

- Coughing
- Choking on food
- Dyspnoea (shortness of breath)
- Crepitations (clicking, rattling or crackling noises in the lungs)
- Consolidation (a firm, dense mass in the lungs)

Important note: Individuals who aspirate do not always have clinical signs of dysphagia. Suspicion and recognition of dysphagia is especially important during admission to residential care because of 'silent aspiration', where material enters the airway but does not trigger the cough reflex. Silent aspiration is common and presents in more than 50% of persons who aspirate. In many cases, fever or sudden deterioration in oxygen saturation may be the only signs[6].

How Swallowing Interacts with Other Domains

Dysphagia can also affect performance in a number of other health care domains. It can impact on many aspects of physical, social and psychological health, and is linked to infections, disability and death. For many families, food and drink signify their culture and social identity; therefore there can be a psychological impact from dysphagia.

Nutrition and Hydration

Swallowing impairments, whether severe or slight, can lead to under-nutrition and weight loss, and dehydration due to a person's physical limitations with swallowing and/or psychological fear of swallowing from previous unpleasant or choking experiences. Under-nutrition and dehydration can compromise rehabilitation, and cause further deterioration in the swallowing ability. Reports of weight loss or loose fitting clothes may indicate under nutrition and dysphagia should be considered.

Oral and dental hygiene

Swallowing impairments can be associated with oral and dental hygiene issues, due to the sometimes inefficient chewing and removal of food from the mouth by swallowing. Also, as people age, they may produce less saliva, making their mouths drier, and, in turn, making the chewing and swallowing process more difficult. Oral hygiene can also stimulate saliva

[4] Australian and New Zealand Society for Geriatric Medicine 2011, 'Position statement: dysphagia and aspiration in older people', *Australasian Journal on Ageing*, vol. 30, no. 2, pp. 98–103
[5] RACGP Silver Book
[6] Australian and New Zealand Society for Geriatric Medicine 2011, 'Position statement: dysphagia and aspiration in older people', *Australasian Journal on Ageing*, vol. 30, no. 2, pp. 98–103.

flow and taste and therefore needs to be monitored in conjunction with the management of swallowing.

Medication
Some medications can potentially affect swallowing ability – such as psychotropic, antidepressant, neuroleptic, anticholinergic, benzodiazepine, antihistamine, antiparkinsonian and antispasticity agents.

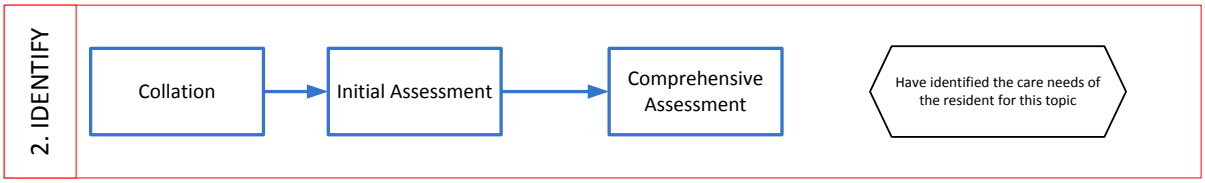
Due to the number of medications often taken by older people, they can experience a drug side effect called 'tardive dyskinesia'. This can involve repeated tongue and mouth movements that affect the ability to swallow safely and increase the risk of choking.

Timing of medications can assist safer swallowing. For example, medications for Parkinson's disease need to be timed so that their effects peak at meal times. Swallowing also has an impact on the safe administration of medications. A person is less likely to choke when properly positioned or when medications can be administered in liquid form rather than taken as whole pills.

Cognition
Dysphagia is associated with a large number of neurological conditions such as stroke, Parkinson's disease, dementia, multiple sclerosis and motor neurone disease. For example, Parkinson's disease can slow tongue movement and cause a loss of coordination when chewing and swallowing.

Mood
A low mood or depression can result from difficulties with swallowing as the older person may be restricted to a vitamised diet, is no longer be able to drink certain pleasurable things, or begins to associate discomfort and/or anxiety with eating and drinking.

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;
- Screen to identify a need (e.g. initial nurse assessment); and
- Completing the comprehensive assessment of the swallowing 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. Following is an example of the types of documents to be collated and reviewed, and the information that is being sought for swallowing.

Document	**Look for**
ACCR	Relevant diagnoses (e.g. dysphagia, neurological conditions, stroke, Parkinson's Disease, dementia, multiple sclerosis and motor neurone disease) Risk factors (e.g. altered level of consciousness, certain medications, hyper extended neck, contractures, long term intubation, speech problems) Signs and symptoms, swallowing status/issues, history of choking or aspiration, dietary needs, dietary aids and assistance
Medical Notes/CMA	Diagnoses, risk factors, signs and symptoms, swallowing status, history of choking or aspiration, dietary needs, dietary aids and assistance, specified feeding techniques may be recommended
Allied Health Professional	Diagnoses, signs and symptoms, swallowing status, history of

notes/assessment (e.g. Dietitian, Speech Pathologist, Occupational Therapist)	choking or aspiration, dietary needs, dietary aids and assistance, specified feeding techniques and monitoring, maintenance of oral hygiene, interventions to reduce the risk of aspiration, recommendations

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

Diagnoses/status	**Examples of care needs**
Dysphagia/ swallowing issues	Ensure a comprehensive assessment by a Medical Practitioner or Speech Pathologist has been undertaken. May require a specified diet e.g. vitamised/soft/thickened diet, high calorie diet and monitoring or assistance with food/drinks. Carers to be aware of food/drink to avoid. Specified feeding techniques and positioning may be recommended or taught by a Speech Pathologist or Medical Practitioner. Medications should be administered safely, swallowing medications is not the same as swallowing food. Oral hygiene to be maintained and/or assisted. Monitor intake, weight, dehydration, lung sounds and temperature (to identify aspiration), regularly re-evaluate swallowing ability.
Neuro- cognitive diagnosis	Check swallowing ability, may require monitoring or assistance with food/drinks due to an identified risk factor and inability to follow safe eating techniques. Refer to a Medical Practitioner or Speech Pathologist for a comprehensive swallowing assessment.
Physical deterioration, sensory loss, communication issues of understanding others and/or communicating to others	Affecting ability to self-care nutritional needs – check swallowing ability, may require physical help or use of aides to reduce swallowing risks, check if at risk of choking.

Resident and Family

Involving the older person and their family/carer in the identification, treatment and care planning process is fundamental to ensuring they have an active and participatory role in the management of swallowing difficulties.

Back to Mrs. Green

Mrs. Green's family provided suggestions on how to improve the taste of the food (e.g., adding spices) to encourage her to eat and to improve her enjoyment from eating. The staff discussed what pleasant events might motivate Mrs. Green and they identified that they did not fully understand the risk of choking with fluids.

The intervention program incorporated the family suggestions and targeted both her nutritional needs and her quality of life. This included adding spices to her meals, the experience of shared family meals, and providing education for the family and staff on safe eating procedures and the risks of choking for people with dysphagia.

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 CHAOP will have the competencies to undertake the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. In particular, the CHA has a swallowing screen suitable for trained nurses.

Note that while the CHA is not a validated swallowing screen, the protocol for its implementation (as discussed following) has been designed to incorporate documentation checks, interviews, some direct testing (i.e. of the gag reflex) and observation of the first food and fluids. The nursing management could also consider if a validated screening tool is suitable for your facility (taking into consideration, staff skill sets, resident profiles and your setting). There is no single recommended screening tool suitable across different settings and professionals. Donovan (2013) states that the swallowing screen tool should be quick, suitable for the staff type, and have proven validity and reliability. Screening tools found in the literature are:

- Self-report questionnaires; e.g., the EAT-10 is a 10 item validated screening questionnaire. It however contains no direct measurement of swallowing, but it is considered suitable across settings (Rofes 2014).
- The Standardised Swallowing Assessment which is referred to in the JBI (2000) information sheet. This is an 8 item test that requires staff training and includes a direct water swallowing test. However it has not been validated against an instrumental examination and there was no information to inform if it had been tested in a residential care setting (Donovan 2013).
- There are clinical bedside assessments such as the V-VST which involves direct testing of swallowing ability by volume-viscosity (i.e., testing different amounts and different textures of food). This would also require staff training and there was no information found on testing in a residential care setting (Rofes 2014).

The **relevant items from the CHA for screening on swallowing** are listed below:

Swallowing

Does the older person:

- have difficulty swallowing? Yes ☐ No ☐
- have a gag reflex? Yes ☐ No ☐
- have any difficulty swallowing food and fluid? Yes ☐ No ☐
- cough while eating and drinking? Yes ☐ No ☐
- require a texture modified diet? Yes ☐ No ☐

These CHA questions can be used to trigger whether a referral to a Speech Pathologist or Medical Practitioner is required for swallowing difficulties. Note also that if the resident is at medium or high risk of malnutrition it is recommended that a referral to the appropriate Allied Health Professional (Dietitian for nutritional advice) or their Medical Practitioner be made. Table 8 sets out the recommended assessment process for informing on the above five swallowing items from the CHA.

Table 8: The Swallowing Screening Assessment Process

Question… Does the older person	**How to investigate the question**
Have difficulty swallowing?	• Is there a diagnosis of dysphagia or an associated diagnosis, noted symptoms? • Review for identification or previous history of swallowing issues; ACCR, documented Allied Health Professional or

	Medical Practitioner notes, interview resident and family • Observe the resident's first meal for signs and symptoms
Have a gag reflex?	• Test- CHAOP Module 4 (p.11) shows how to test a gag reflex
Have any difficulty swallowing food and fluid?	• Is there a diagnosis of dysphagia or an associated diagnosis? • Review for identification or previous history of swallowing issues; ACCR, documented Allied Health Professional or Medical Practitioner notes, interview resident and family • Observe the resident's first meal
Cough while eating and drinking?	• Is there a diagnosis of dysphagia or an associated diagnosis, noted symptoms? • Review for identification or previous history of swallowing issues; ACCR, documented Allied Health Professional or Medical Practitioner notes, interview resident and family • Observe the resident's first meal
Require a texture modified diet?	• Is there a diagnosis of dysphagia or an associated diagnosis? • Review the history- from notes (Allied Health Professional or Medical Practitioner recommendations, ACCR), previous history, interview resident and family

Comprehensive Assessment

The nurse's role in the assessment process is to initially observe, assess, monitor and accurately report on the screening process. Knowledge of swallowing risk factors and signs of dysphagia, along with observation of the person's eating and drinking habits, diet and signs of adequate nutrition and hydration, are essential for early identification of swallowing problems (JBI, 2000).

It is recommended that all residents with a positive response to any of the five screening questions (i.e., they have a potential swallowing problem) have a comprehensive swallowing assessment completed by referral to a Speech Pathologist or Medical Practitioner. The recommended comprehensive assessment steps involve:

- **Initial nurse assessment** swallowing screen questions or a validated and suitable swallowing screening tool. Qualified nurses need to be educated to perform a swallowing screen assessment (Hines et al, 2011; JBI, 2000).

- **Swallowing assessment** – the literature recommends that if swallowing issues are identified during the initial nurse assessment, a comprehensive swallowing assessment by a Speech Pathologist or Medical Practitioner will be necessary.

Clinical Risks

The initial nurse assessment will ensure you have considered the clinical risks related to swallowing. If there is an identified risk of (i) choking, (ii) under-nutrition/malnutrition (iii) dehydration, or (iv) oral hygiene issues it is recommended that the following Standardised Care Processes may be relevant (the Standardised Care Process resources can be found in the Complex Health Assessment Pack and references are provided in the Swallowing Appendix). The relevant Standardised Care Processes (SCP) are:

- Standardised Care Process for Choking
- Standardised Care Process for Unplanned Weight Loss
- Standardised Care Process for Oral and Dental Hygiene
- Standardised Care Process for Dehydration

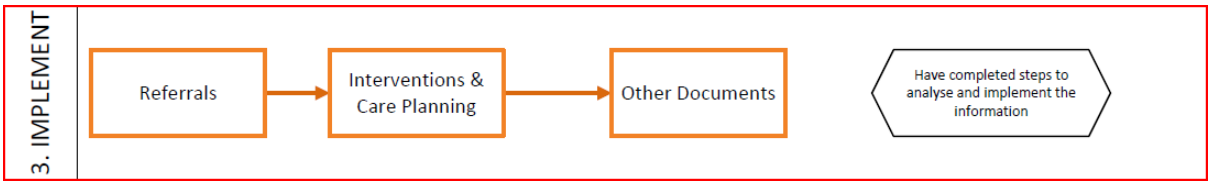
Bringing the information together

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

- Nutrition (e.g. as identified in an initial nurse assessment and the RNDC)
- 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 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.

There are three specific aspects to implement care of the resident's identified needs

- Undertake **referrals as required** to gather further required 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 a swallowing issue is identified during the initial assessment phase a referral to a Speech Pathologist or Medical Practitioner for further assessment will be needed for a comprehensive swallowing assessment (JBI, 2000).

If the person has not received a comprehensive assessment, in order to avoid the risk of aspiration, consideration should be given to withholding oral intake until an appropriate health professional has undertaken the assessment (JBI, 2000). An appropriately qualified nurse should decide if the withholding of oral intake is required or whether it will create an unacceptable health risk for the resident.

In some cases a referral may be required to other medical specialists, such as a gastroenterologist or an ear, nose and throat specialist for further investigations such as an endoscopy or full barium swallow (RACGP 'Medical care of older persons in residential aged care facilities' - a reference to the resource is found in the Swallowing Appendix).

If the diet needs to be modified according to the person's swallowing ability as recommended by a speech pathologist, a referral to a dietitian can also assist in optimising the nutritional status of older patients.

It is recommended that nursing management develops a comprehensive 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, for example (Table 9):

Table 9: Referrals for Swallowing

Health Professional	Source	Contact
Medical Practitioner	Health Service	Name, contact details
Medical Specialist	Health Service	Name, contact details
Clinical Nurse Specialist	Health Service	Name, contact details
Speech Pathologist	Health Service	Name, contact details
Speech/Language Therapist	Health Service	Name, contact details
Dietitian	Health Service	Name, contact details
Dietitians' Association of Australia	Website	http://daa.asn.au/
Speech Pathology Association of Australia	Website	http://www.speechpathologyaustralia.org.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 swallowing should involve evidence informed strategies (refer following) that address the identified 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 list below is a summary of management strategies to support safe oral eating assistance for a person with swallowing issues (JBI, 2000).

Strategies to consider prior to food and drink consumption:

- Ensure a quiet, pleasant environment with no distractions
- Check that the individual is alert and responsive, well rested and pain free
- Check the individual's ability to communicate swallowing difficulty when feeding
- If the individual has a dry mouth – try giving tart or sour foods/fluids before meals to stimulate saliva production and keep well hydrated. There are now artificial saliva products available which are used in cancer care which may be useful to consider where dry mouth is the issue – e.g., Oral Balance.
- Oral hygiene can stimulate saliva flow and taste
- If thick oral secretions are a problem consider proteolytic enzymes, such as papain (paw-paw) before meals

How a modified diet can assist swallowing (after directed by a speech pathologist, medical practitioner or dietition)**:**

- Safer swallowing can be enhanced by using thickened fluids and a semisolid diet with a homogenous texture (food that maintains its bolus shape easily and does not scatter in the oral cavity)
- The use of a bolus with heightened sensory qualities, such as, temperature, flavour and heaviness (for example, cold, sour or sweet foods) may stimulate an improved swallow
- A high calorie, nutritious diet is essential to compensate for reduced intake and the additional physical effort needed to eat and drink

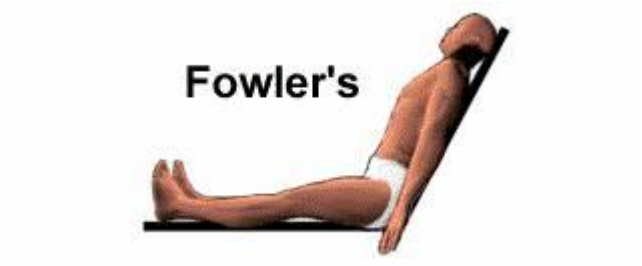
Nurses should be aware of items to avoid for a person with swallowing issues:

- Food and drink of extreme temperature
- Thin liquids (if they are not recommended)
- If mucous is an issue it is probably wise to avoid milk
- Products that melt to a thin liquid in the mouth (e.g. ice chips, some gelatine products, ice cream)
- Foods containing mixed textures, for example, the combination of different consistencies such as is found in vegetable soup (solid and liquid food together)
- Dry crumbly foods
- Particulate foods (for example, rice, dry breads)

- Stringy foods
- Food that requires extensive chewing
- Foods with seeds
- Sticky foods (for example, peanut butter, bananas, soft white bread)

Positioning of persons with a swallowing impairment when eating and drinking

- Sit upright, 90^{o} hip and knee flexion, feet supported flat on floor, trunk and head in midlines, head slightly flexed with chin down
- Do you need to support the head and trunk?
- If bed-bound - Fowler's position with head and neck supported and neck slightly flexed
- If head is unstable support the head (do not use a cervical collar)



Example of Eating Assistance Techniques

- Carer to sit at or below the person's eye level
- Avoid asking questions when the person has food in his mouth
- Give 0.5 to 1 teaspoon of solid food/ or 10-15mls of fluid at a time
- Place in unaffected side of mouth
- The person should not be rushed during eating and drinking processes
- Encourage coughing after swallowing
- Alternate liquids and solids to clear throat
- Offer smaller more frequent meals if the person fatigues quickly
- Check mouth for pocketing of food

Strategies after food and drink consumption

- Check the individual's mouth for any remaining food and provide oral care
- Keep the individual upright for approximately 30 to 60 minutes
- Monitor individual's food and fluid intake and their weight for signs of dehydration or malnutrition
- Monitor lung sounds and temperature to identify signs of aspiration

- Regularly re-evaluate swallowing ability

Other aspects to consider

- Do not commence oral intake for a person identified at risk until they have been assessed by an appropriate health professional (as previously noted an appropriately qualified nurse should decide if the withholding of oral intake is required or whether it will create an unacceptable health risk for the resident).
- Ensure the timing of medications that assist swallowing fit into meal times, and check if the medications can be crushed
- Use verbal and visual cueing for those with cognitive or communication issues
- Provide education for staff to ensure they can safely feed individuals and respond appropriately to emergencies
- Provide education and access to counselling for the resident and family
- Monitor long term weight and nutrition

Back to Mrs. Green

Because Mrs. Green is now immobile and requires assistance with meals and drinks, her Care Plan related to her swallowing issues includes many specific directions, including:

- *How to position her when providing assistance with food and drinks*
- *Very specific information about when and what she should eat, such as frequent but small meals may be more satisfying than trying to manage three meals a day*
- *Communicating food preferences via progress notes and the care plan to keep all staff informed, for example adding spices to her meals, and other comfort foods*
- *Directions on how to keep her hydrated between meals, and her mouth moist*
- *How she prefers to manage any issue with drooling*
- *The importance of slowing down, people with dysphagia need more time*
- *The role of the family e.g., which meals they regularly assist with*

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** – 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.

For example (BCOPE p.119), dysphagia resulting from a stroke is temporary in about 90% of cases in older people (in all settings); therefore, there may be realistic goals for improving their swallowing ability[7]. However, dysphagia resulting from dementia or Parkinson's disease is progressive and a long term approach to care planning may be more appropriate[8].

Based on Mrs. Green's case, an example of one specific goal could be to reduce choking events. This goal will also be:

- Measurable e.g. record adverse events (choking events,)
- Be action oriented e.g. including staff and family education
- Realistic in its aims e.g. the family are motivated and can assist with meals
- Time based e.g. the evaluation date is set at one month after the commencement of the speech pathologists' recommendations by reviewing the progress notes, handover notes, charts, adverse events and interviewing the resident

[7] Sourced from BCOPE (2012): National Stroke Foundation 2010, *Clinical Guidelines for Stroke Management 2010,* National Stroke Foundation, Melbourne.
[8] Australian and New Zealand Society for Geriatric Medicine 2011, 'Position statement: dysphagia and aspiration in older people', *Australasian Journal on Ageing*, vol. 30, no. 2, pp. 98–103.

This approach also incorporates the principles of Person Centred Care and Consumer participation.

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 such as recording choking events. 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. choking when eating), connect the link to the body structures and/or functions that are impacted (e.g. reduced functional swallowing)
- Describe the associated activity limitations (e.g. reduced independence in eating and drinking,). It's important to look at remaining strengths (e.g. personal motivations)
- 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. shared family meals)
- Finally, define the care goals (to improve swallowing) 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 Mrs. Green in regards to swallowing:

- There was a diagnosis of a recent stroke (Medical Notes/ progress notes).
- From the identification process, we identified the body structures/ functions that were affected. The swallowing function was further impaired (Speech Pathologist/Medical Practitioner notes) and she was now immobile (Medical Practitioner notes, PMS assessment) and more dependent with self-care activities.
- These issues resulted in reduced social interactions (resident, family, nursing notes) and increased swallowing difficulties.
- Strategies and subsequent interventions were developed to address the limitations by inviting the family to assist her with some meals, incorporating food preferences, and offering smaller more frequent meals. It is important to look at remaining strengths and motivations, such as family bonds, that can be used to support the person's participation in everyday activities.

Completing the ACFI documentation

The swallowing information collected to this point can now be used for completing parts of **ACFI Question 1 (Table 10)**, **ACFI Question 11** (Table 11) and the **ACFI Question 12 (Table 12).**

Table 10: ACFI Question 1 Checklist (Nutrition) Evidence Requirements and Swallowing

ACFI 1 Nutrition Checklist	**Where to find the information related to the resident who has been referred and found to have an identified 'swallowing issue'**
1.1 Readiness to eat One-to-one physical assistance is required for • Cutting up food OR vitamising food	Speech Pathologist (SP) or Medical Practitioner (MP) or dietitian notes, which recommends cutting up food or vitamising food for a person with dysphagia.
1.2 Eating Supervision is : • Standing by to provide assistance (verbal or physical) OR Providing assistance with daily oral intake when ordered by a person with a PEG tube	Speech Pathologist (SP) or Medical Practitioner (MP) or dietitian notes, or the care plan has a recommendation for "Standing by to provide assistance (verbal or physical)" as part of the "intervention to ensure a safe feeding technique for a person with dysphagia". Also note if the person has a cognitive, sensory or physical impairment that also supports the evidence for assistance.
1.2 Eating One-to-one physical assistance is required for • Placing or guiding food into the resident's mouth for most of the meal	Speech Pathologist (SP) or Medical Practitioner (MP) or dietitian notes, or the care plan has a recommendation for "Placing or guiding the food into the resident's mouth for most of the meal)" as part of the "nursing intervention to ensure a safe feeding technique for a person with dysphagia". Also note if the person has a cognitive, sensory or physical impairment that also supports the evidence for assistance.

Table 11: ACFI Question 11 Checklist (Medication) Evidence Requirements and Swallowing

ACFI 11 Medication	Where to find the information
The time taken to administer medications is relevant to the checklists 4 and 5 and 6. A person with a diagnosis of dysphagia, requires enough time to be allowed for safe administration of medication (e.g. the time taken to swallow). This is evidence of time required in addition to the number and frequency of medications.	Speech Pathologist (SP) or Medical Practitioner (MP) notes or care plan, and it documents medication strategies for a person with dysphagia.

Table 12: ACFI Question 12.6 Checklist (Special Feeding) Evidence Requirements and Swallowing

ACFI 12 Complex Health Checklist	Where to find the information
12.6 Management of special feeding undertaken by an RN, on a one-to-one basis, for people with severe dysphagia, excluding tube feeding. Frequency at least daily.	1. Diagnosis (Medical notes or notes in ACCR- record section, Health Professional, date) AND 2. Directive [by a Registered Nurse or Medical Practitioner or Allied Health Professional]- in Resident file or care plan (record section, Health Professional, date) AND 3. Swallowing assessment- in Resident file (record section, Health Professional, date)

An example of a Special Feeding directive is provided, that will meet ACFI requirements for ACFI 12.6, and provide enough details to ensure the 'treatment' is clearly described, documented and accountable to all stakeholders (resident, family, staff, internal auditors, external auditors).

ACFI 12.6 SPECIAL ASSISTIVE EATING DIRECTIVE

This is assistance by an RN, at least daily

Documentation trail of assessments, Treatment description, Treatment days/times/length, by Staff type, Staff training requirements

Resident name/room: ……

Diagnosis/date …… By HP : ☐ SP ☐ MP

Swallowing Assessment: tool /location/date …….

AHP documents: tool /location/date/profession .. ……..……

Nurse Assessment tool name/location/date: ……

Treatment ☐ Special Feeding **By staff type**: ☐ RN

Treatment to occur on the following days every week (tick days):

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Treatment times: ___:____AM/PM ___:____AM/PM ___:____AM/PM ___:____AM/PM

Average time to complete the process: _____mins per session

Is staff education required? ☐ YES ☐ NO

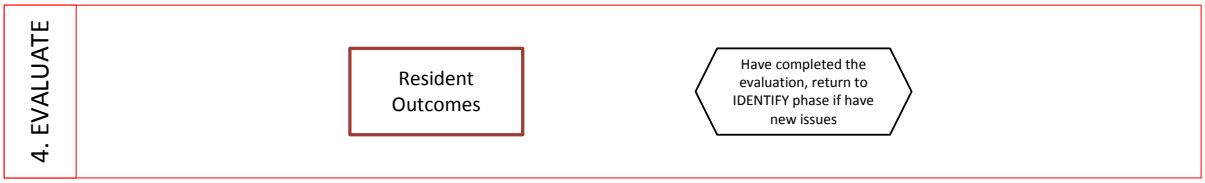
Is resident education required? ☐ YES ☐ NO **Is family education required**? ☐ YES ☐ NO

Provide a detailed description of the treatment: preparation required, type of food/fluid, technique (position, rate of feeding, what to avoid i.e. talking, when to encourage cough, alternate liquids with solids etc), adaptive equipment (e.g. modified cup), after feeding checks, monitoring , goal of treatment

Name: …… Profession: ☐ RN

Signature: …….. Date: ……

Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

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

- Resident Care Outcomes

  With regard to swallowing, for example, has the intervention reduced the risk of choking? This could be determined by regular monitoring of adverse events, for the purposes of evaluating the appropriateness and effectiveness of the treatment.

- Further improvements

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

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.

Outcomes

When we met Mrs. Green in the nutrition topic, she had specific goals for strengthening her body and returning to a normal diet. Over the next six months she made great strides toward that end, but then she suffered a more debilitating stroke. Her condition has a more palliative outlook now.

As noted earlier, SMART goals are realistic. We have no reason to imagine that Mrs. Green will ever be able to return to a normal diet. What we can work toward – and what the staff and her family are committed to – is to maintain a quality to her life. The goal is to make her as comfortable as possible and to make sure she is eating foods that please her and help her maintain her nutrition.

An evaluation of Mrs. Green's care has shown that as her condition has worsened, the goals are now focussed on keeping her as comfortable as possible and making sure that she is eating foods that please her and help her to maintain her nutrition.

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, and how important they are to achieving positive outcomes for their residents.

Summary: Steps and Information Flow

Figure 4 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 (Swallowing screen items);
- Completing the Comprehensive Assessment (by completing Standardised Care Processes to address any clinical risks)

The implementation phase which comprises:

- Completing referrals as required for a comprehensive swallowing assessment 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

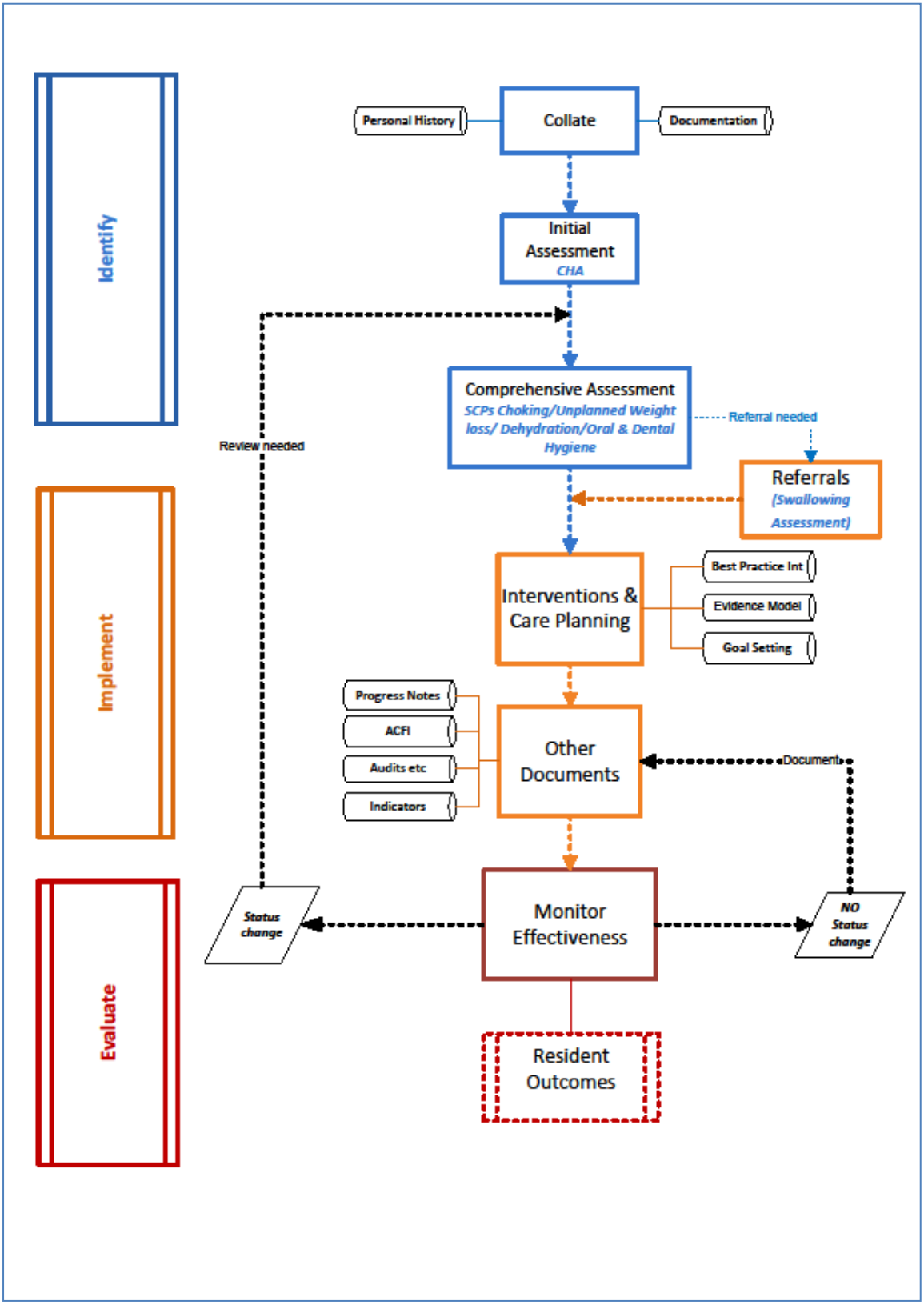
The evaluation phase which comprises:

- 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 4: Swallowing Information Flow



Swallowing Resources

The recommended resources and information on where they are found in the toolkit are listed below (Table 13).

Table 13: Swallowing Topic Resources

Resource Type	Details	Document
Background Reading	CHAOP Modules 4 & 7	Reading Pack
Background Reading	BCOPE. The Toolkit (2012) pp.113-122	Site to download if required Reference in Swallowing References
Background Reading	JBI (2000)	Site to download if required Reference in Swallowing References
Screen	Initial Nurse Assessment (e.g. CHA)	Complex Health Assessment Pack
Standardised Care Process (SCP)	Choking	Complex Health Assessment Pack
Standardised Care Process (SCP)	Dehydration	Complex Health Assessment Pack
Standardised Care Process (SCP)	Oral and Dental Hygiene	Complex Health Assessment Pack
Standardised Care Process (SCP)	Unplanned Weight Loss	Complex Health Assessment Pack
Goal setting example	Quality Of Life Questionnaire	Reading Pack
Workbook Exercises	Practice using a Case Study	Complex Health Workbook Appendix

Swallowing References

The recommended resources and their references are provided below (Table 14).

Table 14: References for the Swallowing Topic

Document	Reference
BCOPE	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. Sourced at:http://www.health.vic.gov.au/older/toolkit/index.htm
NATFRAME Care Profile	Australian Government resource. Reference: National Framework for Documenting Care in Residential Aged Care Services (NATFRAME Section 11). Sourced at: 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
Comprehensive Health Assessment (CHA) for Older People in the Healthcare 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 the 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).
Daniels (2012)	S.K. Daniels, J.A. Anderson & P.C. Wilson (2012). Valid Items for Screening Dysphagia Risk in Patients with Stroke A Systematic Review. *Stroke. 2012. 43:892-897*
Donovan et al (2013)	N.J. Donovan, S.K.Daniels, J.Edmiaston, J. Weinhardt, D. Summeers & P.H.Mitchell (2013). Dysphagia screening: State of the Art: Invitational Conference Proceeding From the State-of-the-Art Nursing Symposium, International Stroke Conference 2012. *Stroke. 2013. 44: e24-e31.*
Hines et al (2011)	S. Hines, K. Wallace, L. Crowe, K.Finlayson, A. Chang & M. Pattie (2011). Identification and nursing management of dyspahagia in individuals with acute neurological impairment (update). *Int J Evid based Healthc 2011; 9: 148-150.*
Joanna Briggs Institute (2000)	Author: Joanna Briggs Institute (JBI) Reference: "Identification and Nursing Management of Dysphagia in Adults with Neurological Impairment"; *Best Practice Volume 4, Issue 2, (2000)* Sourced at: http://connect.jbiconnectplus.org/ViewSourceFile.aspx?0=4313
Miller & Patterosn (2014)	N. Miller & J. Patterson (2014). Dysphagia: implications for older people. *Reviews in Clinical Gerontology 2014; 24; 41-57.*
Medical care of	Author: Prepared by The Royal Australian College of General Practitioners

older persons in residential aged care facilities	(RACGP)– 'Silver Book' National Taskforce Reference: Medical care of older persons in residential aged care facilities 4th Edition. (2006) Funded by the Australian Government Department of Health and Ageing. Sourced at: http://www.racgp.org.au/your-practice/guidelines/silverbook/common-clinical-conditions/dysphagia-and-aspiration/#1
Rofes et al (2014)	L. Rofes, V. Arreola, R. Mukerjee & P. Clave (2014). Sensitivity and specificity of the Eating Assessment Tool and the volume-Viscosity Swallow Test for clinical evaluation of oropharyngeal dysphagia. *Nuerogastoenterology Motil (2014); 26; 1256-1265.*
Sato et al (2014)	E. Sato, H. Hirano, H, Y. Watanabe, A. Edahiro, K. Sato, G. Yamane, G. and A. Katakura (2014). Detecting signs of dysphagia in patients with Alzheimer's disease with oral feeding in daily life. *Geriatr Gerontol Int 2014; 14: 549-555*.
Standardised Care Processes (SCP)	Authors: La Trobe University ACEBAC Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Choking; Dehydration; Oral and Dental Hygiene; Unplanned Weight Loss Sourced at: http://www.health.vic.gov.au/agedcare/downloads/score/choking_scp.pdf http://www.health.vic.gov.au/agedcare/downloads/score/dehydration_scp.pdf http://www.health.vic.gov.au/agedcare/downloads/score/oraldental_hygiene_scp.pdf http://www.health.vic.gov.au/agedcare/downloads/score/weightloss_scp.pdf

Topic 10: Skin and Wounds

The Skin and Wounds Topic

This topic focuses on skin and wound care, and represents the third topic in the Complex Health Workbook. Skin integrity and wound care are interlinked domains often requiring similar treatment strategies; therefore these two topics are discussed in conjunction to provide a more comprehensive approach to their management.

Investigating Skin Integrity and Wounds

The following four steps are replicated across the entire Complex Health Workbook:

1. **Preparation by staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. The background reading includes:
    - CHAOP (Module 4) (Comprehensive Health Assessment of the Older Person), in particular pages 9 – 10.
    - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012), pages 213 – 224.
    - The Australian Wound Management Association Standards for Wound Management

    Links for these resources can be found in the Skin and Wound 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. A comprehensive approach will include:

File Notes Review:

- Aged Care Client Record (ACCR) – Under the Functional Activity Profile may include some detail on skin integrity requirements
- Comprehensive Medical Assessment – which(if available) may include reported skin integrity issues

Screening:

- Initial nurse assessment e.g. Comprehensive Health Assessment (the CHA is associated with the 'Comprehensive Health Assessment of Older People' resource) this records information about skin integrity and identifies if there are wounds.

Further Assessment:

It is recommended that all new residents have a skin assessment that includes a risk assessment of the skin integrity, skin condition, presence of wounds/lesions/oedema, and the condition of any wounds.

The following assessment tools are recommended for assessing skin and wounds.

- A Skin Risk Assessment
    - Waterlow Pressure Ulcer Risk Scale – This is the preferred skin risk assessment tool due to the broader range of information collected to assess for risk factors (compared to the other two tools), and the inclusion of an item on preventative aids and treatments
    - Braden Risk Assessment Scale – This tool is still widely used but does not include clinical indicators. If you chose to use this tool, it is recommended that you refer to the Department of Health (2011) 'Reference Ranges for Aged Care Quality Indicators' (link to this resource is found in the Skin and Wounds References)
    - Norton Scale for Predicting Risk of Pressure Ulcer – This is also commonly used in RACFs, but like the Braden Scale, it does not include clinical indicators. If you chose to use this tool, it is recommended that you refer to the Department of Health (2011) 'Reference Ranges for Aged Care Quality Indicators' (link to this resource is found in the Skin and Wounds Appendix).
- A Skin Integrity assessment
    - Residential Care Services Skin Integrity Assessment
- A Wound Assessment
    - Residential Care Services Wound Assessment and Progress Chart

The Standardised Care Processes of dehydration and unplanned weight loss are relevant to this topic as these clinical risks impact on the skin integrity.

These tools are found in the Complex Health Assessment Pack and are referenced in the Skin and Wounds Appendix.

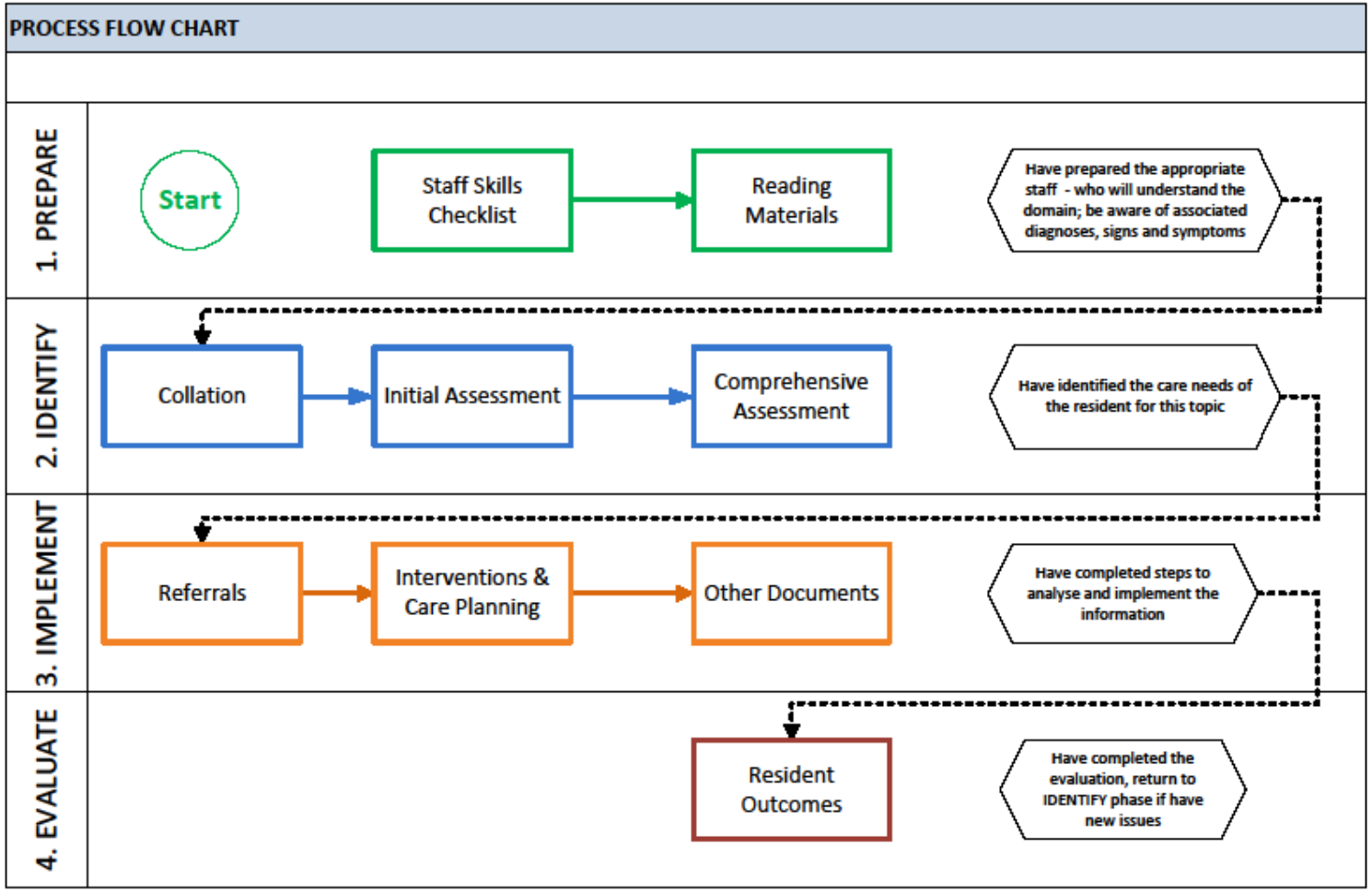
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

   - Undertaking referral options to complete gaps or seek specialist advice
   - Planning evidence informed care strategies to manage skin integrity and wounds and 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 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 workbooks 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: Skin and Wound Process



Getting Started with a Skin and Wound Example

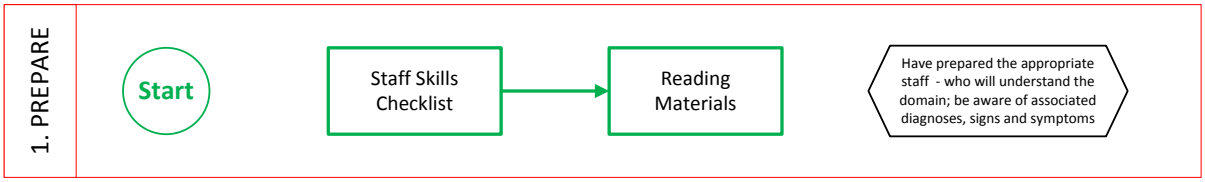
This case study will be referred to as we discuss the skin topic.

Valerie Peach is an 80-year old widowed artist who still loves to paint and draw, but her hand is not as steady as it once was, since her recent chemotherapy treatments for cancer. She has had many health challenges in the last 20 years and is confined to a wheelchair and is a resident at Sunset Home. She has always been independent and socially active, and her sister Dianne is a close friend. Valerie pursued active treatment for her cancer.

She is still weak after her recent treatments; sleeping up to 12 hours at night and taking short naps during the day. Nevertheless, her spirits are good, and she is slowly regaining her appetite and her strength.

The side effects of the cancer treatments have left her skin thin and easy to tear. The nursing staff have identified early signs of a pressure area at the base of the spine and small skin tears on the backs of her hands.

Preparation



There are two specific aspects to **preparing** staff for the management of skin and wound 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 15 provides a structure for nursing management to identify which staff have the skills required to complete activities within the Skin and Wound process. The process includes:

- Identifying the required activities (examples provided in Table 15)
- 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 skills gap found in "Interventions and Strategies", the facility could consider further training of current staff, or securing a health professional with the required clinical knowledge (e.g. wound consultant) that could complete the interventions and care planning.

It is recommended that nursing management refer to the Australian Wound Management Association (AWMA) Guidelines to development of competency assessment for "Pressure Injury Prevention and Management" and "Introduction to wound management" for decision making on required staff skill sets and educational requirements

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

Table 15: Staff Activities for the Skin and Wound Management Processes

Activity	Responsible for sign off	Do the activity
Collating Documents		
Identifying needs from collation documents		
Initial Assessment: (e.g. CHA)		
Pressure Ulcer Risk Assessment: Waterlow OR Braden or Norton		
Residential Care Services Skin Integrity Assessment		
Residential Care Services Wound Assessment and Progress Chart		
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 skin integrity and wound management in older people. It is expected that staff will have:

- A comprehensive understanding of the topic 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 skin and wound management - to assist with the development and implementation of evidence-based care plans

For example, staff who have completed the AWMA Guidelines wound module 1 (Introduction to Wound Management) and the AWMA Guidelines wound module 2 (Pressure Injury Prevention and Management) should have completed the pre-requisites for a good standard of understanding of the topic.

The background reading relevant to the skin and wound topic is:

- **CHAOP (Comprehensive Health Assessment of the Older Person) Module 4** (a copy is found in the Reading Pack). This provides an overview of the skin and lesions that are part of normal ageing and a description of a skin examination (by nurses) that includes inspection and palpation. This module is also relevant to all of the topics included in the ADL and Continence Workbooks, and so skin and wound management should be addressed in conjunction with these other domains.

- **BCOPE (Best Care for Older People Everywhere. The Toolkit. 2012)** p213-214 (a link to the resource is found in the Skin and Wounds References); this covers both skin and wound care and is summarised below. 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.

- **Standards for Wound Management Version 2 (2011)** (a link to this reference is found in the Skin and Wounds References, this resource is from the Australian Wound Management Association.

The background reading material is summarised in the following section. Readers looking for more details are referred to BCOPE and the Standards documents.

Some Basics

Five facts everyone should know about Skin Integrity (BCOPE p.213)

1. Older skin is thinner and sometimes very frail. It will sustain injury easily and take longer to heal
2. Skin integrity is not just about pressure ulcers
3. Skin must be clean and dry. Three proactive steps to protect skin are:

    - Avoid 'drying' soap
    - Apply protective moisturisers
    - Use skin protection devices to avoid skin tears and pressure injuries

4. Choose appropriate wound dressings, assess the whole person and then decide what can be achieved for each wound
5. Maintain other functional areas such as nutrition, mobility, cognition, falls prevention, pain management and continence. Refer early to the interdisciplinary healthcare team

What is Skin Integrity?

Skin integrity means the skin is whole, intact, and undamaged. Skin protects the body's internal organs from damage, helps maintain fluid and electrolyte balance, retains the body's internal temperature and conveys painful and pleasant sensations. Skin integrity is vital to physical and psychological health (BCOPE p. 214). Older skin:

- Becomes thinner
- Loses elasticity and moisture
- Develops folds and wrinkles
- Loses its cushioning layer of subcutaneous fat
- Is prone to bruising and tearing
- Has a reduction in the number of sweat glands, blood vessels and nerve endings

Maintaining skin integrity in older people is paramount during their stay in residential care as pressure sores, skin tears, and wound infections are associated with pain, reduced physical functioning, sleep deprivation, and lowered mood. These factors are detrimental both physically and psychologically to the person's wellbeing.

Skin integrity risks

The skin of older people should be assessed during every staffing shift if they are identified as at significant risk of developing problems with their skin such as (BCOPE p.217):

- Other health issues such as diabetes that are associated with specific skin/wound risks e.g. foot care of diabetics to maintain the skin and early identification of issues
- Losing protective layers of skin due to ageing
- Underweight or overweight, or under-nourished
- Having difficulties washing or drying their skin (i.e. contractures, skin folds, between toes)
- Dehydration
- Immobility
- Incontinence
- At high risk of falls
- Taking medications such as warfarin, prednisolone or chemotherapy
- Confusion or disorientation
- Loss of sensation, reduced blood circulation
- Quality of circulating blood (i.e. anaemia)
- Pressure on bony prominences
- Friction (i.e. during transfers)

Wounds

The **Standards for Wound Management Version 2 (2011)** sets out eight standards to assist in implementing best practice wound management. The Standards encompass the principles of consumer participation, person centered care, best practice and evidence-based care.

"The Australian Wound Management Association Inc. Standards for Wound Management are intended to be reflective of best practice as defined in the literature and in the consensus opinions sought from expert wound clinicians. The Standards are presented as a guide to clinicians, educators and researchers, health students and health care providers who desire to promote optimal outcomes in the care of individuals with wounds or those at risk of wounding."

In particular Standard 3 provides valuable information about a comprehensive assessment approach and includes directives to do the following:

- Perform a comprehensive assessment of health needs including a history of wounds and outcomes, risk assessment of skin integrity, current wounds, nutrition, activity and lifestyle, medication, sensitivities and allergies, pain, and functional status
- Manage the broad range of all health issues

- Include the resident and family in the assessment process, in developing an individualised care plan including taking into account the person's goals and preferences (e.g. a consumer and person centred approach)
- A multi-disciplinary management approach that includes referrals for further assessment, treatment or investigations (e.g., biochemical analysis, microbiology, imaging, vascular assessment, neurological foot examination, nutritional assessment, and/or a psychological assessment for cognition, mood, and quality of life)
- Maintain confidential and secure documentation
- Use evidence-based practices and interventions
- Understand how to assess and modify the physical environment to reduce the risk of damage to skin integrity
- Promote safe activity and mobility
- Understand other aspects of the healing environment (infection control, safe storage of supplies)
- Take action to minimise or manage skin and wound issues

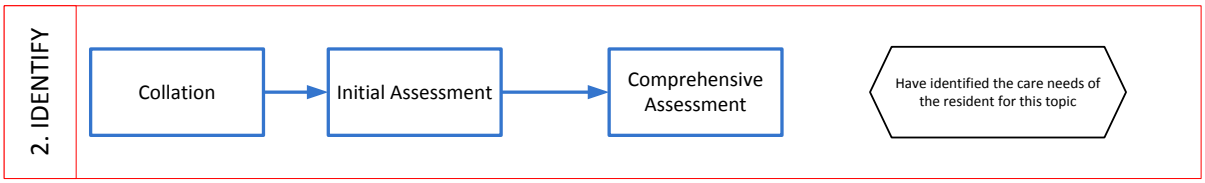
It is recommended that if skin and wound assessment education is required consideration be given to including the AWMA wound module 1 (Introduction to Wound Management) and the AWMA wound module 2 (Pressure Injury Prevention and management) to ensure staff have a good standard of understanding of the topic.

How Skin Integrity and Wounds Interact with Other Domains

Skin integrity issues and wound management are important for many other health care domains as they may be a result of:

- Being immobile – this puts the resident at risk of pressure sores from lack of movement; frequent repositioning and various aids may assist to alleviate the pressure
- Being at risk of falls means the resident is at risk of damaging their skin as a result of friction or trauma
- Being underweight or dehydrated increases the dryness and fragility of the skin
- Being undernourished slows the healing process
- Incontinence can place the older person at increased risk of impaired skin integrity because the over-exposure of moisture on the skin makes it fragile. This fragility increases the likelihood of damage. In addition, ammonia in urine increases the pH of the skin, which can cause irritation and infection
- Certain medications, such as warfarin, prednisolone or drugs used for chemotherapy, can affect the skin's healing ability (BCOPE p.217). Medications that lead to side effects such as confusion and drowsiness, can increase the risk of falls or sedentary behaviour, and therefore increase the risk of skin and wound issues.

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;
- Identify a need (e.g. initial nurse assessment); and
- Completing a comprehensive assessment of the needs of skin integrity and wounds

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 skin integrity and wounds.

Document	**Look for**
ACCR	**Part 4)** Q23/25: Needs help or supervision with health care tasks Q28: Relevant diagnoses (e.g., diabetes, oedema, immobility, contractures, incontinence, sensory loss, arthritis etc) **Part 5)** Q36: Nutrition needs e.g. if noted as underweight Q37 incontinence and any noted skin integrity issues; Q38 Functional and activity program- transfer and mobility

	needs, specialised treatment e.g., skin tears, wound management etc Q39: Sensory and communication issues Q40 Allied Health therapy and aids required
Medical Notes/CMA	Diagnoses, incontinence, nutritional status, mobility, skin integrity and wound status,
Allied Health Professional notes/assessment (e.g. Wound Consultant, Physiotherapist, Dietitian)	Skin integrity and wound status, dietary needs and underweight, mobility and transfer impairments,

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

Diagnoses/issues	**Examples of care needs**
Diabetes	May be a high risk for skin integrity concerns, may require increased observation/assessment of skin to ensure damage is prevented
Arthritis/ physical deterioration	Affecting ability to complete self-care tasks such as toileting, increasing the risk of skin integrity issues.
Mobility impaired	Chair or bed bound - at high risk for skin integrity concerns
Sensory loss - eyes, hearing, smell	Loss of smell and taste may reduce appetite, leading to underweight and increasing skin integrity concerns.
Communication issues of understanding others and/or communicating to others	That require strategies or aids to assist the participation of the person in the management of skin and wound care e.g., communication aides (language cards, picture cards) to assist the resident to participate in skin care activities – such as applying moisturising cream

Resident and Family

It is important to seek input from the resident and his or her family members. As stated in all of the topics, person-centred care can be enhanced by involving the resident and his or her family. When residents understand their conditions, they tend to be more motivated to participate in the management strategies. And similarly, when staff understand the person's personal goals, they can help the resident create strategies for achieving them. In addition, family members can provide insights into what has worked or might work to maximise the resident's wellbeing. Families can also directly influence resident outcomes by providing motivation for the resident.

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 the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA covers assessment of skin integrity, including wounds and foot care.

It is recommended that all new residents have:

- An initial nurse assessment completed (e.g. the CHA tool – Comprehensive Health Assessment –is found in the Complex Health Assessment Pack) to initially identify skin integrity issues.

- A skin risk assessment should be completed. The following three tools are recommended by the AWMA, NATFRAME and are noted to be widely used in the literature. However, of the three tools, the review of the Waterlow tool demonstrated more robust and useful outcomes and is therefore the preferred tool. It is recommended that a risk assessment be undertaken by nursing staff with the appropriate training in the specific tools and in skin and wound management. The three options are:

    - The Waterlow Pressure Ulcer Risk Scale, which provides a risk factor scored across the factors of the resident's build/weight for height, skin type, age, special risks, continence, mobility, appetite, neurological deficits, major surgery/trauma and medication. It provides a list of preventative aids and nursing care management approaches, and codes the treatment. It also provides a wound

classification stage which can be used to complete the clinical indicator data collected by PSRACS (the tool is found in the Complex Health Assessment Pack)

- Braden Risk Assessment Scale, which covers continence, mobility, appetite, neurological deficits, major surgery/trauma and medication (fewer risk factors than the Waterlow). It translates the assessment outcomes into potential clinical risks (the tool is found in the Complex Health Assessment Pack)
- The Norton Scale, which covers risk factors of continence, physical condition, mental condition, activity, mobility, incontinence. It translates the assessment outcomes into a potential risk score (the tool is found in the Complex Health Assessment Pack)

All three tools provide a **risk score** to determine priority. The Norton Scale provides a risk score (based on 5 factors) that is then translated to "at risk or not at risk"; the Braden provides a risk score (based on 6 factors) that is translated into low/moderate/high risk; the Waterlow provides a risk score (based on 6 factors) that is translated into at risk/high/very high.

Only the Waterlow tool provides further information. It lists prevention aids, nursing management and treatments, and most importantly, it provides a wound classification (stage 0 to 4 which can be used to complete clinical indicator data). The Waterlow provides the highest number of objective outcomes. All tools will require training to ensure staff use the tool in a consistent manner to ensure accurate assessment outcomes for the residents.

The Risk Assessment tool can be used to inform one the final step in the comprehensive skin approach (i.e. Residential Care Services Skin Integrity Assessment- found in the Complex Health Assessment Pack).

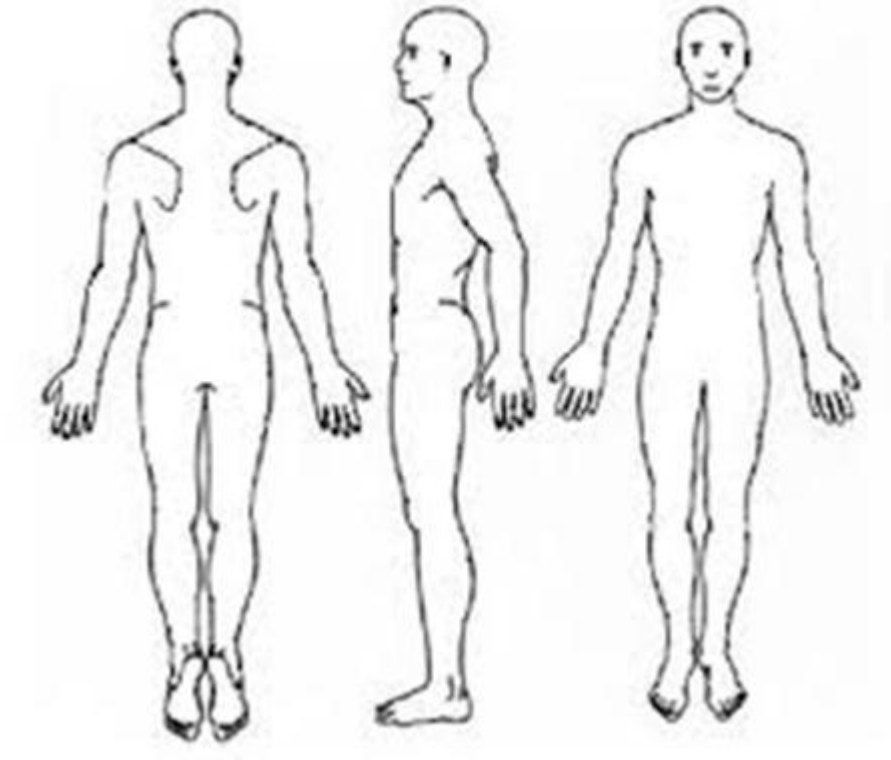
If a possible change in the skin integrity status is identified or flagged it is recommended that the CHA be re-visited (either in whole or the appropriate sections) and a Skin Risk Assessment be completed.

The relevant CHA items for Skin Integrity are listed following:

SKIN INTEGRITY

Normal ☐ Other ☐

Lesions /wounds location…… Identify position of wounds/lesions/oedema on diagram below



If wounds/lesions needs to have assessment of these using validated wound assessment tool

Condition of skin i.e. colour, dryness, texture, thickness……..

Foot care (especially for diabetics)…….....

Identified issues

……..

Comprehensive Assessment

The recommended process is that all <u>new</u> residents have the following steps completed:

- Initial nurse assessment
- Risk Assessment
- A Skin Integrity assessment
    - Residential Care Services Skin Integrity Assessment (found in the Complex Health Assessment Pack). This assessment collects further information about the skin condition, hair and nails

If a wound is noted during the above assessments, a wound assessment should be completed. The recommended wound assessment tool is:

- The Residential Care Services Wound Assessment and Progress Chart (found in the Complex Health Assessment Pack). This assessment covers nearly all of the items listed that are recommended by the AWMA (see list below). Your facility may decide to add further notes on infection to fully cover the AWMA list.

To manage wounds using best practices, a comprehensive evidenced informed assessment is essential. Standard 3.1.4 (AWMA, 2010) describes the following aspects of wounds and their management that should be assessed:

- The type of wound
- Aetiology (cause)
- Duration
- Location
- Clinical characteristics
- Wound edge appearance
- Exudate (type and colour)
- Odour
- Inflammation
- Infection
- Wound pain

It is important that staff undertaking the assessment process understand the terminology and the associated actions required to assess and manage a wound. To manage skin and wound issues, staff will need to know how to:

- Clean the wound using proper techniques
- Use aseptic techniques (and know when they are appropriate)
- Maintain the appropriate wound moisture and pH
- Manage the wound environment, and
- Carry out proper infection control practices

Clinical Risks

If dehydration or under-nutrition is identified, it is recommended that SCORE Standardised Care Processes Dehydration or Unplanned Weight Loss be undertaken (copies are found in the Complex Health Assessment Pack).

Bringing the information together

Skin and wound conditions are intertwined with other topics such as Nutrition, Mobility, and Continence. A multi-faceted investigation approach will ensure you have considered all of the risks related to skin integrity and wounds. When assessing an older person's skin integrity, look beyond pressure injury risk and investigate other risk factors such as the potential for skin to tear, under-nutrition risks, medications, past history of chronic wounds, compromised circulation, and/or neuropathy (BCOPE. p.215).

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 and physical impairments (e.g. as identified in an initial nurse assessment)
- Mobility issues (e.g. as identified in the ADL domain)
- Continence issues (e.g. as identified in the Continence domain)
- Diagnoses, past history and medications (e.g. as identified in collated documents)

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 Mrs. Peach

Valerie's skin integrity assessment outcomes:

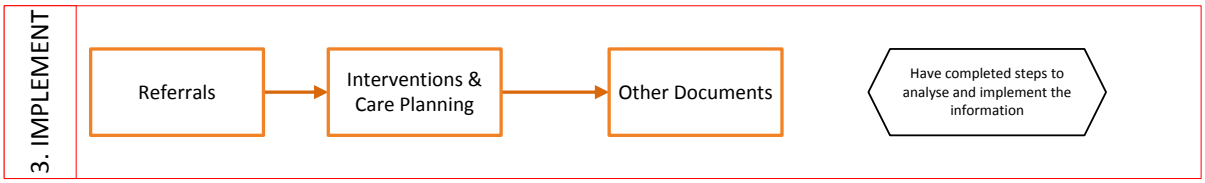
An at-risk sacral pressure area and skin tears on the hands were identified by the care staff and Valerie's facial grimacing during transfers indicated the sacral pressure area was causing pain;

The dietitian recommended an improved diet to assist the healing process;

The physiotherapist recommended an exercise program to strengthen her body, and to help her breathing and digestion;

The wound-care nurse who was brought in for her expert advice on (i) the pressure area and she recommended some changes to the care routine and practices; and (ii) for the skin tear – she recommended specific skin dressings and prevention strategies.

Implementation Process



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

There are three specific aspects to implement care of the resident's identified needs:

- Undertake **referrals as required** to gather further required 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 further investigations or for a specialised assessment that cannot be completed on-site, a referral to a wound consultant, clinical nurse specialist, dietitian (e.g., for a nutrition assessment) , podiatrist (e.g., for a neurological foot examination), diabetes educator, or medical practitioner (e.g., for pathology or imaging investigation) may be needed.

We recommend that nursing management develops a comprehensive 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, for example (Table 16):

Table 16: Referrals for Skin & Wounds

Health Professional	Source	Contact
Medical Practitioner	Health Service X	Name, contact details
Clinical Nurse Specialist	Health Service X	Name, contact details
Wound Consultant	Health Service X	Name, contact details
Physiotherapist	Health Service X	Name, contact details

Diabetes Nurse Educator	Health Service X	Name, contact details
Dietitian	Health Service X	Name, contact details
Podiatrist	Health Service X	Name, contact details

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 skin integrity or wounds should involve evidence informed strategies (refer below) that address the 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

BCOPE (p. 215) presents some general strategies to promote skin integrity and reduce the risk of injury in older persons; these may help in developing individualised strategies to improve the person's skin and wound care in your facility. The strategies are:

- Orient the person to his environment, keeping the area clutter free and well-signposted for easy navigation
- Avoid collision with environmental hazards such as lifting machine parts and wheelchair footplates
- Use protective mattresses, seat cushions, heel wedges and limb protection as appropriate
- Do not using 'drying' soaps on the skin – these can alter the skin's pH balance, making it drier and more susceptible to breaks and infections
- Never use tapes or adhesives that could damage the skin

The **Waterlow Pressure Ulcer Risk Scale** also provides a list of treatment options for maintaining skin integrity. These are:

- Preventative aids
  - specialist mattresses, specialist beds, cushions for wheelchairs
  - avoid use of plastic draw sheets, incontinence pads and tightly tucked in sheets when using specialist beds/mattresses
- Nursing care management approaches such as:-
  - frequent repositioning
  - pain control
  - nutrition supplements
  - correct lifting and handling techniques
  - comfort aids such as sheepskins and bed cradles (to stop friction)

These treatment options can be designed in the care plan to be further extended to both general and specific steps that can be taken during skin and wound care covering[9]:

- **General skin care** for all residents, e.g. identify if a resident is at risk, inspect skin daily, moisturise, prevent injury and skin tears with careful lifting (hoists, slide sheets, etc.) and frequent repositioning (for persons with mobility issues), ensure nutrition and hydration needs are meet (i.e., supplements, referral to dietitian)
- **Skin tears** as a result of bandaging can be avoided with careful selection of tapes, skin tears from knocking into objects can be reduced by protecting the skin (with clothing, bandaging, etc.), and ensuring the environment is well-lit and uncluttered (to avoid falls and injury)
- **Pressure ulcers** can often be prevented by removing pressure or shear or friction and by protecting the skin (e.g. sheepskin booties).
- **Leg oedema** can be cured or prevented by treating the cause, careful monitoring, and protecting the limb from pressure/shear/friction. Also avoid constrictions from clothes or bandaging, elevate the limb, and provide gentle exercise, physical therapies, and/or compression

[9] *Skin Integrity Its maintenance and support. A guide to the principles of prevention and management of skin tears, leg oedema, wounds and pressure injury. This booklet was referenced from the BCOPE resource.*

- **Leg ulcers** require an awareness of the importance of correct diagnosis (venous or arterial) and the correct use of compression (to avoid ulceration or amputation, heart load). Also check colour and temperature of toes

- **Wound management** requires (i) assessing and planning using evidence-based tools, (ii) documenting the stage of the wound, and (ii) consideration of all factors by using an interdisciplinary approach.

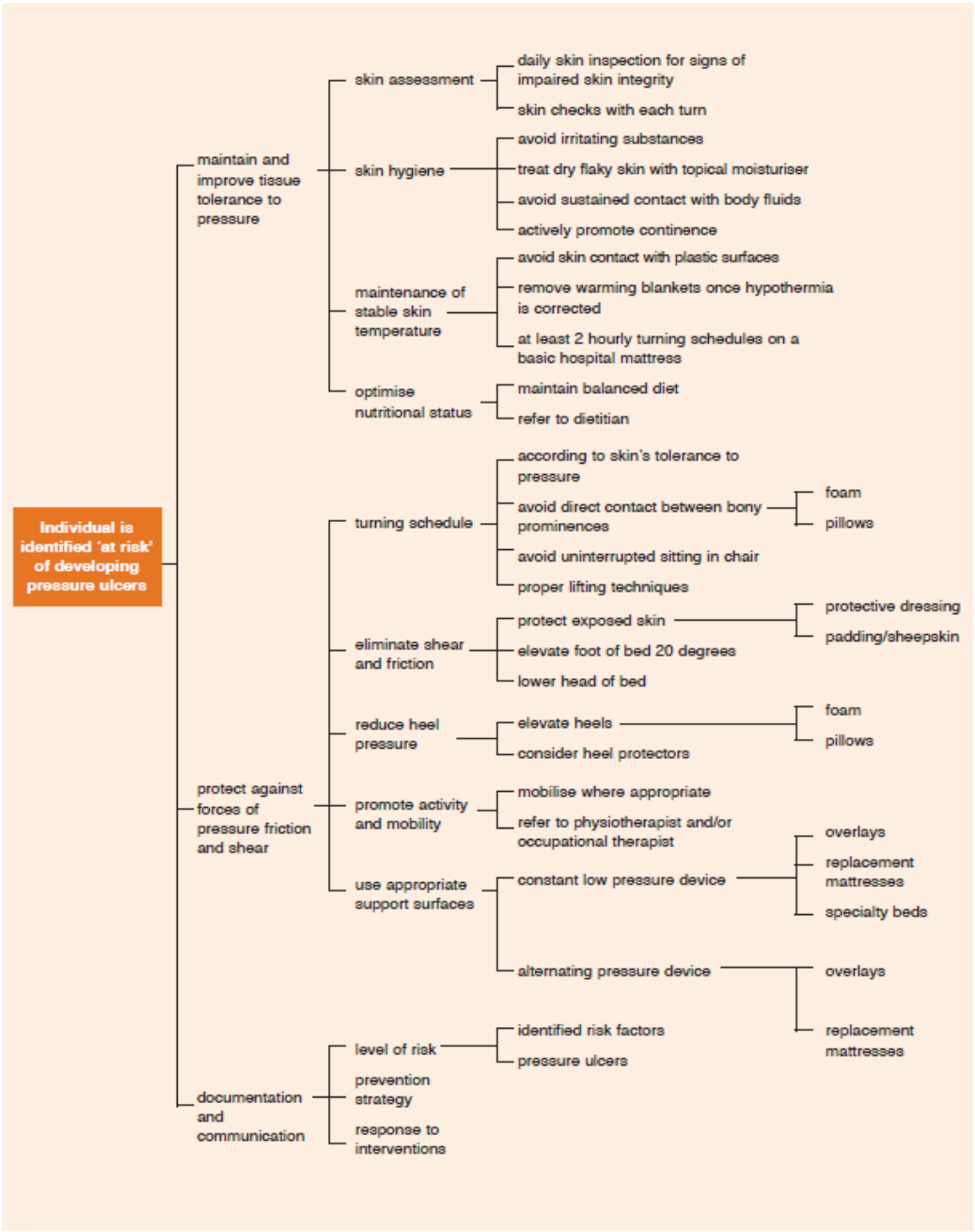
  It also requires

  - Involving the consumer
  - Correct treatment (e.g. selecting an appropriate dressing)
  - Considering the use of primary (directly on the wound) and secondary dressings (to provide protection or securing of the primary)
  - Selecting tapes carefully
  - Covering wounds
  - Quality management processes (good hand washing technique and infection control), and
  - Monitoring (i.e. record shape, depth, colour etc.)

Below is a flowchart sourced from the AWMA website recommended for pressure prevention strategies [10]. This may assist with developing prevention strategies.

[10] *Murray et al (2001)*

Figure 4. Flowchart of pressure preventative strategies.



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.

Back to Mrs. Peach

The Wound Care Specialist nurse refreshed the staff knowledge about hoists, cushioning aides and bandage products, and developed a new care plan in collaboration with Valerie and the staff. The time frame was to review the set goals within a month's time.

Here is a sample of the changes made to Mrs. Peach's care plan:

- *Regular mild analgesic for pain*
- *Fortified diet to assist skin healing*
- *Lifting machine for transfers*
- *Foam cushioning to protect sacrum area when seated*
- *Increased repositioning during day (2 hourly) and at night (4 hourly)*
- *Positioned in bed on her side – using additional pillows*
- *Fingerless gloves to protect the skin tear bandaging when painting*

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 or even improve 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** and **clinical 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** – 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

An example of goal setting using Mrs. Peach's case:

- Specific: e.g. to stop the pressure area from developing into a wound over the next month
- Measurable: e.g. record and monitor the pressure area, record adverse events (knocking skin etc)
- Actions required: e.g. staff refresher training on lifting techniques, dressings, re-positioning
- Realistic: e.g. the residents' overall health is progressing well and the skin integrity status is expected to improve with good management in place
- Time based: e.g. the evaluation date is set at one month after the commencement of the new re-positioning routine by reviewing the progress notes, handover notes, charts, adverse events and interviewing the resident, family and care team.

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 resident's 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 as relevant. 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 their own decisions, may choose to continue with a personal activity when they cannot be fully supervised, that puts them at risk of skin injuries (e.g. gardening without gloves). 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. nutritional risk) or symptoms (e.g. dry skin), connect the link to the body structures and/or functions that are impacted (e.g. damaged skin integrity)
- Describe the associated activity limitations (e.g. skin tears on hands impacted on self-care). It's important to look at remaining strengths (e.g. personal interests)
- 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. skin tear management)
- Finally, define the care goals (e.g. heal skin tears) 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 Mrs. Peach:

- There was a diagnosis of cancer, immobility (evidenced in Medical Notes/ACCR) and symptoms of a pressure area developing and skin tears on the hands (progress notes).
- From the identification process, we identified the body structures/ functions that were affected. The cancer affected the natural healing process, skin integrity risk in the sacral area, skin tears impacted on hands and personal hobby of painting (progress notes).
- These issues resulted in skin tears on the hands, reddening of skin around the sacral region.
- Strategies were developed to address the limitations by protecting the hands (i.e. skin tear management) and sacral areas (i.e. frequent turning, cushioning aids).

Remaining strengths and motivations, such as her personal interest in painting was used to support participation in everyday activities. Evidenced in care plan.

- The aims of the care plan were defined as goals (e.g. increased re-positioning, healing of skin tears) that can be evaluated.

Completing the ACFI documentation

The data collected can now be used to complete the **ACFI 12.5, 12.10 and 12.12 evidence** requirements. Tables 17 to 19 present the evidence requirements for each item. Examples of directives that will meet ACFI requirements for ACFI 12.5, 12.10 and 12.12 are provides, they ensure the 'treatment' is clearly described, documented and accountable to all stakeholders (resident, family, staff, internal auditors, external auditors).

Table 17: ACFI Question 12.5 (Skin Integrity) Evidence Requirements

ACFI 12.5 Checklist	Required information
Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/ or chair, or cannot self-ambulate. The management plan must include repositioning at least 4 times per day.	1. Directive by ☐ Registered Nurse (date, where stored) or ☐ Medical Practitioner (date, where stored) or ☐ Allied Health Professional (date, where stored) 2. Skin integrity assessment (assessment name, date, Health Professional name, Health Professional type, where stored)

ACFI 12.5 SKIN INTEGRITY DIRECTIVE
Resident ID (name/room etc): ……
Diagnosis/date …… By ☐ MP ☐ AHP ☐ ACCR
Skin Assessment: tool /location/date ……
Skin Integrity issue/ position:……
☐ Bed bound ☐ chair bound ☐ Cannot self-ambulate
Management: ☐ Repositioning ☐ Aids ☐ Nutrition ☐ Mobility ☐ Continence ☐ Aids ☐ Exercises
Treatment by staff type: ☐ RN ☐ EN ☐ PCW
Treatment to occur on the following days every week (tick days):
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
Treatment times: ___:____AM/PM ___:____AM/PM ___:____AM/PM ___:____AM/PM
Average time to complete the process: _____ mins per session
Is staff education required? ☐ YES ☐ NO
Is resident education required? ☐ YES ☐ NO **Is family education required**? ☐ YES ☐ NO
Provide a detailed description of the treatment: preparation required, repositioning, checks to be made, what is to be recorded, goal of treatment

Name: …… Profession: ☐ MP ☐ RN ☐ AHP

Signature: …… Date: ……

Table 18: ACFI Question 12.10 (Chronic Wounds) Evidence Requirements

ACFI 12.10 Checklist	Required information
Management of chronic wounds, including varicose and pressure ulcers and diabetic foot ulcers.	1a. ☐ Diagnosis (name of document, date, name of Health Professional, Health Professional type, where stored) or 1b. ☐ ACCR (where stored) 2. Directive by ☐ Registered Nurse (date, where stored) or ☐ Medical Practitioner (date, where stored) or ☐ Allied Health Professional (date, where stored) 3. Wound assessment (assessment name, date, Health Professional name, HP type, where stored) 4. Record of Treatment (where stored)

ACFI 12.10 WOUND DIRECTIVE
Resident ID (name/room etc): ……
Wound Diagnosis/date …… By ☐ MP ☐ Other In ☐ ACCR
Wound Assessment: tool /location/date ……..
Type of wound/ stage/ position
Management: ☐ Dressings ☐ Nutrition ☐ Mobility ☐ Continence ☐ Aids/Equipment ☐ Exercises
Wound Dressings by staff type: ☐ RN ☐ EN ☐ PCW
Treatment to occur on the following days every week (tick days):
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
Treatment times: ___:____AM/PM ___:____AM/PM ___:____AM/PM ___:____AM/PM
Average time to complete the process: _____mins per session
Is staff education required? ☐ YES ☐ NO
Is resident education required? ☐ YES ☐ NO **Is family education required**? ☐ YES ☐ NO
Provide a detailed description of the treatment: wound cleansing technique; wound dressing equipment (ointments, primary and secondary bandages etc), aids/equipment (e.g. mattresses, cushions, heel protectors), what to check for, what to record and where, goal of treatment.

Name: …… Profession: ☐ MP ☐ RN ☐ AHP

Signature: …….. Date: ……

Below is an example of a Record of Treatment that will meet ACFI requirements for ACFI 12.10.

ACFI 12.10 WOUND Record of Treatment

Resident ID : ……..

ACFI 12.10 WOUND DIRECTIVE Date ……

Day & Date	Signature	Staff Name & Profession

Table 19: ACFI Question 12.12(Oedema et al) Evidence Requirements

ACFI 12.12 Checklist	Required information
Management of oedema, deep vein thrombosis or arthritic joints or chronic skin conditions by the fitting and removal of compression garments, compression bandages, tubular elasticised support bandages, dry dressings and/ or protective bandaging.	1a. ☐ Diagnosis (name of document, date, name of Health Professional, Health Professional type, where stored) or 1b. ☐ ACCR (where stored) 2. Directive by ☐ Registered Nurse (date, where stored) or ☐ Medical Practitioner (date, where stored) or ☐ Allied Health Professional (date, where stored)

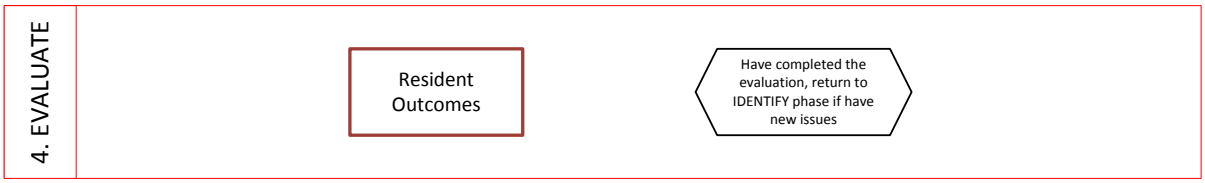
ACFI 12.12 OEDEMA etc DIRECTIVE
Resident name/room: ……
Diagnosis/date …….. By ☐ MP ☐ ACCR
Management: ☐ Compression garments ☐ Compression bandages ☐ Support bandages
☐ Dry dressings ☐ Protective bandages ☐ Nutrition ☐ Mobility ☐ Continence ☐ Aids ☐ Exercises
Compression garments or bandages/dressings by staff type: ☐ RN ☐ EN ☐ PCW
Treatment to occur on the following days every week (tick days):
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
Treatment times: ___:____AM/PM ___:____AM/PM ___:____AM/PM ___:____AM/PM
Average time to complete the process: _____mins per session
Is staff education required? ☐ YES ☐ NO
Is resident education required? ☐ YES ☐ NO **Is family education required**? ☐ YES ☐ NO

Provide a detailed description of the treatment: preparation required, equipment required, how to apply garment/bandage/dressing, aids to assist, what to check for, what to record, goal of treatment

Name: …… Profession: ☐ MP ☐ RN ☐ AHP

Signature: …….. Date: ……

Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better (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.

- Resident Care Outcomes

  With regard to wounds, for example, has the intervention reduced the size of the wound? This could be determined by regular monitoring of the wound size, colour etc after each intervention for a set time, for the purposes of evaluating the appropriateness and effectiveness of the treatment.

- Further improvements

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

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.

Outcomes

One month on Valerie and the staff reviewed the file notes (nursing, doctor and allied health progress notes) and they also assessed the outcomes against the goals included in the care plan. They found:

- That the pain has improved, but analgesia was still required
- The at-risk sacral area has not developed into a pressure sore
- The skin tears on the hands have healed and
- There are no new skin integrity issues

The evaluation provides the proof that what they had put in place to heal Valerie's skin integrity issues had worked. The evaluation showed care staff what is or is not working and provided the basis for reviewing the interventions being used to achieve the goals, and how important they are to achieving positive outcomes for their residents.

Summary: Steps and Information Flow

Figure 6 below shows the Skin and Wound 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 (Skin Risk Assessment, Skin Integrity Assessment, Wound Assessment, and completing Standardised Care Processes to address any clinical risks)

The implementation phase which comprises:

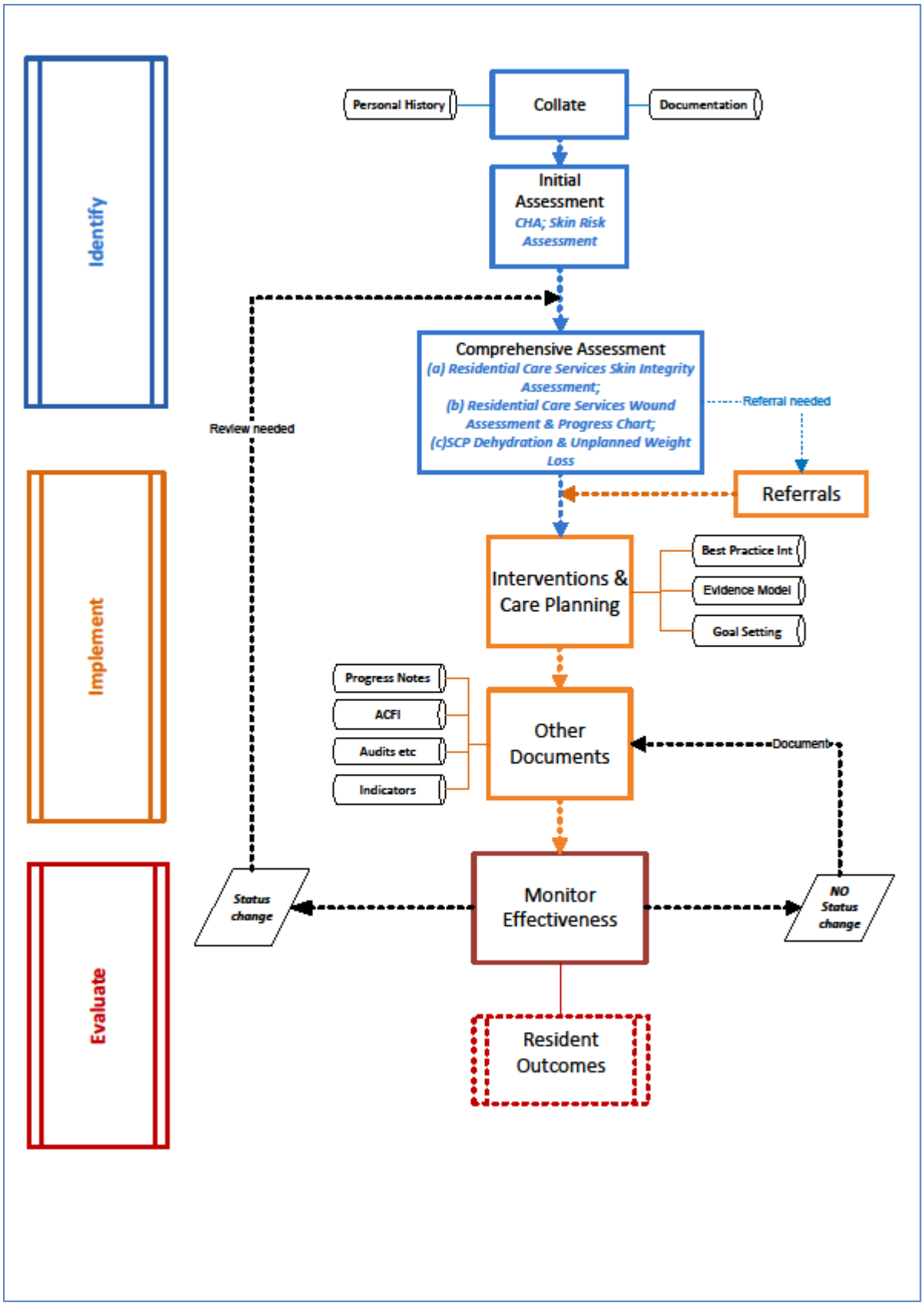
- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

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.

Figure 6: Skin and Wounds Summary: Steps and Information Flow



Skin & Wound Resources

The recommended resources are listed below and information on where they are found in the toolkit (Table 20).

Table 20: Skin & Wound Topic Resources

Resource Type	Details	Where found
Background Reading	CHAOP Module 4	Reading Pack
Background Reading	BCOPE. The Toolkit (2012) pp.213-220	Skin & Wound References (facility to download if required)
Background Reading	Standards for Wound Management Version 2 (2011)	Skin & Wound References (facility to download if required)
Assessments	Initial Nurse Assessment (e.g. CHA)	Complex Health Assessment Pack
Skin Risk Assessments	Waterlow OR Braden OR Norton	Complex Health Assessment Pack
Skin Assessment	Residential Care Services Skin Integrity Assessment	Complex Health Assessment Pack
Wound Assessment	Residential Care Services Wound Assessment and Progress Chart	Complex Health Assessment Pack
Goal setting	Quality Of Life Questionnaire	Reading Pack
Standardised Care Processes (SCP) for Skin & Wounds	Dehydration; Unplanned weight loss	Complex Health Assessment Pack

Skin & Wounds References

The recommended resources are listed below and references are provided (Table 21).

Table 21: References for the Sin & Wound Topic

Document name	Reference
Best care for older people everywhere (BCOPE). The toolkit.	Author: Department of Health Victoria (2012) Sourced from: http://www.health.vic.gov.au/older/toolkit/index.htm
Braden Risk Assessment Scale	Author: Barbara Braden and Nancy Bergstrom (1988) Sourced from NATFRAME at: 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
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 the 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).
Guidelines to development of competency Assessment Tools. Module One: Introduction to wound management Module Two: Pressure Injury Prevention and Management	Australian Wound Management Association (AWMA) Ref: Module 1: Introduction to wound management Sourced at: http://www.awma.com.au/publications/module_1_awma_intro-jul13.pdf Ref: Module 2: Pressure Injury Prevention and Management Sourced at: http://www.awma.com.au/publications/module_2_awma_pipm-jul13.pdf
Medical care of older persons in residential aged care facilities	Author: Prepared by The Royal Australian College of General Practitioners (RACGP)– 'Silver Book' National Taskforce Reference: Medical care of older persons in residential aged care facilities 4th Edition. (2006) Funded by the Australian Government Department of Health and Ageing. Sourced at: http://www.racgp.org.au/your-practice/guidelines/silverbook/common-clinical-conditions/dysphagia-and-aspiration/#1
Murray et al (2001)	Murray LD, MHA RN • Magazinovic N, BHSc RN • Stacey MC, DS FRACS (2001). *Clinical practice guidelines for the prediction and prevention of pressure ulcers (2001)*
National Framework for Documenting Care in	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource.

Document name	Reference
Residential Aged Care Services (NATFRAME) Care Profile	Sourced from: 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
Norton Scale for Predicting Risk of Pressure Ulcer	Author: Doreen Norton, Rhoda McLaren & A.N Exon-Smith *Ref: An Investigation of geriatric nursing problems in hospital. National corporation for the care of old people (now Centre for Policy on Ageing), London 1962.* Sourced at: 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
Residential Care Services Skin Integrity Assessment	Author: Koch, S., and Garratt, S. (2001). Ref: Assessing Older people: A practical guide for health professionals. MacLennan and Petty Pty, Ltd. Sourced from NATFRAME at: 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
Residential Care Services Wound Assessment and Progress Chart	Author: Koch, S., and Garratt, S. (2001). Ref: Assessing Older people: A practical guide for health professionals. MacLennan and Petty Pty, Ltd. Sourced from NATFRAME at: 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)	Authors: La Trobe University ACEBAC Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Dehydration; Unplanned Weight Loss Sourced at: http://www.health.vic.gov.au/agedcare/downloads/score/dehydration_scp.pdf http://www.health.vic.gov.au/agedcare/downloads/score/weightloss_scp.pdf
Standards for Wound Management 2nd Edition 2010	Author: Australian Wound Management Association (AWMA) Ref: Standards for Wound Management 2nd Edition 2010 Skin Integrity: *Its maintenance and support*. A guide to the principles of prevention and management of *Skin Tears, Leg Oedema, Wounds, Pressure Injury.* Eastern Health (2008) Sourced at: http://www.awma.com.au/publications/2011_standards_for_wound_management_v2.pdf
Waterlow Pressure Ulcer Risk Scale	Author J. A. Waterlow (1995). Sourced from NATFRAME at:

Document name	Reference
	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

Complex Health Workbook Exercise

Now that you have worked through the pain, swallowing, skin and wounds topics, 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 one of the Complex Health topics

Pain: ACFI 12.3/12.4a/12.4b

Swallowing: ACFI 12.6

Skin Integrity: ACFI 12.5

Wounds: ACFI.10

Oedema etc: ACFI 12.12

What clinical history is relevant?

What personal history is relevant?

Start to link the evidence together from the case study

Diagnoses

……

Issues identified

……

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 ……..

Develop three goals with the following aspects

- Has a single issue focus
- Measurable
- Action orientated strategy
- Realistic and achievable
- Can be evaluated (does it work?)

Resident QoL goal: ……..

Clinical goal: ……

Complete the relevant ACFI 12 Checklists and check you have the required evidence for an ACFI claim and any additional evidence.

Evidence	Description
□ Simple Pain Directive by RN/MP/AHP	**12.3** Pain management involving therapeutic massage or application of heat packs, at least weekly, involving 20 minutes of staff time in total.
□ Complex Pain Directive by RN/MP/AHP	**12.4a** Complex pain management and practice undertaken by an allied health professional or registered nurse. Frequency at least weekly AND Involving at least 20 minutes of staff time in total.
□ Complex Pain Directive by MP/AHP	**12.4b** Complex pain management and practice undertaken by an allied health professional. Ongoing treatment as required by the resident, at least 4 days per week**.**
□ Pain Assessment	By whom, date, document name and where stored
□ Pain Treatment of Record	
□ Pain related diagnosis □ ACCR □ Pain related notes by MP/AHP	***Additional evidence*** By whom, date, document name and where stored
□ Skin Directive by RN/MP/AHP	**12.5** Complex skin integrity management for residents with compromised skin integrity who are confined to bed and/ or chair, or cannot self-ambulate. The management plan must include repositioning at least 4 times per day.
□ Skin Integrity Assessment	By whom, date, document name and where stored
□ Mobility impairment diagnosis □ ACCR □ Skin Integrity notes by MP/AHP	***Additional evidence*** By whom, date, document name and where stored
□ Dysphagia diagnosis	By whom, date, document name and where stored

Evidence	Description
□ Special Eating Assistance Directive by RN/MP/AHP	**12.6** Daily management undertaken by an RN, on a one-to-one basis, for people with severe dysphagia.
□ Swallowing assessment	By whom, date, document name and where stored
□ ACCR □ Special Eating notes by MP/AHP	***Additional evidence*** By whom, date, document name and where stored
□ Wound related diagnosis	By whom, date, document name and where stored
□ Wound Directive by RN/MP/AHP	**12.10** Management of chronic wounds, including varicose and pressure ulcers and diabetic foot ulcers
□ Wound Assessment	By whom, date, document name and where stored
□ Wound Treatment of Record	
□ Wound related notes by MP/AHP	***Additional evidence*** By whom, date, document name and where stored
□ Related diagnosis	By whom, date, document name and where stored
□ Oedema, deep vein thrombosis or arthritic joints or chronic skin conditions Directive by RN/MP/AHP	**12.10** Management of chronic wounds, including varicose and pressure ulcers and diabetic foot ulcers
□ ACCR □ Related notes by MP/AHP	***Additional evidence*** By whom, date, document name and where stored