Evidence-Based Clinical Assessment Toolkit (EBCAT)

Medication Workbook

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PRACS Leadership Group

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Other Contributors

Professor Rhonda Nay who reviewed the Complex Health Workbook.

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Acronyms and Glossary

ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
BAF	Behavioural Assessment Form
BCOPE	Best Care For Older People Everywhere
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CCF	Care Continuum Framework
CDAMS	Cognitive, Dementia and Memory Service
CDC	Consumer Directed Care
CHA	Comprehensive Health Assessment (CHA) for Older People in the Health Care System
CHAOP	Comprehensive Health Assessment of the Older Person
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence Based Clinical Assessment Toolkit
EBCAT 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 Medication Workbook

The Medication Workbook is one of six of the Evidence Based Clinical Assessment Toolkit (EBCAT). It is one of four resources relevant to the Medication Topic:

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

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

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

The mandatory evidence for medication is a current medication chart. This workbook will assist a service to meet the ACFI evidence requirements and to provide supporting information beyond compliance, using familiar and freely available Australian toolkits and resources including:

- National Medication Guidelines [*Guiding Principles for Medication Management in Residential Aged Care Facilities (2012)* and *Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities (2006)]*
- 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 Process (SCP) for polypharmacy developed as part of the Strengthening Care Outcomes for Residents with Evidence (SCORE) project.
- A Medication Self-administration Assessment
- Best Care for Older People Everywhere (BCOPE). The toolkit.

Topic 7: Medicines

The Medication Topic

This topic focuses on safe medication management and the impact on other domains.

Investigating Medication

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

1. **Preparation of staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required.

   The background reading includes:

   - Guiding Principles for Medication Management in Residential Aged Care Facilities (2012;) and
   - Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities (2006).
   - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

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

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

   File Notes Review:

   - Aged Care Client Record (ACCR) – Part 4 diagnoses which may inform on medication (e.g., Diabetes Mellitus Type 1 requires insulin injections), diagnoses which inform on possible assistance required (e.g., sensory or cognitive impairments); Part 5 Q38 Q42 with comments on medication
   - Comprehensive Medical Assessment – which (if available) may have for example, a list of the medicines, the reason for each medicine, allergies, drug intolerances, and assistance required
   - Medication Chart which will have a picture of the person, list of the current medicines (type, dosage, time taken), allergies, and drug intolerances.

Screen:

- Initial nurse assessment e.g. the CHA is an initial nurse assessment based on the 'Comprehensive Health Assessment of the Older Person' resource), which records information about allergies and drug intolerance, current medication, cognitive status.

Further Assessment:

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

- Use the Medication Self-administration Assessment to assess the person's ability to self-administer medicines if they are currently doing so
- Record the time taken to assist with the administration of medicines (if staff provide assistance).
- The SCORE Standardised Care Process is also recommended for addressing the clinical risk of polypharmacy.

These screening and assessment tools are referenced in the Medication Appendix and copies are found in the Medication Assessment Pack.

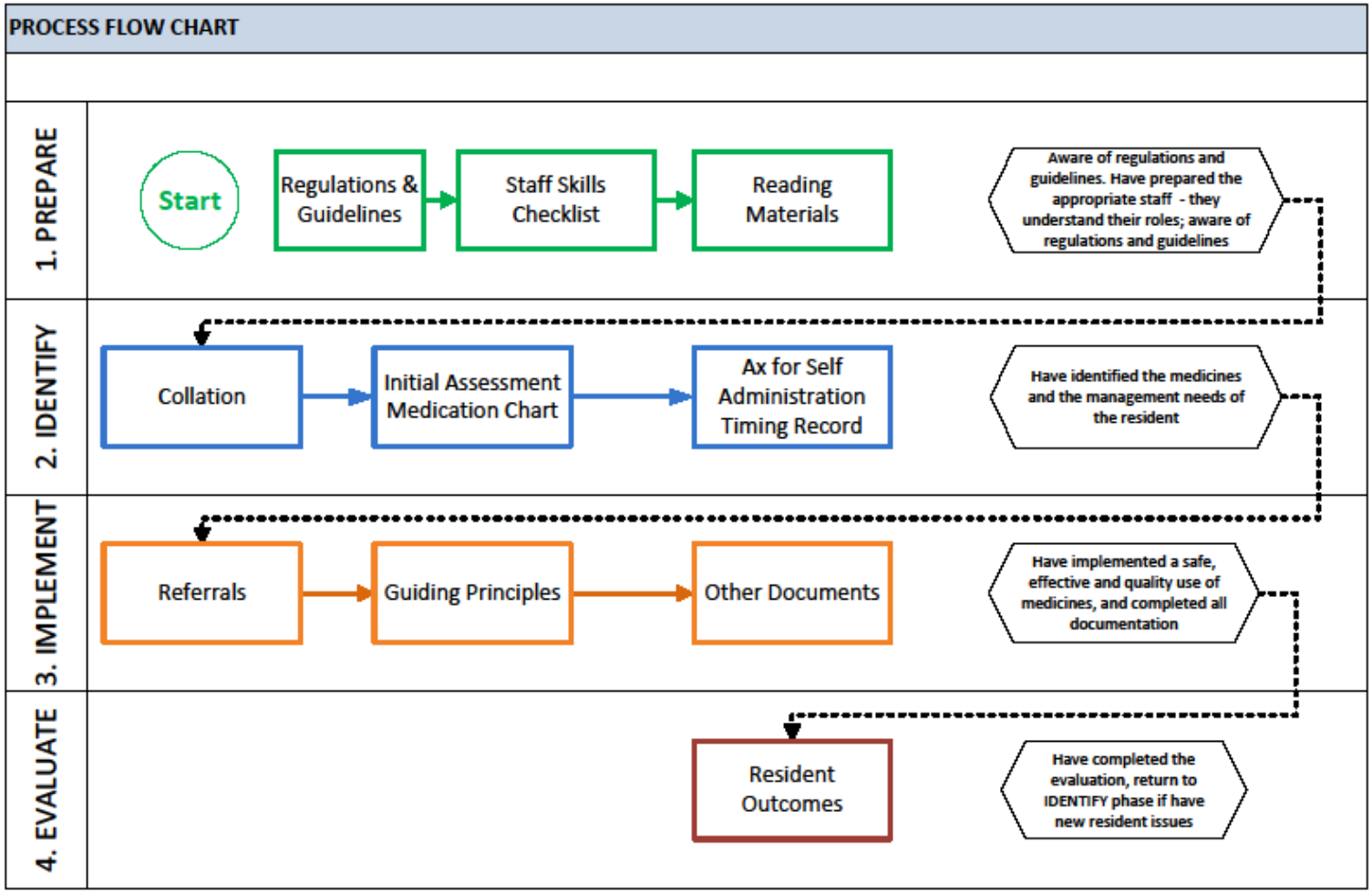
3. **Implementing** – based on the information from the identification phase this covers making needed referrals, implementing guidelines, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:

- Undertaking referral options to GP/Pharmacist/Medication Advisory Committee to complete gaps or seek specialist advice
- Implementing guidelines to support a safe medication process (the Guiding Principles for Medication Management in Residential Aged Care Facilities (2012))
- Planning evidence informed care strategies to assist the person to maintain or possibly improve their participation ability
- Listening to and setting goals with the consumer (resident and family) to hear their perception 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 11 documentation

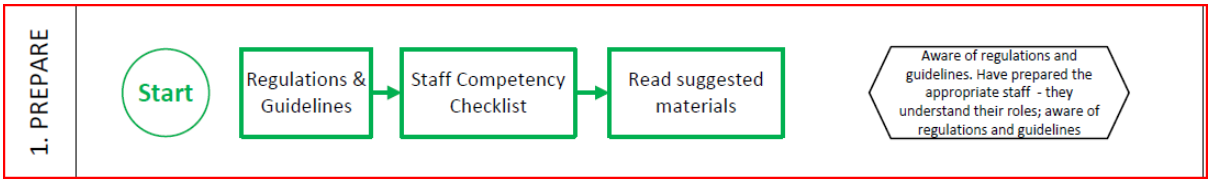
4. Evaluating – monitoring and evaluating the effectiveness of the process, regularly reviewing at times of resident or medication changes, and looking for ways to further improve the care outcomes for residents.

The overall medication 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 EBCAT Workbook follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

Figure 1: Medication Management Process



Preparation



There are three specific aspects to **preparing** staff for the management of medicines. They are:

1) Staff being aware of the national guidelines, regulatory requirements and local organisational policies;

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

3) Completing the pre-reading if required

Guidelines, Regulations & Local Policy

Two resources provide information about how to meet national regulatory requirements and guidelines (references are found in the Medication Appendix):

1. *Guiding Principles for Medication Management in Residential Aged Care Facilities (2012)*
2. *Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities (2006)*

The resources promote the safe, quality use of medicines and medication management in Residential Aged Care Facilities (RACF). As noted on page 1, it is intended to:

- Assist RACF to develop, implement, and evaluate locally specific policies and procedures
- Support those involved in assisting residents
- Support residents in the medication management process

It also provides information on the roles and responsibilities of staff in the management of medication, the 17 principles underlying the process, and the appropriate state and territory contacts for regulatory advice.

National, state and territory legislation and regulation, and relevant professional standards govern medication administration roles, responsibilities and practice by a number of health professionals in RACFs. While nursing staff are most commonly responsible for the

administration of medicines in RACFs, it is recommended that managers and staff be aware of national, regional, and local organisational medication management policies.

National Guidelines

"GUIDING PRINCIPLE 14: ADMINISTRATION OF MEDICINES BY RACF STAFF

The RACF should ensure that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.

Registered nurses are qualified and legally authorised to administer medicines under the Health Practitioner Regulation National Law Act 2009, and relevant state and territory legislation and regulation.

Under the Health Practitioner Regulation National Law Act 2009, all enrolled nurses working under the direction and supervision of registered nurses may administer medicines except for those who have a notation on the register against their name that reads 'Does not hold Board-approved qualification in administration of medicines'.

Registered and enrolled nurses are professionally regulated through the Nurses and Midwives Board of Australia and are accountable to professional standards.

In some jurisdictions, assistants in nursing/personal care workers (however titled) perform medicines-related tasks in accordance with state or territory legislation and regulation and RACF policy and procedures. These staff members are not professionally licensed, so are not bound by standards set by a licensing authority."

[Guiding Principles for Medication Management in Residential Aged Care Facilities (2012,) p58)].

Victorian State Regulations

The Victorian government website provides a summary of the relevant regulations for aged care managers. The information was prepared by the Drugs and Poisons Regulation Group (DPRG) to assist Approved Providers in understanding their obligations under the *Drugs Poisons and Controlled Substances Act 1981* (the Act) and Regulations 2006.

The legislation provides further details and is available at the Legislation Victoria website (http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/LTObjSt5.nsf/0/652e75ad1b785534ca257789000756c4/$FILE/81-9719a091.pdf).

An overview of some key information from the summary of the relevant regulations for aged care managers is provided below (http://www.health.vic.gov.au/dpcs/agedcare-manage.htm)

The Relevance of the Drugs & Poisons legislation

Drugs and Poisons legislation applies when a resident in an aged care service becomes more dependent on others for the management and administration of prescribed medicines.

Key terms

- Understanding Schedule 8 poisons (Controlled Drug) -drugs with more strict legislative controls, e.g. cocaine, morphine.
- Understanding Schedule 4 poisons (Prescription Only Medicine) - drugs for which prescriptions are required, e.g. antibiotics.
- "Aged care service"/ "approved provider" /and "high level residential care" have the same meanings as in the Aged Care Act 1997 of the Commonwealth.
- Registered Nurse means a nurse registered by the Nursing and Midwifery Board of Australia as a 'Registered Nurse' in the national register of nurses (and equivalent to those previously registered in Division 1, 3 or 4 of the Nurses Board of Victoria register).
- Enrolled Nurse means a nurse registered by the Nursing and Midwifery Board of Australia as an 'Enrolled Nurse' in the national register of nurses (and equivalent to those previously registered in Division 2 of the Nurses Board of Victoria register)
- In the Drugs Poisons and Controlled Substances Regulations 2006, the term "nurse" is defined to include registered nurses and enrolled nurses.
- The term "imprest drugs" describes Schedule 4 and Schedule 8 poisons that are **not** supplied on prescription for a specific person but which are obtained by an establishment under the authority of a Health Services Permit (HSP).
- A Registered Nurse (not an Enrolled Nurse) may **manage** the administration of medication to residents receiving high-level residential care. The Registered Nurse with overall responsibility for management of medication is to be readily identifiable to staff and able to be contacted by DPRG.
- Management by a Registered Nurse may occur in a variety of ways- they could **delegate the routine supervision** of other workers to whom they have **delegated the task of administering** medicines. A Registered Nurse may only delegate the administration of medicines to someone appropriately qualified to administer medicines. This means that Registered Nurses may use their professional judgement about whether to administer medicines themselves or whether to delegate the administration to someone with appropriate qualifications or scope of practice to administer medicines by the specified route.
- Enrolled Nurses (who do not hold a Nursing and Midwifery Board of Australia approved qualification in medicines administration) and personal care workers (with

appropriate medicines administration training) may, in some circumstances, be competent to administer medicines under the delegation of a Registered Nurse with appropriate supervision.

- There is advice on the storage of schedule 4 and 8 poisons, and requirement for maintaining records of all administrations of these poisons.
- The responsibility of nurses is further detailed is found at

http://www.health.vic.gov.au/dpcs/reghealth.htm

Local Medication Policy

Your local home will usually have a medication policy that specifies, for your home:

- Who will administer medicines
- Who will supervise the administration of medicines
- How the home manages an efficient and safe medication system that meets all regulatory and quality requirements.

Your policy will assist you in planning how to meet those requirements.

Recommended Staffing Skill Set

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

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

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in the medicines assessment and management activity, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge 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 and the Medication Management Process

Activity	Responsible for sign off	Does the activity
Collating Documents		
Timing Record		
Assessment for the Self-Administration of Medicines		
Medication Chart		
Documenting into file notes		
Determine and action Referrals		
Administration of medicines requiring assistance		
Administration of a subcutaneous/ intramuscular/ intravenous drug		
Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Review the Medication Chart		
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 medication issues in older people. It is expected that staff will have:

- A comprehensive understanding of the domain and how it is impacted from 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 practices associated with medication- to assist with the development and implementation of evidence-based care plans

The background reading relevant to the medication topic is:

The **Guiding Principles for Medication Management in Residential Aged Care Facilities** (2012) (referenced in the Medication Appendix).

- This resource provides information on the roles and responsibilities of staff in the management of medication, detailed information on the seventeen principles underlying a quality medication process and on the contacts for the appropriate state regulatory advice.

The **BCOPE** resource (Best Care for Older People Everywhere – refer Medication Appendix)

- It covers why medicines are important.

Some Basics

What are medicines?

"The term 'medicine' includes prescription and non-prescription medicines, and complementary health care products." (Guiding Principles for Medication Management in Residential Aged Care Facilities 2012, p.1)

For ACFI 11 claiming purposes, medicine refers to:

- Any substance(s) listed in Schedule 2, 3, 4, 4D, 8 or 9 of the Standard for the Uniform Scheduling of Drugs and Poisons (and its amendments) and/ or
- Medication(s) ordered by an authorised health professional or authorised for nurse initiated medication by a Medication Advisory Committee or its equivalent. This

excludes food supplements, with or without vitamins, and emollients (e.g. sorbolene cream, aqueous cream, etc).

Why is medication management important?

Most people in residential aged care facilities (RACFs) take medicines, and many take multiple medicines for different health conditions. RACFs must support and often manage each resident's medicines needs . . . including those moving between the RACF and other care settings or providers. (Guiding Principles for Medication Management in Residential Aged Care Facilities 2012, p.1)

While medicines make a significant contribution to:

- Preventing and treating disease,
- Increasing life expectancy and
- Improving quality of life

They also have the potential to cause harm. Inappropriate or incorrect use of medicines can have an adverse effect on health.

Older people may be prescribed a number of medications to support their health. When multiple numbers of medicines are taken, there are associated risks of **polypharmacy** and adverse drug reactions. An up-to-date and accurate medication list is essential to facilitate safe prescribing in any setting. BCOPE (2012, p. 201-4) advises staff to take a medication history, confirm the information and reconcile the information.

Most people in aged care will be considered high-risk persons and should be reviewed as a priority. High-risk persons are described (BCOPE p.199) as those who:

- Are aged 75 years and over
- Are prescribed medicines that require monitoring
- Are taking 5 or more medicines
- Have a cognitive or sensory impairment
- Manage their own medicines
- Have recently been discharged from hospital

Five facts everyone should know about medication (BCOPE Medication p.199)

1. **Medication reconciliation** [1] should be performed on admission for every resident.

[1]Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines (http://www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/)

2. High-risk residents should be reconciled as a priority.
3. Prescribing medicines to older people must be carefully planned and monitored because age-related changes, as well as the risks of polypharmacy, predispose older people to adverse drug reactions.
4. Non-adherence to medication instructions is common among older people and may be related to several factors.
5. Medications may be implicated in older patients presenting with falls, confusion and incontinence.

How Medication Interacts with Other Domains

Nutrition

The side-effects from medications can be a cause of appetite changes, including both increases and decreases[2].

Dexterity

Impaired finger dexterity can affect the ability of the person to administer their medications.

Swallowing

Persons with impaired swallowing may require supervision of medications to ensure there is no risk of choking.

Falls Risk

Medications are one of the most easily reversible risk factors that need to be considered in a falls assessment process (p.148), for example, polypharmacy is associated with falls, antipsychotics predispose a person to falls due to sedation, and withdrawal from psychotropic medications has been shown to decrease the risk of falls[3].

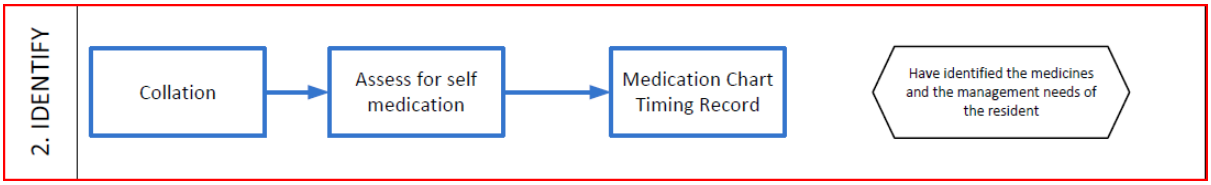
Cognition

People living with dementia or other cognitive impairments may not recognise the purpose of medications or they may be distracted by everything else happening in the room. People with moderate or higher cognitive impairment will usually require a minimum of supervision with managing and administration of their medications due to inability of the person to understand or follow the process.

[2] Flanagan et.al.(2012). Managing under nutrition in the elderly. AFP Vol41, No9, Sept 2012. Pp.695-699 (http://www.racgp.org.au/afp/2012/september/managing-undernutrition-in-the-elderly/)

[3] Zeimer. H. (2008) Medications and Falls in Older People Journal of Pharmacy Practice and Research Volume 38, No. 2, 2008. Pp. 148-151. (http://jppr.shpa.org.au/lib/pdf/gt/2008_06_Zeimer_GT.pdf)

Identification Process



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

- Gathering the history from current documentation from carers, family and the consumer
- Identifying a need for self-medication or assistance with medications (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, lists of medicines and associated symptoms, and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for nutrition.

Document	Look for
ACCR	Diagnoses, impairments, assistance required with medicines
Medical Notes/CMA	Diagnoses, swallowing status, lists of medicines, purpose of medicines
Medication Chart	Lists of medicines (type, dosage, times administered), Picture of person, prescribing MP, pharmacist, allergies, drug intolerances, preparation of medicines

Examples of how the collated diagnoses and issues that may be indicators of care needs are provided below:

Diagnoses/status	Examples of care needs
Dysphagia and or swallowing issues	May require medicines to be prepared (e.g. crushed), or require monitoring or assistance when swallowing medicines
Diabetes	Diabetes mellitus type1 is insulin dependent, requiring regular insulin injections. NIDDM (type 2) may have prescribed diabetic medications
Arthritis/ dexterity	Affecting ability to hold medicines or place them in the mouth, may require physical help or aides with medicines
Cognitive Impairment	May require supervision when taking medicines, or be unable to self administer medicines
Sensory loss- eyes, hearing, smell	That require strategies or aids to assist the management with the administration of medicines; e.g. supervision when taking medicines
Communication issues of understanding others and/or communicating to others	That require strategies or aids to assist the management with the administration of medicines; For example, communication aides (language cards, picture cards) to assist the resident to participate in the activity.

Resident and Family

It is also important to include and seek input from the resident and his or her family members to ensure you have collected a complete and accurate understanding of all the medicines (including over the counter) they are taking, any known medication side effects, and preferences.

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Complex Health Assessment (CHA) for Older People in the Health Care System. The CHA covers most domains and topics likely to impact on the health care needs of a person. Based on evidence informed practice, nurses (RN's and EN's) who have received training on a resource such as the Comprehensive Health Assessment of the Older Person (CHAOP) have the competencies to undertake a comprehensive health assessment. In particular for medication, the CHA covers allergies, drug intolerances, swallowing issues, eating assistance and current medications.

If a resident has a change in their health status and the CHA is reviewed, these items will also help to indicate if the medications may need to be reviewed.

The box below presents the CHA items specific to medicines:

DETAILS OF ALLERGIES AND ANY DRUG INTOLERANCES

Insert details……

PERSON'S CURRENT MEDICATION:
(including prescribed and no-prescribed medication- drug chart/Weber sheet can be attached)

Insert details……

EATING:

Does the person need assistance with eating Yes □ No □

- If YES, then complete a comprehensive assessment.

What assistance does the person require with eating……

Identified issues……

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	☐

Swallowing impacts on a person's ability to safely take medicines. Compromised swallowing may have serious health implications because of a risk of aspirated pneumonia or choking. The CHA has five swallowing questions and the box below sets out the recommended assessment process for informing on these swallowing items.

Question	**How to investigate the question**
Do they have difficulty swallowing?	• Is there a diagnosis of dysphagia or an associated diagnosis, or symptoms of compromised swallowing have been noted • 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
Has 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 Approach

For the medication domain it is recommended that all new residents have a comprehensive approach completed. This involves:

- If the resident has requested to self administer medicines, then complete a **Self-Administration of Medication** assessment**.** This will determine if it is safe for the resident to self-administer including from an aide such as a Webster pack (refer to the Medicine Appendix and a copy of the assessment is found in the Medication Assessment Pack).
- A current and accurate **Medication Chart**
- Document a **Medication Timing Record** over 1 day to determine the length of time it takes to administer medicines to a resident. This will strengthen the medication practice by highlighting residents who need extra assistance in this area (and the reasons why), and provide information to help predict the care staff resources needed for medication requirements. It will also provide supporting evidence for ACFI funding purposes (refer to the Medication Assessment Pack for an example).

The thirteenth guideline (*Guiding Principles for Medication Management in Residential Aged Care Facilities,* 2012) states that *the RACF should support those residents who wish to administer their own medicines as part of maintaining their independence.*

The suggested assessment is the **Self-Administration of Medication Assessment** (a reference is found in the Medication Appendix and a copy is found in the Medication Assessment Pack). This assessment asks questions related to:

- Resident preferences, previous self administration history
- Demonstration of capability - gross/fine motor skills, ability to open packets etc, ability to lock and unlock medicine drawer, ability to self inject etc
- Impairments that may impact on ability to self administer- cognitive impairment, communication, substance abuse,
- Resident knowledge and understanding of how to safely manage their medicines
- Strategies to assist self administering

A **current medication chart** completed by an authorised health professional, should record the details about all medicines currently taken by the resident. Medication charts are an important tool within residential aged care facilities.

The Department of Health's *Guiding Principles for Medication Management (2012)* summarises the importance of recording residents' medication in residential aged care:

- Residents self administering medicines should have a list of their medications
- Resident receiving administration of medicines should have a medication chart
- Medication charts provide:
  - A record of the prescriber's clinical intention for a resident's treatment
  - An order for the pharmacy supply of a resident's medicine
  - A record of administration of the medicine to the resident
  - Key tool for monitoring, review and reconciliation of a resident's medication management information
- Medication charts should record
  - Resident identification details and photo
  - GP, pharmacist details
  - Resident allergies, drug reactions
  - Alerts (e.g., residents with same names)
  - Staff initials/dates when medicine is administered
  - Details about comprehensive medication reviews
  - Details about the medicines (dose, time, route, requires crushing etc)
  - Sections for different medicines (PRN, emergency, nurse initiated, resident initiated etc)

The National Residential Medication Chart developed by the Australian Commission on Safety and Quality in Health Care is designed to provide a consistent format for medication orders and administration records, and improve the processes for chemist dispensing and claiming for the supply of medicines under the Pharmaceutical Benefits Scheme or Repatriation Pharmaceutical Benefits Scheme.

It is important that an accurate medication history is collected, recording all medications being taken at the time of admission, recording GP and pharmacy details, the source of the information, any adherence issues and any other relevant information (e.g., allergies).

If there are multiple medication lists, reconcile the information – a process of comparing various medication lists to avoid errors in transcription. This is important as the decision to select and use a medicine may occur at different points:

- The resident or carer may select a non-prescription, complementary or alternative medicine
- A person authorised to prescribe medicines may order a medicine for the resident within their scope of practice and prescribing authority; and
- An authorised and qualified nurse may initiate a medicine from a pre-approved list or order

A **medication timing record** (for ACFI claiming purposes) documents the time taken providing medication assistance over 24 hours of regular and authorised daily medications. It does not include the preparation of medications (refer to the ACFI user Guide p.34). It is suggested that the timing be recorded in minutes and seconds (e.g., 3 minutes and 30 seconds), then totalled over the 24 hour period, and rounded up to the nearest whole minutes. This will provide an accurate recording.

Clinical Risks

To assess for the clinical risk of polypharmacy, it is recommended that the **SCORE Standardised Care Process for Polypharmacy** be completed.

To reduce the risk of polypharmacy it recommends:

- Ensure only staff deemed competent and within their scope of practice administer medicines
- Monitor medicines for inappropriate orders (for example, inappropriate medicine for the resident, wrong dose, potential for interaction with other medicines)
- Document the reason (indication) for each drug
- Document the resident's response to medicines
- Document any adverse responses to medicines
- Report any adverse responses to the GP. When a new drug is ordered check the need for all current medications – can anything be ceased?
- Use a computerised drug management system if possible
- Ensure that an up-to-date list of medications accompanies residents to specialist appointments or hospital visits
- Ensure the facility has a system for recording and reviewing any medication adverse events
- Use an appropriate dose administration aids

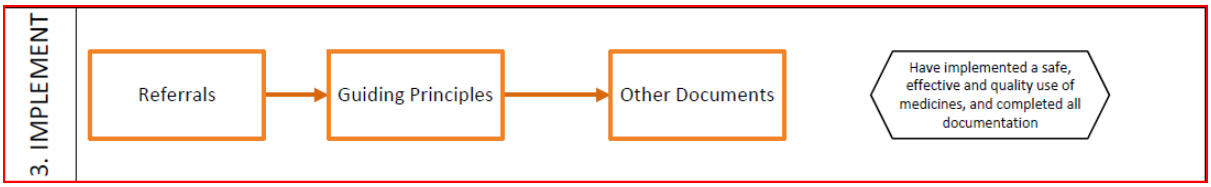
Further information on all recommended Standardised Care Processes (SCP) is found in the Medication Appendix and copies are found in the Medication Assessment Pack.

Bringing the information together

Consider the impact from assessments undertaken in other domains, such as:

- Cognitive impairment as identified in the Cognition domain
- Sensory impairment as identified in an initial nurse assessment
- Physical impairment as identified in the ADL domain

Implementation Process



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

- Undertake **referrals as required** to complete further needed information
- Incorporate the **national guiding principles** into the care practices
- 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

Referrals are made when a further advice or assessment is needed or the home does not have the expertise to undertake the assessment. With regard to medication, such a referral might be made to a medical practitioner or to a medical specialist such as geriatrician or psychiatrist for reviewing the current medicines. Any authorised health professional that can prescribe medicines could be involved in reviewing and prescribing medicines. For example a review may be considered when, the person's behaviour has settled significantly and they may be able to reduce the dose; or the side effect of a medicine has put the person be at too high a risk of a fall.

If the resident has a chewing/swallowing issue, a referral to the appropriate allied health professional may be required (Speech Pathologist for swallowing assessment, Dietitian for nutritional advice) or their Medical Practitioner.

The medication advisory committee can assist in overseeing the implementation of the guidelines.

A pharmacist can assist in medication reviews and dispenses medicines.

A physiotherapist could assist with improving the dexterity of a person so that they could self administer and handle medicines.

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

Table 2: Referrals for Medication

Health Professional	Source	Contact
Medication Advisory Committee	Local	Name, contact details
Pharmacist	Health Service	Name, contact details
Clinical Nurse Specialist	Health Service	Name, contact details
Speech Pathologist	Health Service	Name, contact details
Physiotherapist	Practice details	Name, contact details
General Practitioner	Practice details	Name, contact details
Geriatrician	Health Service	Name, contact details
Psychiatrist	Health Service	Name, contact details

Interventions

The ***Guiding Principles for Medication Management in Residential Aged Care Facilities*** *(2012)* provides a comprehensive guide to the management of the medication process. It is based on 17 guiding principles which should be considered when planning the medication system for all residents. The principles have been summarised as follows:

- Each RACF should have a Medication Advisory Committee
- Current and accurate information resources on medicines should be available to all residents, carers, staff and visiting health care professionals.
- The RACF should support informed and considered selection of all medicines used in the facility.
- The RACF should also support informed selection and safe use of complementary, alternative and self-selected non-prescription medicines used by residents.
- The RACF should develop policies and procedures 1) covering safe practices in nurse-initiation of non-prescription medicines 2) guiding the use and review of standing orders where these are used in the facility, 3) for the management of an emergency stock of medicines where this is used, and 4) to guide dose administration, aid needs assessment, and cover preparation, use, monitoring and quality assurance.
- For purposes of safety and proper administration, the RACF should ensure all residents have a current, accurate and reliable record of all medicines selected, prescribed and used.

- Each resident's medication management should be reviewed regularly.
- The RACF should ensure that supplies of medicines are maintained.
- The RACF should ensure all medicines, including self-administered medicines, are stored safely and securely and in a manner that maintains the quality of the medicine, and that all unwanted, ceased or expired medicines are disposed of safely.
- The RACF should support those residents who wish to administer their own medicines as part of maintaining their independence.
- The RACF should ensure that staff are appropriately qualified and authorised to administer medicines, and that administration practices are monitored for safety and quality.
- The RACF should ensure that residents, their carers and staff administering medicines know which oral dose medicines can and cannot be altered in form, such as by crushing or chewing and any special conditions relating to the alteration or administration of specific medicines.
- The RACF should regularly review and evaluate each area of medication management for outcomes and take follow-up action where required.

Care Planning

The Medication Chart will hold and document all medicines prescribed and used.

- Medication charts provide:
  - A record of the prescriber's clinical intention for a resident's treatment
  - An order for the pharmacy supply of a resident's medicine
  - A record of administration of the medicine to the resident
  - Key tool for monitoring, review and reconciliation of a resident's medication management information
- Medication charts should record
  - Resident identification details and photo
  - GP, pharmacist details
  - Resident allergies, drug reactions
  - Alerts (e.g., residents with same names)
  - Staff initials/dates when medicine is administered
  - Details about comprehensive medication reviews
  - Details about the medicines (dose, time, route, requires crushing etc)
  - Sections for different medicines (PRN, emergency, nurse initiated, resident initiated etc)

(*Guiding Principles for Medication Management (2012)*)

The resident's Care Plan will also hold relevant medication information and it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs.

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

The NATFRAME Care Plan records allergies, administration preference and strategies for assisting care. You may want to consider extra items such as how other impairments impact on the ability of the resident to take medicines independently, and other individual preferences or information recorded in the Medication Chart.

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 goal may be to maintain self-administration of medicines. We can record that the resident has been objectively assessed as capable, provide exercises to maintain dexterity capability and interview the resident and family for their feedback.

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 between health professionals, about what has been investigated and the information collected, what has been implemented, and what is or isn't working. It's a communication tool that can help all staff give the best possible care.

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

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

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required
- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate)
- Record the evaluation of the care provided including the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes
- Incident forms or adverse medication events should be completed recording the associated issues (e.g., polypharmacy, choking). 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. diagnoses - dementia, stroke and dysphagia) or symptoms (e.g. short concentration and attention span), and connect the link to the body structures and/or functions that are impacted (e.g. impaired cognition and swallowing). Evidence is found in the file notes (ACCR, CMA, progress notes, assessments in file notes).
- Describe the associated activity limitations (e.g. Swallowing impairment affects time required to take medications. Requires physical assistance when taking medicines due to cognition and dysphagia). It's important to look at remaining strengths (e.g. fluid/food preferences).
- 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. Evidence is found in the Care Plan and Medication Chart.
- Finally, define the care and resident goals that will be evaluated. Goals give purpose to the care and provide a measurement for evaluating the outcomes. Evidence is found in the Care Plan.

For example, if the goal is to address a resident's medication assistance:

- Set a specific target, for example to have no episodes of choking while taking medications over the next month
- Measure the effect by reviewing adverse events, after one month interview the resident and family for their feedback
- Describe the action to achieve the goal, e.g., documented steps for supervising medications to be written up in the care plan, staff education to be provided.
- Check it is realistic, the resident and family collaborated with the development of the strategy, it fits into the normal practices, and it is affordable
- Make it time-based, for example to be reviewed after one month

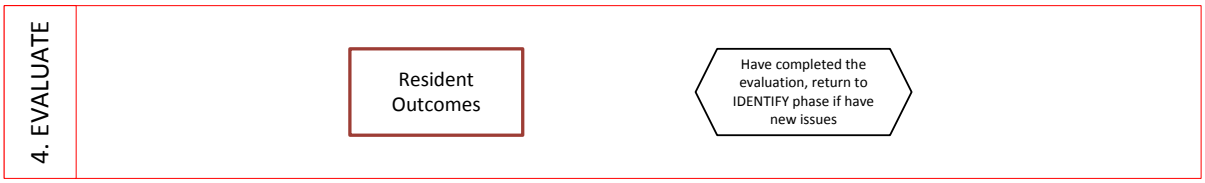
Completing the ACFI documentation

The data collected can now be used to complete the ACFI 11 checklists as described in Table 3.

Table 3: ACFI Question 11 Checklists

ACFI Question 11 Checklist	Where to find the information
No medication	Medical Practitioner notes Initial Nurse Assessment
Self-manages medication	Medical Practitioner notes Initial Nurse Assessment and resident interview Self-administration of medication assessment
Application of patches at least weekly, but less frequently than daily	Medication chart Medical notes/ Care Plan
Needs assistance for less than 6 minutes per 24 hour period with daily medications	Medication chart Medication timing record Medical notes / ADL Assessments e.g., dexterity/ Cognitive Assessments/ Care Plan
Needs assistance for between 6-11 minutes per 24 hour period with daily medications	Medication chart Medication timing record Medical notes/ ADL Assessments e.g., dexterity / Cognitive Assessments/ Care Plan
Needs assistance for more than 11 minutes per 24 hour period with daily medications	Medication chart Medication timing record Medical notes/ ADL Assessments e.g., dexterity / Cognitive Assessments/ Care Plan
Needs daily administration of a subcutaneous drug	Medication chart Care Plan
Needs daily administration of an intramuscular drug	Medication chart Care Plan
Needs daily administration of an intravenous drug	Medication chart Care Plan

Evaluation Process



The evaluation process considers:

- Resident Quality of Life outcomes

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

- Resident Care Outcomes

  With regard to medicines, for example, has the intervention stopped choking events? This could be determined by reviewing adverse events.

- Further improvements

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

Evaluation is just a step in the ongoing work of the provision of quality care and quality of life. Some types of evidence are collected to identify issues and some for outcome measurement purposes.

For example, in the example of goal setting, after one month the evaluation process would lead you to:

- Review adverse event documents for the past month to check if the resident has had any choking events during medication administration.
- Interview the resident and family for their feedback on the intervention, find out if it working for them, and consider if new strategies should be implemented.
- Make a determination as to whether the interventions are working.

Summary: Steps and Information Flow

Figure 2 shows the medication topic phases and steps in the process (excluding the preparation phase). It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment and Medication Chart;
- Completing the Comprehensive Assessment (Assessment for Self Administration of medications if applicable, Medication Timing Record 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
- Implementing the National Medication Principles
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

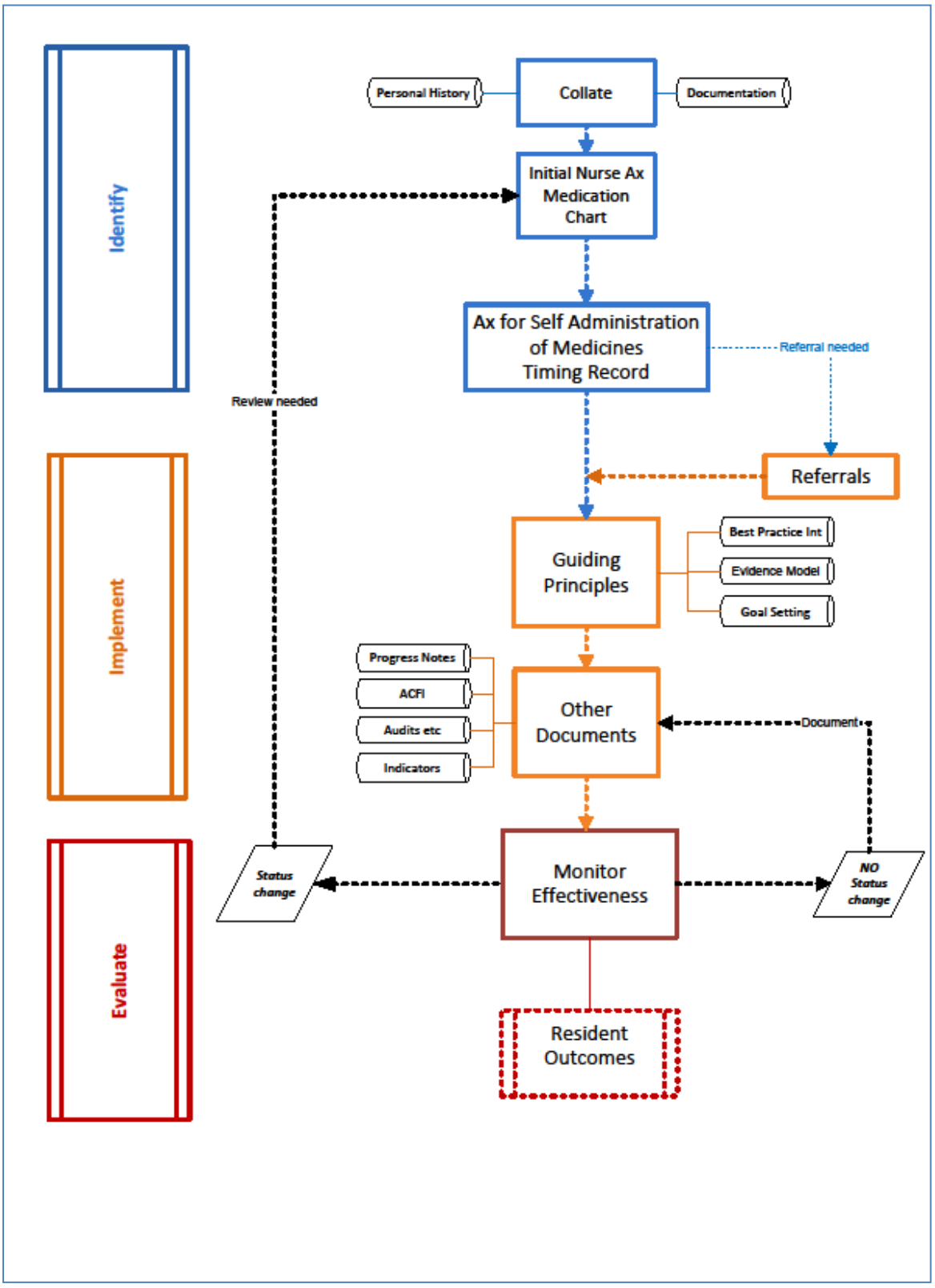
The evaluation phase which comprises:

- 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: Medication Information Flow



Medication Resources

The recommended resources and information on where they are found in the toolkit are listed below (Table 4).

Table 4: Medication Resources

Resource Type	Details	Toolkit Document
Background Reading	*Guiding Principles for Medication Management in Residential Aged Care Facilities (2012)* *Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities (2006)*	Reading Pack (facility to download)
Background Reading	BCOPE pp.199, 201-4	Reading Pack (facility to download)
Screen	Initial Nurse Assessment (e.g. CHA)	Medication Assessment Pack
Self-administration Assessment	Medication Self-administration Assessment	Medication Assessment Pack
Medication Timing Record	Example provided	Medication Assessment Pack
Standardised Care Processes (SCP)	Polypharmacy	Medication Assessment Pack
Goal setting example	Quality Of Life Questionnaire	Reading Pack
Workbook Exercises	Practice using a Case Study	Medication Workbook Appendix

Medication References

The resources recommended to ensure effective implementation of the toolkit and a comprehensive assessment approach to care in this domain are listed below (Table 5) and references provided.

Table 5: References for the Medication Topic

Document	Reference
BCOPE	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. http://www.health.vic.gov.au/older/toolkit/index.htm
Comprehensive Health Assessment (CHA) for Older People in the Health Care System	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria. The CHA is an example of an initial nurse assessment, it is based on the CHAOP resource.
Comprehensive Health Assessment of 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).
Medication Self-administration Assessment	Sourced from 'Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities' (2006) p.62-63 http://www.health.vic.gov.au/dpcs/downloads/medication/resource_kit_apac.pdf
Medication Chart	Referred to in the Department of Health ACFI User Guide https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-user-guide
Standardised Care Process: Polypharmacy	Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Authors: La Trobe University ACEBAC http://www.health.vic.gov.au/agedcare/downloads/score/polypharmacy_scp.pdf
NATFRAME Care Profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi
Resource Kit to Implement APAC Guidelines	Department of Human Services, Resource Kit to enable implementation of the APAC Guidelines for Medication Management in Residential Aged Care Facilities' (2006). http://www.health.vic.gov.au/dpcs/downloads/medication/resource_kit_apac.pdf
Medication management guidelines	Department of Health and Ageing (2012), Guiding principles for medication management in residential aged care facilities http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm
Reference Ranges for Aged Care Quality Indicators	Department of Health (2011), Development of Reference Ranges for Aged Care Quality Indicators. http://www.health.vic.gov.au/agedcare/publications/quality_ranges.htm

Medication Workbook Exercise

Now that you have worked through the Medication Topic, you are ready to complete a small case study. You may choose to do this by yourself or as a group discussion.

Insert a case study relevant to ACFI 11

What clinical history is relevant?

What personal history is relevant?

Medication Appendix

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 up to 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

……

Medication Appendix

Complete the following ACFI 11 Checklists and note the evidence you have for that claim.

Highlight the relevant part of the response	**Evidence**
No medication	
Self-manages medication	
Application of patches at least weekly, but less frequently than daily	
Needs assistance for less than 6 minutes per 24 hour period with daily medications	
Needs assistance for between 6-11 minutes per 24 hour period with daily medications	
Needs assistance for more than 11 minutes per 24 hour period with daily medications	
Needs daily administration of a subcutaneous drug	
Needs daily administration of an intramuscular drug	
Needs daily administration of an intravenous drug	