Better Care Better ACFI

A two day training workshop on the
Evidence **B**ased **C**linical **A**ssessment **T**oolkit

Welcome

This 2 day training workshop will introduce you to the

Evidence Based Clinical Assessment Toolkit (EBCAT) resources.

Designed by Applied Aged Care Solutions.

To support PSRACS staff to become leaders in providing BETTER CARE & achieving BETTER ACFI outcomes.

AACS trainers

Janet Opie & Akira Kikkawa

Objectives

At the end of the 2 day workshop you should:

- ❑ Know about the EBCAT resources and how to access them
- ❑ Know about the recommended evidence based assessments
- ❑ Understand the purpose of documentation
- ❑ Understand how to develop and use an Evidence Profile
- ❑ Understand how to develop and use a SMART goal
- ❑ Know how to develop evidence-based Care Plans
- ❑ Know how to develop accurate and robust ACFI claims
- ❑ Understand how to achieve **BEST CARE** for residents & **BETTER ACFI** claims

Program Day 1

9.30 – 10.45am	Objectives & Background Documentation and Evidence EBCAT Process: Phases 1-4 Evidence Profiles
10.45 – 11.00am	BREAK
11.00 – 12.30pm	Evidence for the Care Plan & ACFI (Part 1 Physical Functioning)
12.30 – 1.00pm	LUNCH
1.00 – 2.15pm	Evidence for the Care Plan & ACFI (Part 2 Pain)
2.15 – 2.30pm	AFTERNOON TEA
2.30 – 4.00pm	Developing an evidence-based Therapy Care Plan Case study Summary and Close of Day 1

Program Day 2

	Day 2
9.00 – 10.45am	Review of Day 1 and objectives Developing an evidence-based Behavioural Care Plan -Evidence for the Care Plan & ACFI (Part 3 Cognition & BPSD)
10.45 – 11.00am	BREAK
11.00 – 12.30pm	Developing an evidence-based Behavioural Care Plan -Evidence for the Care Plan & ACFI (Part 4 Depression)
12.30 – 1.00pm	LUNCH
1.00 – 2.15pm	Case Study: How to support the ACFI
2.15 – 2.30pm	AFTERNOON TEA
2.30 – 3.30pm	Documentation for good care and ACFI Summary and Close of Workshop

Introductions

Applied Aged Care Solutions

- Developer of ACFI tools and audit process
- Work history with government and the industry
- AACS and ACFI reviews

Your expectations

Background

Why the EBCAT and BCBA were developed
To streamline assessment and care processes with the goals of improving the clinical outcomes and quality of life for the residents and best possible ACFI claims.
In response to ACFI changes for more stringent evidence, and lessons from the ACFI and documentation review processes by AACS
Care and funding best defended when o Based on evidence-informed clinical practices and tools o ACFI is integrated with the broader care documentation

Background

How resources were developed
o Driven by an evidence-informed process
o Based on a structured and systematic research approach, sound evidence and principles, and Australian resources
o Around a consistent (nursing) process - Prepare, Identify, Implement, Evaluate

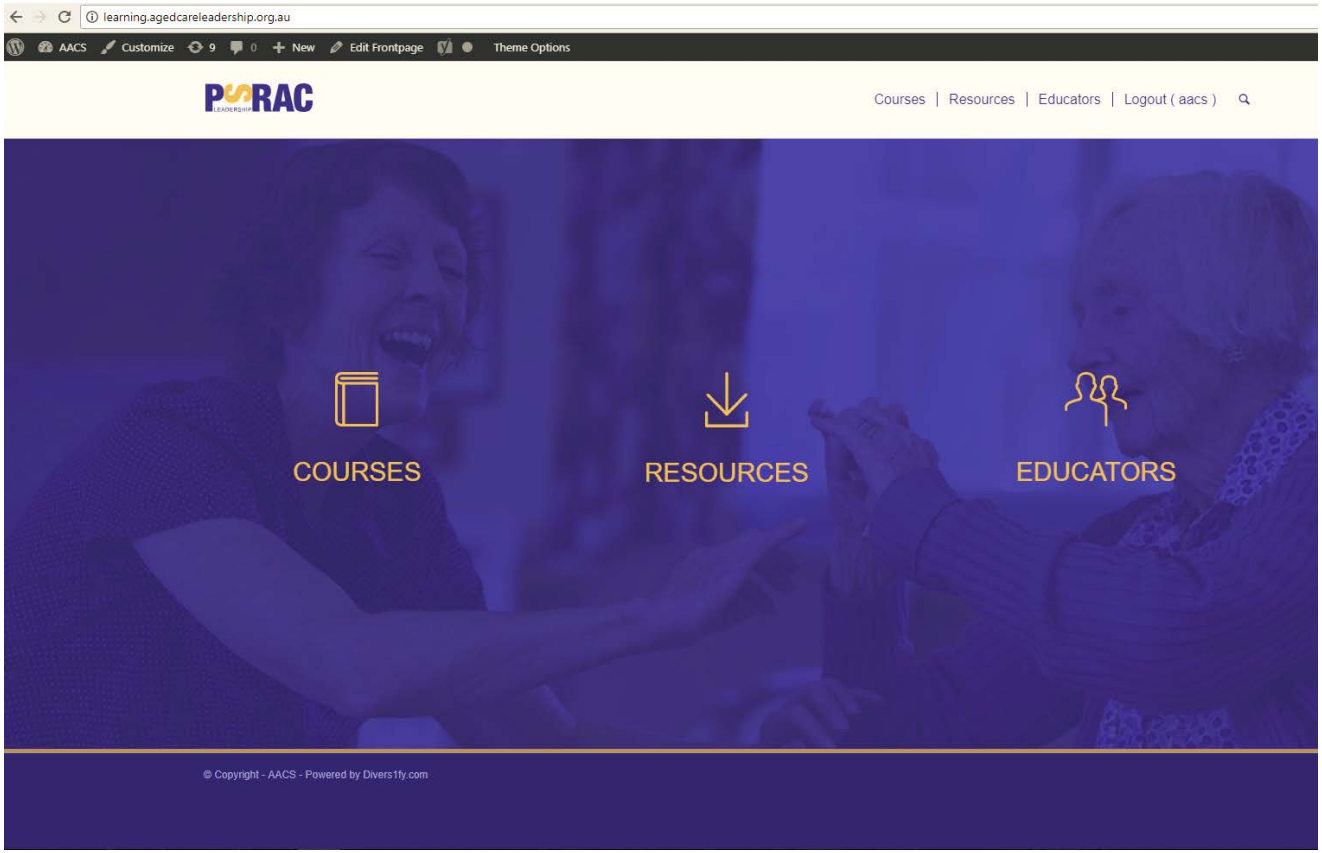
Background

What was developed
o EBCAT resources
o BCBA Training
o Evidence-based assessments to identify needs and to evaluate care
o A process that leads to accountable documentation
o Evidence-informed care plans that are innovative, best practice, improve the resident quality of care and life
o Accurate and robust ACFI claims

BCBA E-learning

http://learning.agedcareleadership.org.au

Interactive educational modules for individuals or led by an educator. Register for access.



Courses- Assessment Tutorials

Video assessment tutorials provide an interactive experience on the assessment and care planning aspects of the presented topics. There are quizzes to test user understanding of the information presented.
Swallowing Screen and Care Planning
Assessing Falls Risk in a resident with no history of a recent fall
Assessing Falls Risk in a resident after a recent fall
Assessing ADL needs using an observational approach
Assessing mobility of a resident with moderate to severe limitations
Assessing mobility of a resident with severe activity limitations
Assessing cognition of a resident who is not suitable to be interviewed
Assessing cognition using the PAS-CIS

Courses- EBCAT

Presentations walk the user through the EBCAT process and assessment tools for each domain and topics. Providing an interactive experience with feedback to users on their level of knowledge on the presented information.
Introduction (Introductory Guide)
Activities of Daily Living presentation and resources (ADL Workbook & Assessment Pack & Quick Guide & ADL Quiz) and ADL Case Study
Continence presentation and resources
Cognition presentation and resources
Behavioural Expressions presentation and resources
Medication presentation and resources
Complex Health presentation (Pain, Swallowing, Skin & Wounds) and resources
General Quizzes (ACFI & EBCAT quizzes)

Resources

🕮 Workbooks (6)	Reference material for each domain
🕮 Assessment Packs (6)	Recommended tools for each domain
🕮 Quick Guides (6)	Overview of process & tools for each domain
🕮 BCBA Participant Workbooks	As provided in BCBA training sessions
🕮 ACFI Resources	User Guide, Assessment Pack, Answer Appraisal Pack, Classification Principles 2014
🕮 Assessment Support Materials	Implementation Guide for Falls; PAS User Guide; PMG Kit; Continence Tools for RACS Education Guide
🕮 Global Resources	BCOPE; CHA; CHAOP; QOL; SMART Goals; SCP

ACFI Refresher

ACFI Principles

ACFI is not prescriptive, it allows the facility to direct the appropriate care plan and interventions using best practices.

ACFI is not a comprehensive assessment, but is complimentary to a nursing assessment, Quality Assurance approach.

Legislation requirements ensure the delivery of all aspects of care, => quality of care and quality of life issues of the resident are rights of paramount importance.

— *Aged Care Accreditation, Specified Care and Services*

ACFI Refresher

ACFI Changes related to assessments and evidence requirements

- 2013: **Further evidence** to support funding claims in ADL and in pain.
- 2013: More stringent penalties for providers with **inaccurate or misleading** ACFI appraisals from 1 July 2013
- 2017: **Further evidence** required to justify why PAS-CIS could not be conducted
- 2017: ACFI 11 into 3 ratings, ACFI 12 (12.1 score, 12.4b timing, 12.12 a /b) => CHC matrix changes
- Future: **Possible increased mandatory assessments** and possible addition of **therapy program** (Review of the ACFI Report, 2017 by AACS at https://agedcare.health.gov.au/reform/review-of-the-aged-care-funding-instrument-report)

ACFI Evidence Types

	Domain	Diagnoses	Required evidence	Supporting Evidence
	Source Docum'ts	***12/12 lifespan 540, 550A, 550B, 560*** ACCR; MP notes/ letters		Clinical Reports
1-4	ADLs	Supporting evidence- Physical, Sensory, Cognition, Behav'l	***6/12 lifespan*** Evidence-based $A_{x:}$ e.g. MNA, FRAT, PMS, ROM,	Physio Assessment
5	Continence	Incontinence, Flowchart	***6/12 lifespan*** Continence Records	Comprehensive Assessment; Prior evidence of incontinence
6	Cognition	Supporting evidence- Dementia dx, Mental Health dx	***6/12 lifespan*** PAS-CIS	Clinical Report
			Q6 Checklist	Memory, personal care, orientation, communication
7-9	Behaviours	Dementia, MH	***6/12 lifespan*** Behaviour Records;	Documentation of behaviours, CA_x
10	Depression	Depression/Mood	***6/12 lifespan*** CSDD	Clinical Report
11	Medication		Medication Chart	
12	Complex Health	For some items	Pain/Skin/Swallowing/ Wound A_x ; Directives for all items; (ongoing) Records of Treatment for some items	

ACFI Business Rules

Classification	Will not generally expire
	Expires six months after entry from in-patient hospital event
	Expires when on Extended Hospital Leave (EHL) for 30 days or more
	Expires six months after returning from EHL
	Expires when more than 28 days elapse between transfers from another aged care facility
	Expires on Secretary request
	Expires six months after “significant change” claim
Sig Change	Increase of 2 or more classification levels in one domain or one jump in two domains
	If have HIGH in ADL and increase from MED to HIGH in CHC

ACFI Business Rules

Re-appraisals	Can be made 12 months after classification
	If classified NNN
	Within 2 months of transfer from another aged care facility
	Begins one month before a classification expires until one month after it expires
	If classification expires during EHL, it is for 2 months starting on day of return
Appraisals	Not in first 7 days unless resident leaves before 7 days passed
	Conducted within 2 months of entry, can be submitted after 28 days
	Do not be late, reduced daily subsidies if after 3 months from appraisal period

ACFI Evidence Lifespan

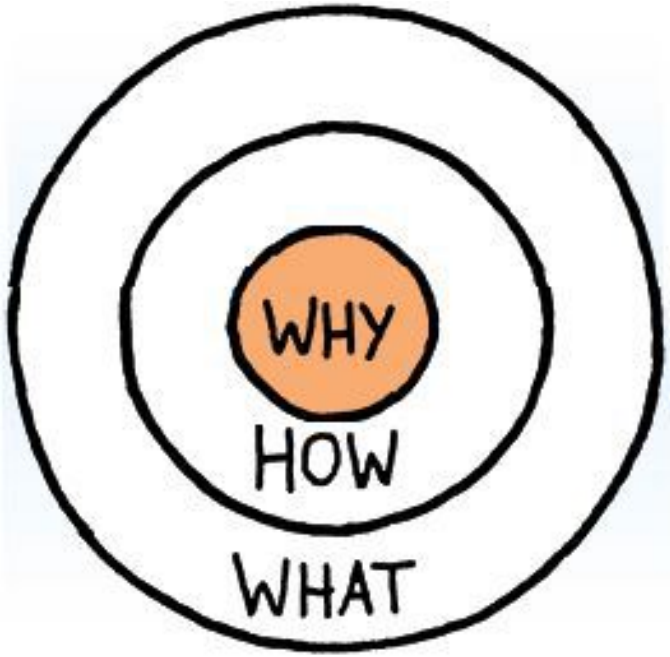
#	Type	Details	Can use for
1-4	Assessment	Evidence-based	6 months
5	ACFI Assessment	Continence Record	6 months
6	ACFI Assessment	PAS – CIS or Checklist	6 months
7-9	ACFI Assessment	Behaviour Records	6 months
10	ACFI Assessment	Cornell	6 months
11	Source Document	Medication Chart	12 months
12	Source Document	Directives; Assessments (Pain, Skin Integrity, Swallowing, Wound);	12 months
	Source Document	Medical Diagnoses	unlimited
	Source Document	Mental & Behavioural Diagnoses: 540, 550, 560	12 months
	Source Document	Mental & Behavioural Diagnoses; other	unlimited

Item	Item	Dx or ACCR	Directive	Ax	Record
1	Blood pressure daily		MP		Yes
2	Blood glucose daily		MP		Yes
3	Pain management weekly		RN or MP or AH	Pain	Yes
4a	Complex Pain by RN/AHP - weekly		RN or MP or AH	Pain	Yes
4b	Complex Pain by AHP - 4/week		MP or AH	Pain	Yes
5	Complex Skin Integrity – 4/ day		RN or MP or AH	Skin	
6	Special feeding by RN daily for dysphagia	✓	RN or MP or AH	Swallowing	
7	Suppositories and enemas weekly		RN or MP		Yes
8	On going Catheter care	✓	RN or MP		
9	Chronic infectious conditions	✓	RN or MP		
10	Chronic wounds	✓	RN or MP or AH	Wound	Yes
11	Intravenous fluids etc		Auth NP or MP		
12a/b	Arthritis & Oedema, Oedema, Chronic skin	✓	RN or MP or AH		
13	Oxygen therapy not self managed	✓	RN or MP		
14	Palliative care		CNC/CNS or MP	Pain	
15	Stoma care	✓	RN or MP		
16	Suctioning, tracheostomy care	✓	RN or MP		
17	Ongoing tube feeding	✓	RN or MP or AH		
18	Technical equipment for continuous monitoring [CACP]		RN or MP		Yes

Documentation & Evidence

The Purpose of Documentation

- **WHY** do we care about documentation?
- **HOW** do we achieve good documentation?
- **WHAT** must we do?



Documentation & Evidence

WHY: The Purpose of Documentation

Professional care is founded on sound evidence and good documentation practices, and this results in robust evidence being available for ACFI claims.

Documentation & Evidence

There is a clear link between

Evidence-based assessments and a good documentation process will result in BETTER CARE outcomes for the resident + BETTER ACFI's

Documentation & Evidence

Statement: “Mr. V. needs two staff to assist with mobility.”

Is this describing

- Evidence of a care need?
- Information about how to provide care?

What should the ‘evidence of a care need’ look like?

Documentation & Evidence

It might be a documented diagnosis, an assessment of physical functioning, how that impacts on the mobility function, and what type of assistance is required to address the identified issue:

Documentation & Evidence

For example

"Mr. V. has a diagnosis from his GP of severe arthritis in his left hip, the physical functioning assessment results indicate an unsteady balance and gait which impacts on his mobility. To address the unsteady balance and gait the physiotherapist recommends a 4WF and physical assistance from two staff when ambulating out of his bedroom e.g. staff member on each side, providing weight bearing support and guiding the mobility aid".

Common Documentation Issues

Diagnosis	Lack of supporting diagnoses, to strengthen the evidence
Assessment	Lack of details (beyond the score) that inform on care needs
Analysis	Where is the linking of the evidence (diagnoses, source information, collated information and assessment outcomes) to the impairment or need and then the link to the strategy?
Description	Level of assistance is not fully described
Incongruence	Across documents (assessments, progress notes, Care Plan etc.), within documents
Clerical Errors, Accuracy	Missing name, profession, signature, correct date, incorrect scoring, out of date information documentation

❖ Activity: Documentation & Evidence

Topic of Nutrition

- Review the facility's documentation
- Identify the documentation issues, gaps, incongruities
- Consider the appropriateness of the information as evidence for ACFI purposes
- Complete ACFI 1

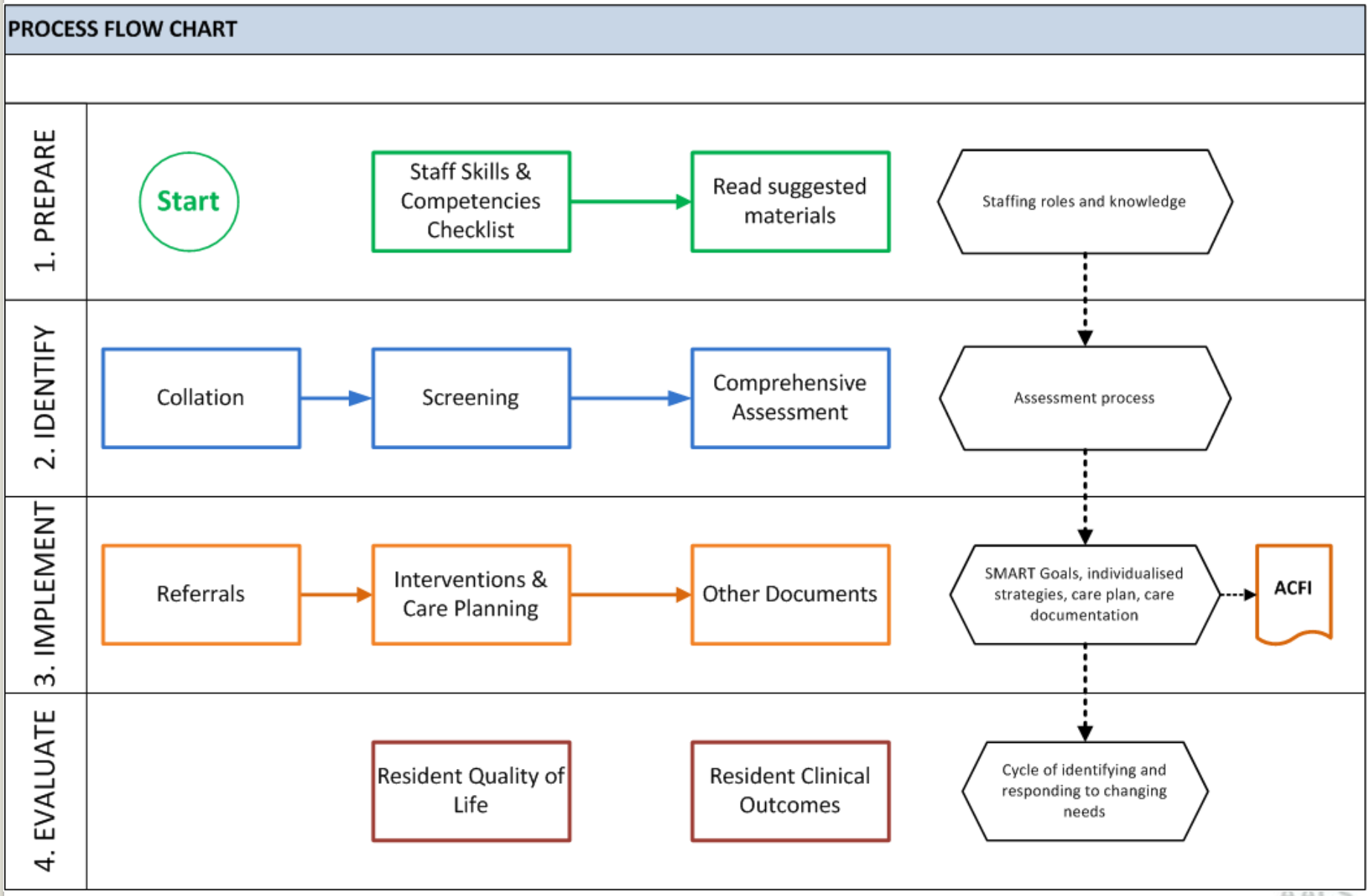
EBCAT Process

The 4 step process is based on a nursing process:

1: Preparation
2: Identification
3: Implementation
4: Evaluation

The EBCAT documentation process is designed to be applied across care needs, no matter the assessment tool or the funding tool.

Process

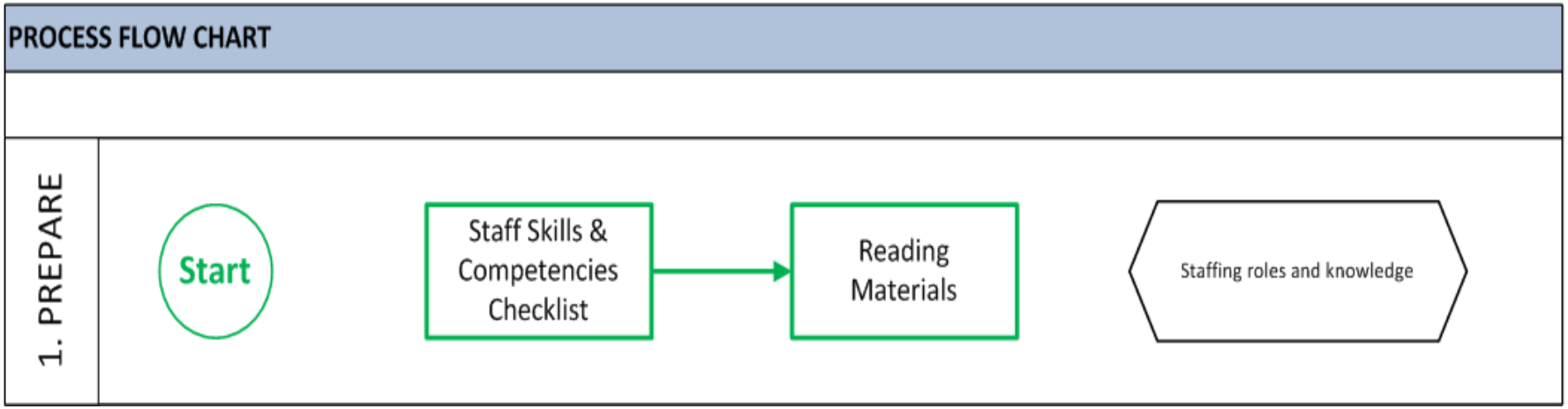

PROCESS FLOW CHART
1. PREPARE
Start
Staff Skills & Competencies Checklist
Read suggested materials
Staffing roles and knowledge
2. IDENTIFY
Collation
Screening
Comprehensive Assessment
Assessment process
3. IMPLEMENT
Referrals
Interventions & Care Planning
Other Documents
SMART Goals, individualised strategies, care plan, care documentation
ACFI
4. EVALUATE
Resident Quality of Life
Resident Clinical Outcomes
Cycle of identifying and responding to changing needs

Process applied across domains

Domains	Topics	ACFI Q
Activities of Daily Living	▪ **Nutrition** ▪ **Mobility** ▪ **Self-Care**	▪ ACFI 1 ▪ ACFI 2 ▪ ACFI 3, 4
Continence	▪ Continence	▪ ACFI 5
Cognition	▪ **Cognition**	▪ ACFI 6
Behavioural Expressions	▪ **Behaviours, Mood** and Psychiatric symptoms	▪ ACFI 7, 8, 9, 10
Medicines	▪ Medicines	▪ ACFI 11
Complex Health	▪ **Pain** ▪ **Swallowing** ▪ Skin and Wounds	▪ ACFI 12.3, 12.4a, 12.4b ▪ ACFI 12.6 ▪ ACFI 12.5, 12.10, 12.12

EBCAT Process Phase 1: Preparation

- Organisational Readiness
- Selecting team members
- Preparing team members

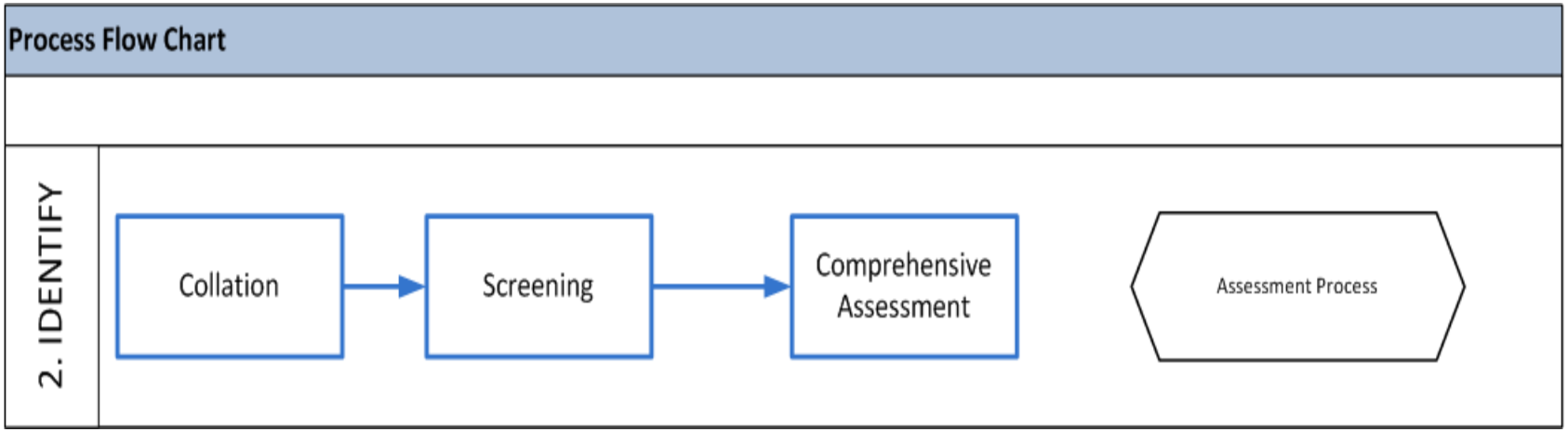


Preparation

- **Introductory Guide** provides details about preparing the organisation.
- Think about the staff skills, experience or qualifications required. How can any gaps be identified and addressed?
  - **Workbooks** provide activity templates for identifying required staffing resources
  - **Workbooks** provides reading summaries for each Topic
  - **BCBA e-learning** provides training modules
  - **Training** on the Topic, assessments, tools

EBCAT Process Phase 2: Identification

- Collate and review available information from documents, resident and family
- Conduct a screen
- Conduct assessments



Collation

Review the File Notes

Collating and reviewing current documentation enables a picture to be built of the resident's relevant history.

What documents should be collated and reviewed?

Include the Consumer

Quality of life is not primarily defined by medical care, but by the way the person feels about their situation. The aim is to understand the things that are important to the individual and use this knowledge to enhance their enjoyment of life

How do you include the resident and their family?

Screening – Initial Nurse Assessment

The **recommended screen** for most topics including Nutrition:

- Initial nurse assessment - EBCAT uses the Comprehensive Health Assessment (CHA) for Older People in the Health Care System.

Who can do this activity?

- Based on evidence-informed practice, nurses (RNs and ENs) 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.

Why screen for swallowing?

- Victorian Institute of Forensic Medicine (Aug 2017) recommendations for prevention of injury-related deaths in RACS- choking incidents.

Comprehensive Assessment

An in-depth assessment approach follows the initial screening. In the topic of Nutrition the following are recommended:

- Natframe assessments: **Resident Nutrition Data Card** (RNDC) or
- Natframe/NSAF assessments: **Mini Nutritional Assessment** (MNA).
- **Range of Movement** (ROM) across all joints be completed on residents.
- **Grip test**

📖 **ADL ASSESSMENT PACK at the BCBA e-learning portal**

Assessment Tools

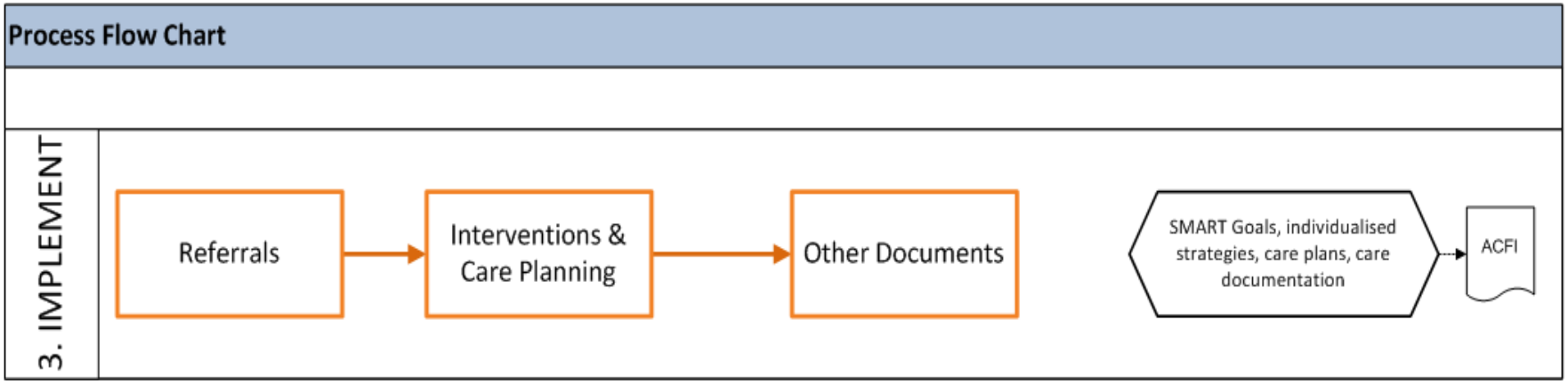
Domain	Topic & Source	Assessment
ADL	Nutrition Mobility Self-care (NATFRAME & CHA)	RNDC, (MNA) ROM, Grip test FRAT, (PMS with guided instructions) Observation of Performance
Continence	Continence (ACF)	Continence Records, Continence Resources for Community and Residential Care
Cognition	Cognition (DOMS)	PAS-CIS, KICA-COG, RUDAS, (SMMSE)
Behavioural Expressions	Behaviours (NATFRAME) Mood & Psychiatric symptoms	Behaviour Records, Modified BAF Modified Cornell Scale Of Depression in Depression (CSDD)

Assessment Tools

Domain	Topic & Source	Assessment
Medication	Administered Medicines (APAC Kit)	Self-administration of Medicines Assessment
Complex Health	Pain (PMG Kit)	Observation: Abbey and PAINAD Interview: Modified Residents Verbal Pain Inventory Pain Intensity: Visual Analogue & Thermometer
Complex Health	Swallowing (CHA)	Standardised method provided to complete 5 screen items
Complex Health	Skin & Wounds (NATFRAME)	Waterlow Skin Integrity Assessment Wound Assessment

EBCAT Process Phase 3: Implementation

- Referrals
- Interventions, SMART Goals and the Care Plan
- Complete ACFI and other care documents



Referral Lists

Referral lists, based on what is available in your local area and a list of important website contacts to find a practitioner or advice.

A suggested format for a Referrals table is provided for each Topic in each 📖 **EBCAT Workbook**.

Interventions

The interventions should improve or maintain the health status and the Quality of Life (QoL) of the resident.

- Each 📖**EBCAT Workbook** discusses evidence-informed strategies.
- The 📖 **EBCAT Resource Pack** provides an example QOL questionnaire.
- The Evidence Profile identifies where interventions are required.

Care Planning

- Addresses a range of issues to improve or maintain the residents' health status, participation and their quality of life.
- **Individualised** for each resident, inclusive of resident and family views.
- Provides a form of **communication** between the care team.

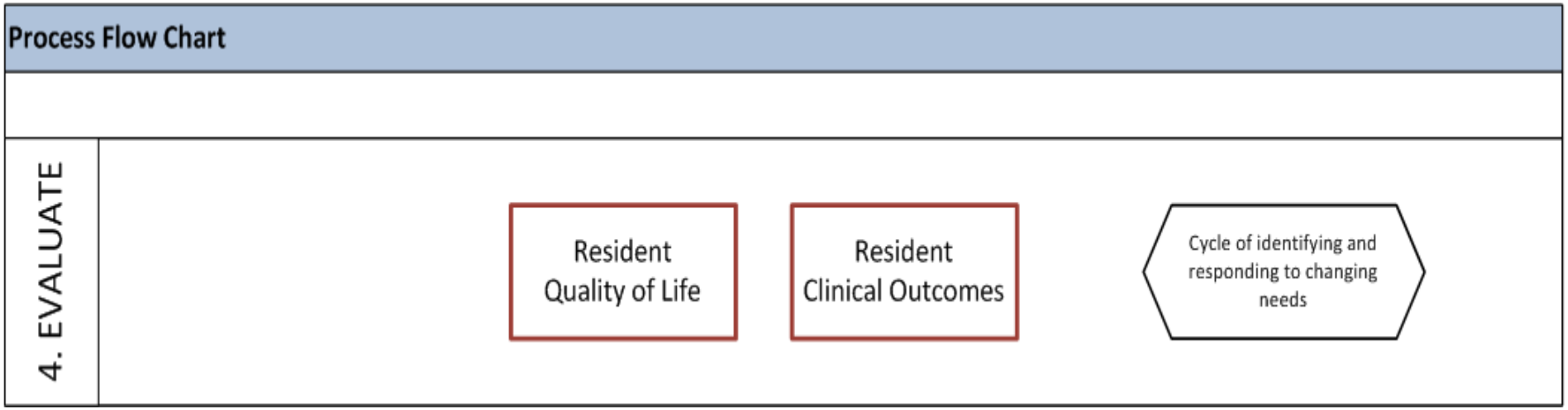
Completing the ACFI

- The EBCAT process will result in the maintenance of objective documentation, that can support robust ACFI claims.
- The e-learning package contains case studies for users to test their skills and knowledge for ACFI.
- Each 🕮 **EBCAT Workbook** sets out the source information to support the ACFI.
- The following table is taken from the ADL Workbook (Nutrition Topic).

ACFI Question 1: Nutrition	Examples: where to find the evidence
All ACFI 1 checklist items	Dietitian or Speech Pathologist notes ACCR/NSAF or Medical Practitioner notes
Readiness to eat: Supervision - placing utensils in hand	ROM Assessment (dexterity and wrist) Documented impairments- physical, sensory, cognitive
Readiness to eat: Physical Assistance - cutting up food or vitamising food	RNDC: Type of diet & Texture
Eating: Supervision - standing by to provide assistance - daily oral intake for PEG feed	RNDC Chewing & Swallowing ability MNA - at nutritional risk (weight loss, recent acute illness)
Eating: Physical assistance - placing or guiding food into the resident's mouth for most of the meal	RNDC Eating Assessment (Total Assistance)

EBCAT Process Phase 4: Evaluation

Evaluation is an essential component of any process as it is the means of determining whether the strategies implemented have achieved the intended outcomes.



Evaluation

- Evaluation involves a systematic determination of the intervention outcomes
- Further improvements
- Emerging new issues
- The goal setting stage provides objective criteria to determine success or otherwise of the intervention
- A quality of life tool can be used
- Family and staff feedback can be collected
- The evaluation criteria can be quantitative or qualitative

Improving Documentation: Evidence Profile

A transparent rationale for why the resident requires a specific type of assistance. The evidence can then deliver accurate care information, and robust and appropriate ACFI claims.

- Underlying issues and symptoms
- Linked to the body structures and/or functions that are impacted
- And the associated activity limitations or issues
- Leading to how to improve resident participation and enjoyment of life

Evidence Profile - linking the evidence

- **Underlying reason why the resident needs the care**
- Sound evidence to base CARE on
- Accurate responses for the ACFI questions
- Maintaining documentation provides easy access to the resident's current care needs
- The following example uses Nutrition to show the development of an Evidence Profile, it demonstrates what evidence may have been collected.

❖ Activity: Swallowing Observation

❖ **Video** - Swallowing Observation

- From the video take notes about his swallowing and the food
- Complete the swallowing screen

❖ Activity: Build an Evidence Profile

Evidence Profile, Care Planning and completing the ACFI

- Build the Evidence profile from the background notes and the swallowing screen
- Develop the Care Plan & the Evaluation approach
- Use the information to complete ACFI 1

Building the Evidence Profile

Swallowing Example	Source
	ACCR (Jan 2015)
	GP (May 2015)
	Resident Interview (April 2015)
	Swallowing Screen
	MNA (June 2015)
	SP Report (June 2015)

Building a Care Plan example

Evidence ⇨ Actions	Source Document
The resident has diagnoses of Parkinson's Disease, dysarthria and dysphagia. The dysphagia has impacted on the type of food that he can safely swallow. To address his swallowing issues:	To be documented in the Care Plan
Referrals made to	Physiotherapist Speech Pathologist
The physiotherapist introduced an XXX program to address the reduced ROM in the joints.	Physiotherapist
The speech pathologist recommended XXX strategies for staff. Nurse educator to run sessions for staff.	Speech Pathologist Training Plans and Records
Nutritional Status- MNA; Adverse Events; Meal satisfaction (resident), sense of competency (staff)	Evaluation Plan

Developing an evidence-based Care Plan

Evidence-based Therapy Care Plan

Part 1 (Functional)

- Wellness based approach
- Physical Functioning Assessments
- Evidence Profiles
- Care Plans
- Evaluation Plans
- ACFI Outcomes

Part 2 (Pain)

- Pain Assessments
- Implementing a Therapy Program

Developing an evidence-based Care Plan

What is a wellness based approach

"Wellness is building on strengths and goals of individuals to promote independence in daily living skills" *(Nous Group)*

Exercise and therapy can:

- Positively impact on chronic disease prevention, functional status, psychological well-being and social outcomes
  (Baum, Merom, & Bull, 2016)

- Maximise opportunities for personal independence, social connectedness, security, activity and dignity
  (BCOPE, 2012)

Physical Functioning Assessments

What are the Physical Functioning Assessments?

Activities of Daily Living		
Mobility	Physical Mobility Scale	NATFRAME
Mobility	Falls Risk Assessment Tool	NATFRAME
ADLs	Range of Movement	CHAOP
ADLs	Grip Test (optional)	Reference

CHAOP- Comprehensive Health Assessment of the Older Person

NATFRAME- National Framework for Documenting Care in Residential Aged Care Services

Grip Test reference: J Nutritional Health Aging 2012; 16(9): 769-74)

Range of Movement

Range of Movement (ROM)- UL demonstration

- The ROM scores 12 joints for muscle strength, tone and movement.
- The strength of each movement is recorded on a (0-5 scale), if less than 3 then disability is present.
- The joints assessed are: temporomandibular, neck, shoulders, elbows, forearms, wrists, fingers and thumb, hips, knees, ankles, toes, spine.
- Module 3 of the CHAOP informs on ROM assessment.
- For nursing staff (with the appropriate training).

❖ Activity: ROM

- ❖ Video - ROM assessment
  - Take notes on the ROM assessment (Lower limbs)
  - Build the Evidence Profile

Falls Risk Assessment Tool (FRAT)

- The FRAT is a validated assessment tool.
- A *screening* tool – provides a risk score and identifies residents most at risk.
- An *assessment* tool – identifies risk factors and assists with the planning and management of the at-risk residents.
- For nursing staff (with the appropriate training).

❖ Activity: Falls Risk Assessment Tool (FRAT)

❖ Video – FRAT Care Planning

- Take notes on the FRAT care planning (Physio and care staff)
- We will discuss the FRAT score and the care discussion
- In groups, complete the Evidence Profile, Care Plan & Evaluation.

❖ Activity: FRAT Score

FRAT Item	Score
Recent Falls- one in last 3 months	
Medications- sedatives, diuretics, anti-hypertensives	
Psychological- no anxiety, dementia, depression, has insight and judgement	
Cognitive Status - Mildly impaired	
RATING:	
Any changes to rating?	
Why?	

❖ Activity: ROM & FRAT Evidence Profile

The PMS Evidence	Source
	Assessment: Range of Movement – lower limb
	Assessment: FRAT
	Care Plan
	Evaluation Plan

Physical Mobility Scale (PMS)

Functional Assessment

- The Physical Mobility Scale (PMS) was specifically developed for residential aged care.
- The PMS can be completed by the nursing staff with the appropriate training.
- It has 9 items scored from 0-5 (dependent to independent scale) and produces objective information for care planning.
- Guidelines for the use of PMS

❖ Activity: Physical Mobility Scale (PMS)

PMS Assessment & Evidence Profile

❖ **Video** - PMS Assessment

- Score the PMS as you watch the video, discussion of PMS score
- In groups, complete the Evidence Profile, Care Plan
- Score the ACFI items (Q2-Q4) using the PMS

❖ Activity: PMS Score

PMS Item	Score
Supine to Side Lying (R/L)	
Supine to Sit	
Sitting Balance	
Sitting to Standing	
Standing to Sitting	
Standing Balance	
Transfers	
Ambulation/Mobility	

❖ Activity: PMS Evidence Profile

The PMS Evidence	Source
	PMS Item Standing Balance, score= 0
	PMS Item Supine to side, score =1
	Care Plan

Possible concerns

What happens when the initial PMS or FRAT scores are different between assessors?

- Where did the differences arise?
- What may have caused the different scores?
- How should the scores be interpreted and used effectively?

Discuss- to establish a safe and effective care plan from the assessment results

Process for an evidence-based Care Plan

Process => ACFI Outcomes + Good care

- Accountable documentation process
- Quality communication
- Congruent Evidence Profile
- Objective outcomes (for ACFI and Evaluation)
- Evidence-based care

Developing an evidence-based Care Plan

Evidence-based Therapy Care Plan

Part 1 (Functional)

- Wellness based approach
- Physical Functioning Assessments
- Evidence Profiles
- Care Plans
- Evaluation Plans
- ACFI Outcomes

Part 2 (Pain)

- Pain Assessments
- Implementing a Therapy Program

Why Pain Assessments

Role of Pain assessments in good care?

- Pain is broader than the ACFI, and is highly prevalent in RACF
- Pain impacts on ADLs, cognitive skills and behaviour
  - Quality of life
  - Ability to function effectively
  - Level of social interactions
  - Appetite
  - Sleep, resting patterns and psychological wellbeing (anxiety, depression)

  (PMG Kit for Aged Care, 2007)
- Interventions can help to address pain → function → independence, wellbeing

PMG Kit Guidelines

- Pain assessment is an ongoing process - admission, significant changes, suspected, at least every three months;
- Combined observational and self reports;
- Diagnosis is vital for effective management;
- A multi-faceted investigation approach;
- Appropriate structured pain assessment;
- Pain intensity scales for ongoing evaluation

Pain Assessments

Pain assessments		
Screening	COLDSPA	CHA
Pain Assessment	Abbey/ PAINAD	PMG Kit
	M-RVBPI	PMG Kit
	Pain Intensity Tools	PMG Kit

CHA - Comprehensive Health Assessment
PMG Kit- The PMG Kit for Aged Care (2007) - Pain Management Guidelines

Screening for Pain- COLDSPA

C	Character (type)
O	Onset
L	Location
D	Duration
S	Severity
P	Pattern
A	Associated factors
	Observations (facial expressions, vocalisations, body movement, autonomic)

❖ Activity: Pain Screening

COLDSPA

- ❖ **Video** Observation of pain
- ❖ **Video** Resident informing on pain

C	Character (type)
O	Onset
L	Location
D	Duration
S	Severity
P	Pattern
A	Associated factors

❖ Strategies for Pain

❖ Video Pain management discussion

❖ Building a Pain Evidence Profile

Build the Pain Evidence Profile

Evidence, Care Plan and Evaluation	Source Document
	Diagnoses
	COLDSPA
	Resident Interview
	Care Plan
	Evaluation

PAINAD

Pain Assessment In Advanced Dementia

- Breathing
- Negative Vocalisation
- Facial Expression
- Body Language
- Consolability

Scoring

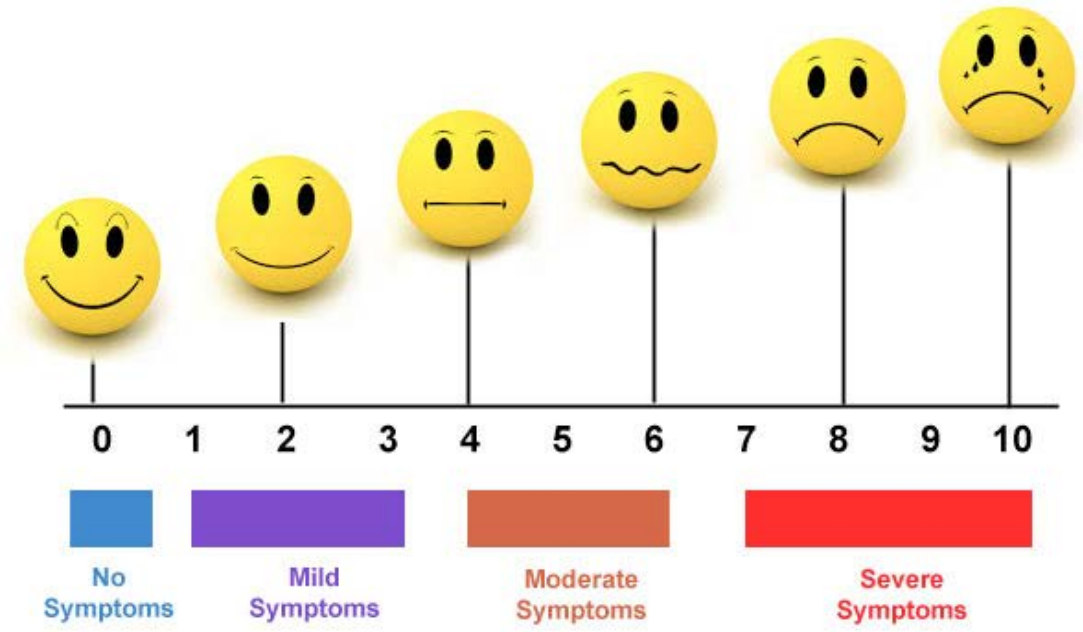
- Descriptions for scoring: (0) (1) (2)
- Range 0-10 (0 being no pain)

PAINAD

	0	1	2	score
Breathing	Normal	Occasional, short period	Noisy, labored, Cheyne-Stokes	
Negative vocalisation	None	Occasional, low level	Repeated calling out, loud moaning, crying	
Facial Expression	Smiling, inexpressive	Sad, frightened, frown	Facial grimacing	
Body Language	Relaxed	Tense, distressed pacing, fidgeting	Rigid, clenched fists, knees pulled up, pulling or pushing away	
Consolability	No need to console	Distracted, reassured by voice or touch	Unable to console, distract, reassure	

❖ Activity: PAINAD

❖ **Video** - PAINAD



ABBEY PAIN SCALE

Abbey items

- Vocalisation
- Facial Expression
- Change in body language
- Behavioural change
- Physiological change
- Physical changes

Scoring:

- Absent (0), Mild (1), Moderate (2), Severe (3)
- 0-2 (none), 3-7 (mild), 8-13 (moderate), 14+ (severe)

Implementing a Therapy Program

Why a wellness/therapy care plan?

Individualised Needs	Intervention Strategies	Communication	Evaluation

• IDENTIFY
• Assessments
  • Physical
  • Pain
  • Psychological
	• IMPLEMENT
	• Evidence-based
	• Referrals
	• SMART goals
		• IMPLEMENT
		• Clear documentation
		• Detailed directives
			• EVALUATE
			• Review SMART goals
			• Objective re-assessment

EBCAT PHASE 2 | EBCAT PHASE 3 | EBCAT PHASE 4

Wellness/Therapy Program

Turning interventions into SMART goals

SMART Goals are:

- **S**pecific
- **M**easurable
- **A**ction-oriented
- **R**ealistic
- **T**ime-based

Resident Goals ≠ Clinical Goals

❖ Activity: Wellness Therapy Plan

- In the first table, an Evidence Profile has been started. You can add more evidence (from other topics maybe) to build your Evidence Profile.
- In the second table, you will describe one SMART goal based on the evidence.
- Include a principle e.g. Person Centred Care.
- Discussion of developed goals.

Why are directives important

- Form of communication … impact on the quality of care delivered and on the robustness of ACFI claims

- To meet the new User Guide requirements- which **applies to ACFI appraisals or reappraisals with a date of effect on or after 1 January 2017.**

Directive description

A **Directive** must:

- be given by a Health Professional acting in their scope of practice;
- be given by a medical practitioner or registered nurse, if specifically required by the item;
- direct the manner in which the care is to be provided, the qualifications of any person involved in providing the care, and the frequency of the treatment; and
- identify the associated management and /or treatment plan.

Ref: ACFI User Guide Page 38

❖ Activity: Document a directive

Statement: “Care staff to apply heat packs for 20 minutes per week”.

Example of a Directive

ACFI 12.3. SIMPLE PAIN DIRECTIVE - Therapeutic Massage AND/OR Application of Heat Packs
for Simple Pain management by care staff for a min of 20 mins per week of staff time in total

Resident name/room: ……..
Assessment tool/date: ……

Treatment ☐ Application of heat packs

Treatment/s 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 ___:___AM/PM ___:___AM/PM ___:___AM/PM

Treatment length: _____mins per session

By staff type (tick) ☐ PCW ☐ EN ☐ RN

Describe the treatment (body part, equipment, preparation, goal of treatment):

Signature/Date
Name/Qualification

❖ Activity: Wellness & Risk Management

Complete the Care Plan including a

- SMART goal
- Physical Therapy Plan
- Risk Management - a care staff member has documented that after his morning routine (pain and PD medications, shower etc.), Don can safely mobilise with 'supervision' from staff. They are concerned that he will lose his independence if he is not allowed to walk without physical assistance.
- What should be documented in the Care Plan?
- How could his mobility independence be promoted or improved?

Summary Day 1

Background	Why EBCAT and BCBA were developed
Resources	http://learning.agedcareleadership.org.au
Documentation & Evidence	Why: Better care, better quality, better communication How: Documentation- assessments, care plans, progress notes What: Evidence of care need, rationale, how to give care
4 Phases	Preparation, Identification, Implementation, Evaluation
Physical Functioning & Pain Assessments	Why it is important and how to use the assessment tools
Developing evidence-based Therapy Care Plan	Benefits and outcomes of wellness-based exercise therapy Identifying needs from assessments Implementing strategies, communicating with directives Using the evidence to inform on ACFI and good care Evaluating the care plan – SMART goals