Better Care Better ACFI

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

Welcome Back

To the Better Care Better ACFI training

Designed by Applied Aged Care Solutions.

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

AACS trainers

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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

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

Objectives

At the end of the 2 day workshop you should:

- ❑ Know about the EBCAT training resources and how to access them
- ❑ Know about the EBCAT 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

Developing a Behavioural Care Plan

Evidence-based Behaviour Care Plan:
Dementia Care & Behavioural Management

Part 3: Cognition & BPSD

Cognition Assessment

- PAS-CIS
- ACFI 6 Checklist

Behavioural Assessment

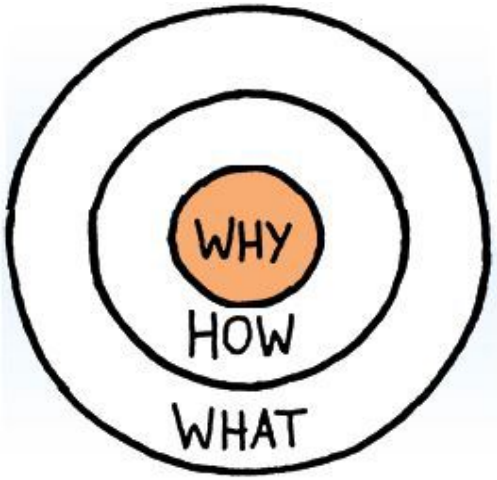
- Objective description
- BAF (ABC approach)

Part 4: Depression

Depression (mood) Assessment

- Modified CSDD

Developing a Behavioural Care Plan



WHY Dementia care and associated BPSD is a core business of aged care. Care planning promotes the quality of life of residents.

HOW Best practice process, evidence-based tools, innovative use of assessment information

WHAT Cognition, Behavioural, Depression assessments and Care Planning.

Assessment of Cognition

WHY: *Cognitive deficits impair a person's ability to function independently in performing everyday living activities, and it will impact on how they interpret and respond to the environment. Understanding the level of cognitive impairment helps in understanding what assistance the person needs.*

WHAT: *Cognition is the set of all mental abilities and processes related to knowledge, attention, memory, judgement, reasoning, decision making, comprehension and language.*

Assessment of Cognition

HOW:

Psychogeriatric Assessment Scales-Cognitive Impairment Scale (PAS-CIS)

- Can the person be interviewed?
- If the resident cannot be interviewed or the PAS-CIS is not suitable, then complete the

ACFI 6 Checklist

Any supporting evidence?

- Other cognitive assessments when the PAS-CIS is not suitable and the resident can be interviewed
- Clinical Reports, ACCR, Diagnoses
- Congruence with the claim

PAS-CIS

Validated for aged care nurses (with training)

Preparing = fit it into Day 9, when I am free?

PAS-CIS = 0 (no impairment) BUT

SMMSE = 0 (severe impairment)

Consists of 9 questions, scored out of 21, score gives a rating. What do you document?

❖ Activity: ACFI 6 PAS-CIS

❖ Video- PAS-CIS Assessment

Psychiatrist Ian Presnell undertaking the cognitive assessment with a resident

Things to note:

Video 1: Setting the scene

- Building rapport, to help put the person at ease
- Informing when the assessment is commencing
- Getting consent

❖ Activity: ACFI 6 PAS-CIS

❖ Video- Discussing the PAS-CIS

Things to note:

Video 2: Discussing the interview

- The PAS-CIS interview process
- The scoring for each PAS-CIS item
- Which items require more detail to score
- Common mistakes when scoring

❖ Activity: ACFI 6 PAS-CIS

Discussion

- Scoring the PAS-CIS
- Notes taken
- Your experience of cognitive assessments
- Using other cognitive assessments
- What do you take away from a total score?

❖ Complete the quiz

Using Cognitive Assessment Outcomes

Area	PAS-CIS	Impairment
Language	Q1: write a sentence	Impaired reading and writing- the person cannot provide written responses or follow written cues.
Memory	Q2: Registration - name 3 objects Q5: Repeat name & address	If memory is compromised, then do not complete higher level cognitive testing. Provides insight into attention and duration of period of focus.
Memory (Episodic recall)	Q2: Re-call the three objects Q5: Recall name and address	Episodic memory is the recollection of where and when events happened in one's own experience. The person will not be able to recall information, such as whether a relative has visited, or how long they have been somewhere.

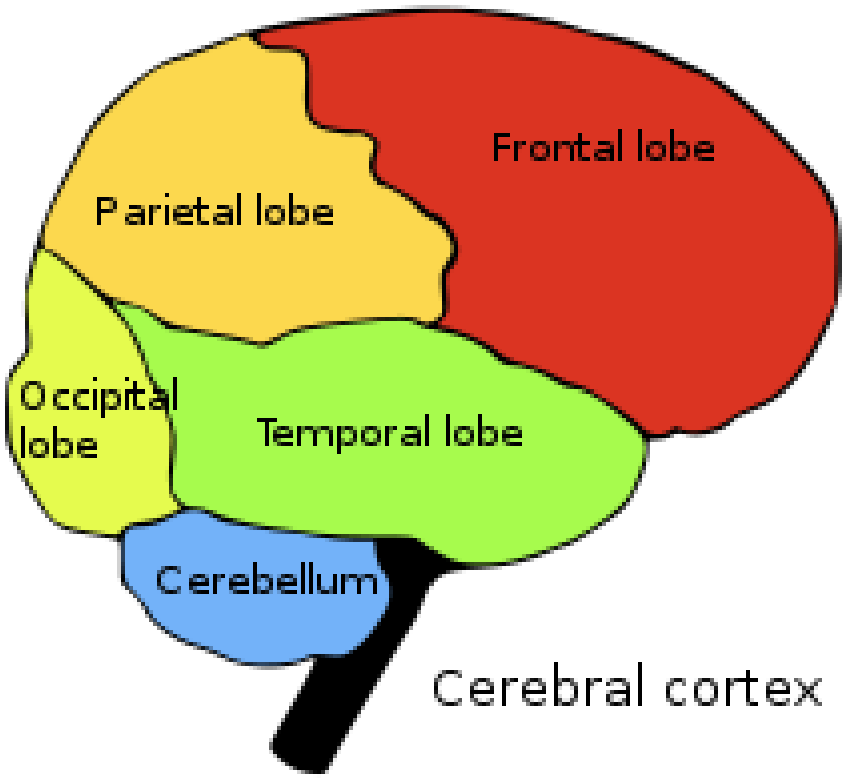
Using Cognitive Assessment Outcomes

Area	PAS-CIS	Impairment
Memory (Semantic recall)	Q3: Famous people Q4: New years eve	Semantic memory is a person's knowledge about the world e.g. facts about events. Usually deteriorates later than episodic memory. The person may have lost access to well learned knowledge- they will not know why they are in the facility, are unlikely to recognise close relatives, and may have loss of recall of earlier life activities.
Perceptual Motor	Q6: Copy the drawing	Loss of skill in ordering processes to make up a whole sequence, so maybe cannot complete an entire activity like bathing.

Using Cognitive Assessment Outcomes

Area	PAS-CIS	Impairment
Perceptual Motor	Q7/8: Read aloud and do the action	The inability to execute a learned purposeful movement is called apraxia. Reading a sentence is also testing language skills. If they cannot do the action they will probably not respond to verbal requests to undertake some daily activities like showering or toileting independently.
Perceptual Motor	Q9: What objects are seen in the picture	The person is no longer able to make sense of the complexity of the sensory world. Sundowning behavior, misunderstanding of things seen (e.g. phantom spouse or other delusional phenomena). They are likely to become agitated and distressed due to the misperception.

Diagnosis & Location can also inform



❖ Activity: ACFI 6 Checklist

❖ Video- ACFI 6 Checklist

Short scene with resident

Discussion between psychiatrist and staff member

Discussion of ACFI 6 checklist for the resident

Start an Evidence Profile, include the following:

- Rationale for the selected level of cognitive deficit
- Evidence to support the checklist result
- Evidence to support choosing *not* to do the assessment?

Evidence Profile

ACFI 6 Checklist Evidence	Source
	Background ACCR GP Family Interview
Memory: Personal Care: Orientation: Communication:	**Checklist** Rating Documentation
	Assessment
To be added	**Behavioural**

Assessment of Behaviours

WHY: *The investigation of behavioural expressions includes assessing cognition, behavioural and psychological symptoms (i.e. mood). If not managed, it leads to a decreased quality of life for the resident.*

WHAT Behaviours: *Behavioural and Psychological Symptoms of dementia (BPSD) - such as agitation, wandering, verbal and physical behaviours, depression, anxiety and psychosis.*

BPSD

- Identify and reduce triggers for BPSD.
- Actively listen to, respond and reassure the patient.
- Be aware that patients with dementia are very sensitive to non-verbal cues … a calm and gentle manner has a positive effect.[4]
- Avoid surrounding the patient with too many staff/people … provide the same staff.
- Provide activities to reduce agitation … quiet areas to retreat to … avoid over stimulating environment.
- Be aware that these symptoms can be an expression of an unmet need such as pain or discomfort.[5]
- Use specialist support from services such as **The Dementia Behaviour Management Advisory Service which provides a 24-hour telephone support service.**

Ref: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/older-people/cognition/dementia/dementia-bpsd

Assessment of Behaviours

HOW:

- An objective description of Behaviours

- A standardised assessment of the contextual setting of the behavioural expression to help identify the trigger/s

Any supporting evidence?

- Clinical Reports, ACCR, Diagnoses
- Congruence with the ACFI claims

Behavioural Description

- How to keep it objective?
- Broader than ACFI behaviours
- Think beyond ACFI definitions
- *What is seen and heard*
- Requires staff intervention

Contextual Description

Standardised to provide consistency and can be trained to

Recommend:

- *ABC Approach*
  - **Antecedent**s (environment- where and when)
  - What is the **Behaviour**
  - What were the **Consequences** - how disruptive is the behaviour and how effective were any strategies.

- *Modified Behaviour Assessment Form (BAF) from the NATRAME*
  - Can then inform on the **ACFI Behaviour Record**

❖ Activity: Behavioural Descriptions

- Write a behaviour description from your experience
- What are the most difficult behaviours?
- Discussion

❖ Activity: Behavioural Assessment

- **Video – Describing Behaviours A**
- **Video – Describe Behaviours B**

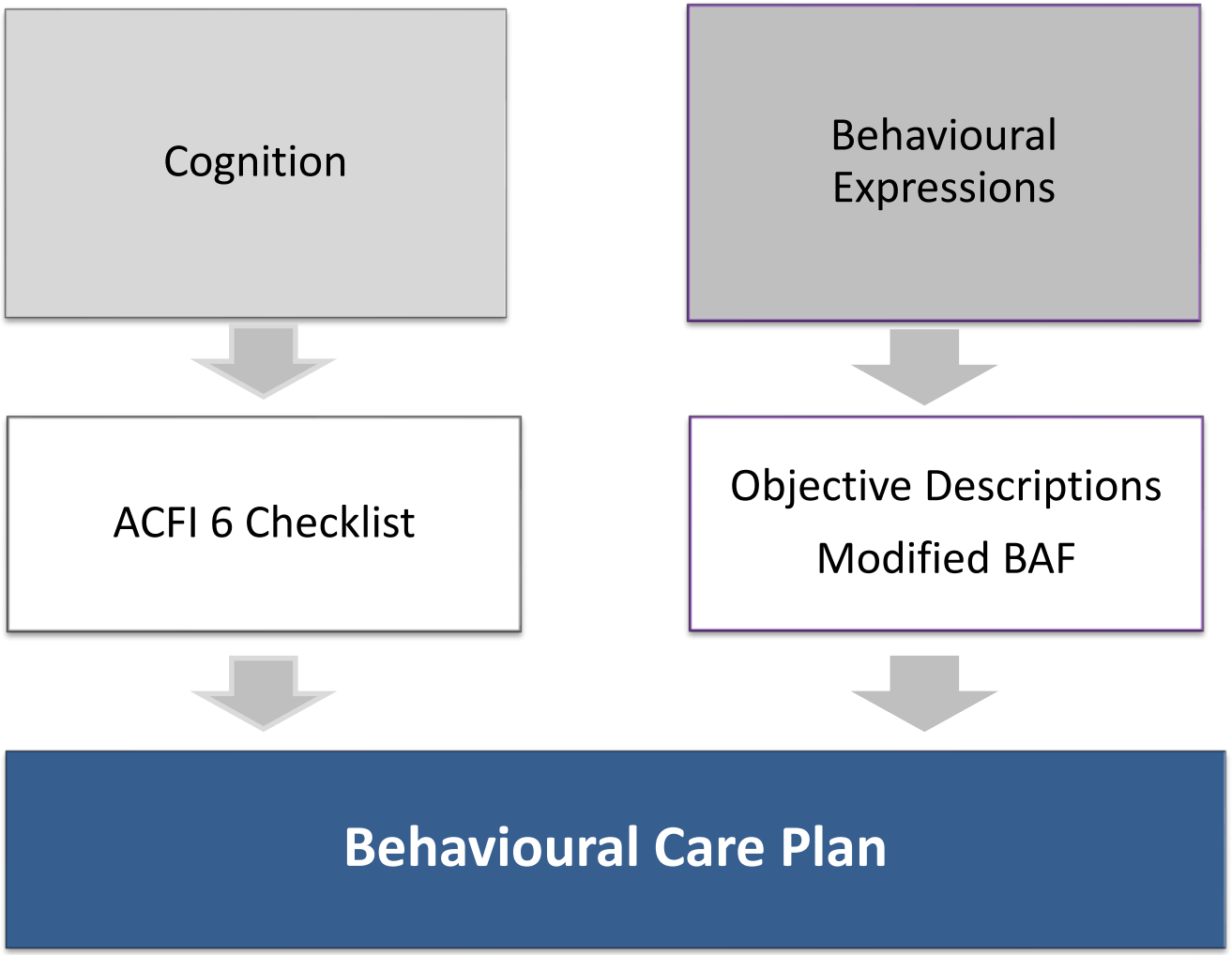
  - Complete the modified Behaviour Assessment Form (BAF)
  - Discussion
  - Complete the Evidence Profile
  - Discussion

Modified Behaviour Assessment Form

ABC	Context	Description
Antecedent	Place	
	Who was present	
	What was happening	
Behaviour	(objective description)	
Consequences	Strategies	
	Disruptiveness (refer to scale)	

Evidence Profile

Evidence	Source
	Background ACCR GP Family Interview
Memory: Personal Care: Orientation: Communication:	**Checklist** Rating Support Documentation
	Assessment
*	**Behavioural**


Cognition
Behavioural Expressions
ACFI 6 Checklist
Objective Descriptions
Modified BAF
Behavioural Care Plan

❖ Activity: Behavioural Care Plan

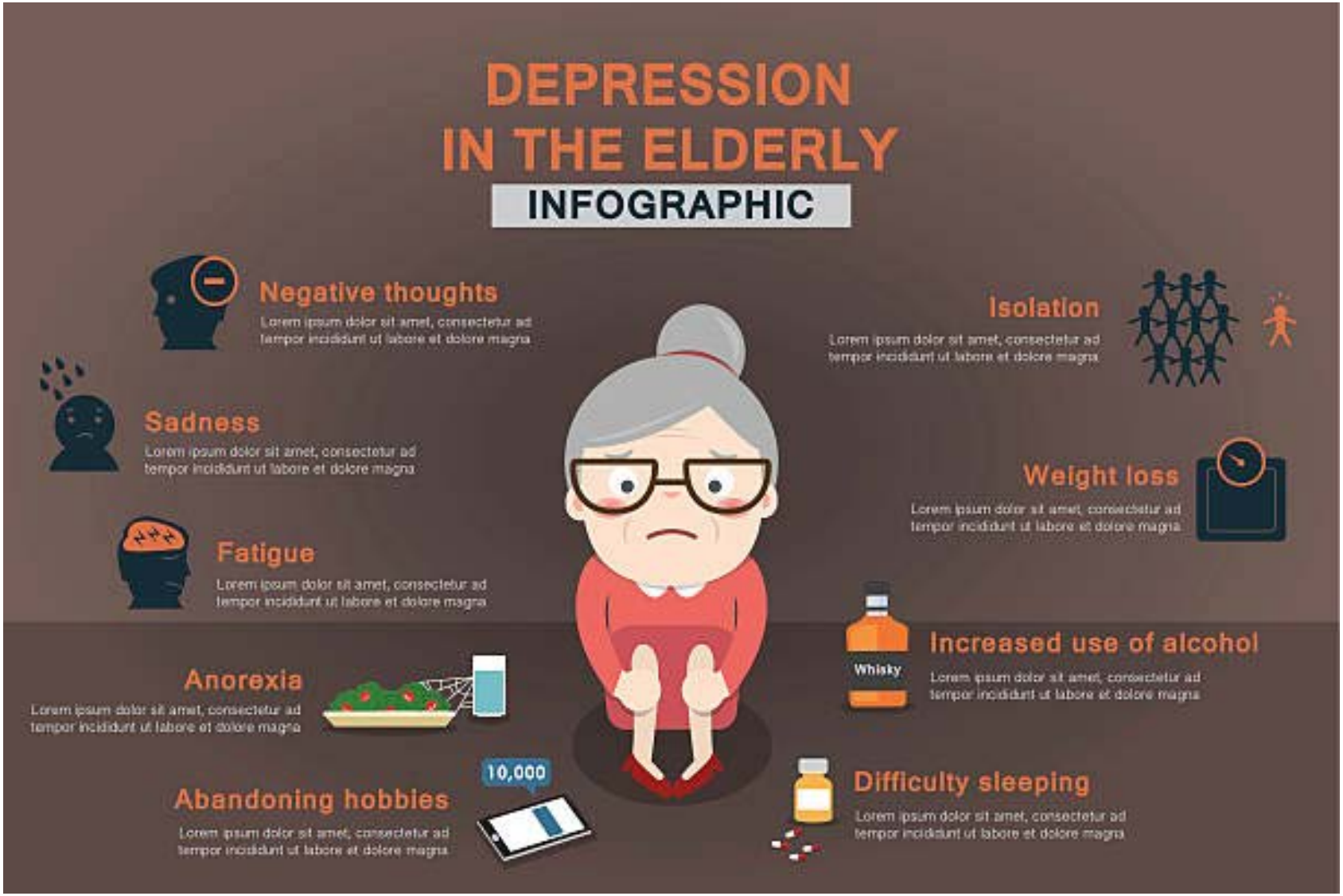
- Complete the Behavioural Care Plan
- Complete the Evaluation Plan
- Discussion

Assessment of Mood

WHY: Not well recognised or detected in older people, and can be easily missed. Reduces a person's quality of life and their relationships with friends and family. Think proactively about the possibility and assess whether it may be present.

https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/depression-and-ageing

HOW: Modified Cornell Scale for Depression In Dementia (CSDD)


DEPRESSION
IN THE ELDERLY
INFOGRAPHIC
Negative thoughts
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Isolation
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Sadness
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Weight loss
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Fatigue
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Whisky
Increased use of alcohol
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Anorexia
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
10,000
Abandoning hobbies
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna
Difficulty sleeping
Lorem ipsum dolor sit amet, consectetur ad tempor incididunt ut labore et dolore magna

Modified CSDD

Validated for use by aged care nurses (with training)

Prepare – read detailed instructions, resident background

Prepare – care staff to note daily symptoms of mood, behaviour, appetite, sleep, negative ideas/thoughts for at least one week

HOW Interview resident and/or informants, read notes.

Consists of 19 questions, scored out of 38, score gives a rating. What do you document?

Modified CSDD scoring

- The symptoms must have occurred in the past week
- Provide an objective description of the symptom/behaviour in context for that resident
- The exclusions should be followed
- Mild = minor interference (regular encouragement required with ADLs, social and interpersonal) and symptoms occur occasionally (not every day)/or often (nearly every day)
- Severe = major interference (limited participation in ADLs, social and interpersonal) and symptoms occur often

❖ Activity: How to document for CSDD

- **Video - CSDD Assessment**
  - Interview related to the three items that scored
  - Take notes and complete the Anxiety item
  - Think of one strategy for the resident

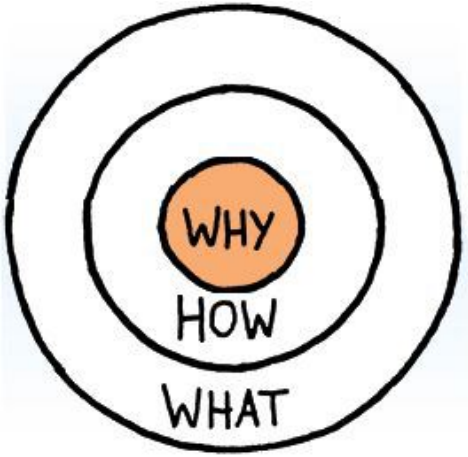
- **Video - CSDD Care Planning**
  - Discussion of care strategies that staff can implement

Documentation for Good Care and ACFI

- Why do we care about documentation?
  (communication, evidence, accountability, quality care, resident quality of life, accurate and robust ACFI claims)

- How do we achieve it?
  (have processes and tools in place, train the staff)

- What must we do?
  (collate, assess, refer, analyse the evidence, develop Care Plans, evaluate)



Documentation for Good Care and ACFI

Documentation process for good care and robust evidence

- Group discussion
  - What documentation do you produce?
  - What is the process or steps?
  - How are the roles delegated to staff?
  - How do you update the information?
  - What checks are in place (for accuracy, viable claims etc.)?
  - What happens if your ACFI is knocked back?

Documentation Processes

PROCESS

Admission	Communication	Care Reviews	ACFI
Collation	Daily handover	Progress Notes Summaries	Data stored where? Evidence trail, source evidence, assessments, ACFI Pack, IT
Daily Progress Notes first 28 days	Daily Progress Notes	ROD process & tools	Identifying changes
Comprehensive Assessment- first 28 days	AHP documentation	Care Plan Evaluations	Auditing, checking of ACFI packs
Evidence Profile -> Care Plan, Consumer Participation	Other	Assessments Redone	ACFI Review process & method
Complete admission ACFI (vital it is accurate)	Consumer Conferences, Surveys, Group Meetings	Process to identify changes to trigger care reviews	ACFI in Progress, Benchmarking
CARE PLAN created Initial ACFI submitted within 2 months	Current status	Notes, Assessments, Care Plan reviewed / updated	Changed status identified ACFI updated

ACFI Pack Check List

Please tick each item provided as evidence.

Resident Name & Location

	Mandatory Assessments ✓ Tick if available	Supporting Evidence ✓ Tick if available	Name document/s scanned & emailed
Source Evidence	☐ ACCR ☐ Completed ACFI in Progress (i.e. the claim)	☐ CMA/GP Notes ☐ Progress Notes ☐ Hospital Discharge Notes/ Letters ☐ Specialist Reports ☐ Other	
ADLs ACFI 1-4	☐ Nutritional Ax ☐ Mobility Ax ☐ Personal Hygiene Ax ☐ Toileting Ax	☐ Swallowing Ax ☐ Functional/PMS/ROM Ax ☐ Dietary Ax ☐ Falls Ax ☐ Physiotherapy Ax ☐ Speech Pathologist Ax ☐ Dietitian Ax ☐ Occupational Therapy Ax ☐ Podiatry Ax	
Continence ACFI 5	☐ 3 Day Urine Record	☐ Continence Ax	
	Urine Record uses Code 4 =>	☐ Urinary Flow Chart	
	Urine Record uses Code 4 =>	☐ GP/ACCR Dx of Urine Incont.	
	☐ 7 Day Bowel Record		
	Bowel Record uses Code 7 =>	☐ Bowel Flow Chart	
	Bowel Record uses Code 7 =>	☐ GP/ACCR Dx of Faecal Incont.	
Cognition ACFI 6	☐ PAS Ax	☐ Mental/Behavioural Dx ☐ Clinical / Specialist Report	
	☐ PAS Checklist	☐ Memory impairment ☐ Communication/Speech imp. ☐ Orientation impairment	
Behaviour ACFI 7-9	☐ Record for Wandering Behaviour ☐ Record for Verbal Behaviour ☐ Record for Physical Behaviour ☐ Mental/Behaviour Dx for High claim	☐ Behaviour Ax ☐ Psychogeriatric Ax ☐ Behaviour Team Ax	
Depression ACFI 10	☐ Cornell Scale for Depression ☐ Dx of Depression for C/D claim	☐ Clinical/Specialist Report ☐ Previous Diagnosis	
Medication ACFI 11	☐ Medication Chart	☐ Medication Self Ax ☐ Medication Ax	
Complex Care ACFI 12 Indicate item no. in box	12.☐ ☐ Dir ☐ Ax ☐ Dx ☐ Record 12.☐ ☐ Dir ☐ Ax ☐ Dx ☐ Record 12.☐ ☐ Dir ☐ Ax ☐ Dx ☐ Record 12.☐ ☐ Dir ☐ Ax ☐ Dx ☐ Record 12.☐ ☐ Dir ☐ Ax ☐ Dx ☐ Record *Pain, Skin Integrity, Special Feeding by RN, and Wound claims have mandatory Ax; GP directive is mandatory for 12.1/12.2	☐ CNS/In reach Ax ☐ NP Report ☐ ACCR/NSAF ☐ CMA/GP Report ☐ Record of Nursing Therapies ☐ Acute/Specialized Nursing CP ☐ Diabetes Care Plan ☐ Wound Care Plan ☐ Other	

Ax=assessment. Dir= Directive. Dx=diagnosis. GP=General Practitioner. CNS=clinical nurse specialist.
ACCR-aged care client record. NSAF-My Aged Care document. CP=Care Plan. NP = Nurse Practitioner

❖ ACFI Case Study: Frank

- Read the background and assessment information
- Complete the requested information for:
  - ACFI 1-4
  - ACFI 6
  - ACFI 7-9
  - ACFI 10
  - ACFI 12

Common Documentation Issues

Diagnoses - are the start of good care	Can support the claim, even when not mandatory.
Notes/Descriptions-both legal notes and communication between staff/health professionals, and can be used in ACFI reviews	Lacking clarity and details.
Assessment - essential for evidence-informed practices.	Assessment goes beyond the ACFI requirements, it is not just a score, but a rich source of information.
Analysis – demonstration of expertise	The rationale should be transparent and documented.
Incongruence- across and within documents	If it is not documented WELL it is not done WELL?
Clerical Errors, Accuracy	Simple to address effectively

ACFI Tips

The purpose of any assessment, should be to inform on BETTER CARE and sometimes BETTER ACFI outcomes
ACFI flows from the assessment and care planning processes
Assessments can objectively inform on the current status of the ACFI claim
Document beyond the assessment scores
The selection of assessments and the documentation of outcomes underpin evidence-based care planning and robust ACFI claims
An Evidence Profile documents the source of the evidence – you will always be ready for an ACFI review
An Evidence Profile documents the rationale for both interventions and ACFI claims
Check for congruence across documents by reviewing the Evidence Profile

ACFI Tips

Ensure the documentation (ACFI claim, assessments, Care Plan, progress notes etc.) is consistent and reflects the current status of the resident
Does the documentation clearly record what type of assistance is required with specific aspects of the activities of daily living and why
Ensure the documentation clarifies what the “assistance” actually entails
ACFI User Guide p5 (description of assistance)- Physical Assistance is required from one person/s throughout the specified activity. The activities are described on p8 of the ACFI User Guide
Check there is consistency across the three items of ACFI 2 Mobility, ACFI 12.5 Skin Integrity and ACFI 7 Wandering, or clearly explained
Does the documentation provide the rationale for cutting up food?
Is it possible to supervise meals when claimed?
Does the documentation link the interconnections between ADL and cognition etc.

ACFI Tips

Can a resident need full physical assistance in the bathroom, but not in the toilet?
Does ACFI 6 support the ADL claims?
It is expected that a person with moderate cognitive impairment will require supervision e.g. they may have difficulty following verbal prompts, remembering the required process movements (i.e. that are associated with using mobility aids and/or learning new ways to transfer).
It is expected that a person with severe cognitive impairment will require physical assistance at least sometimes e.g. they do not initiate or complete activities.
Scheduled toileting ACFI User Guide p22: “If claiming for scheduled toileting, you must provide documentary evidence of incontinence prior to the implementation of scheduled toileting e.g. ACCR or a flowchart completed prior to scheduled toileting being implemented.”
Be aware of (and use) referral sources for expert advice (and evidence)

ACFI Tips

Provide supporting evidence for not using the mandatory PAS-CIS assessment
If the resident can be interviewed, but the PAS-CIS is not appropriate, consider other validated cognitive assessments
Provide supporting evidence for the ACFI 6 checklist… clinical reports etc.
The items of an assessment can provide valuable information for care planning
Support staff with training on assessments, documentation and best practice strategies
Document behaviours objectively- what is heard or seen
Know where best practice assessments and advice can be sourced from
Further background information on the ABC approach is found in the: IPA Complete Guides to Behavioural and Psychological Symptoms of Dementia (BPSD) –Specialists Guide and Nurses Guide

ACFI Tips

ACFI claimed behaviour must meet the criteria found in the ACFI User Guide p44
A cognitive or mental health diagnosis would be expected as part of an investigation of frequent or severe behavioural concerns
A cognitive diagnosis would be expected if the resident has moderate or severe cognitive impairment
A referral and review by a Behaviour Specialist (e.g. DBMAS; Psychiatrist; Psychologist) and a detailed Behaviour Care Plan should be expected for severely disruptive behaviours
Supporting evidence of the behaviour would be expected e.g. impact on ADLs in ADL assessments, a clinical report, CMA notes etc.
Verbal resisting care does not include physical resistance of care, or when there is a reasonable resident request.
Constantly physically agitated is not climbing out of chair and being at risk of falling, or being related to a toileting need.

ACFI Tips

Not all behaviours can be claimed under ACFI
Record all mood symptoms, describe them in detail. If they overlap with ACFI 8 or 9 behaviours, be aware that ACFI User Guide states cannot claim behaviour in both ACFI 8/9 and ACFI 10. e.g. agitation, delusions.
Cross check CSDD items with ACFI User Guide page 44
The responses to the Cornell Scale for Depression in Dementia (CSDD) are critical in validating the assessment and in the linking of the information to the care planning and the care continuum.
The CSDD responses should address the question parameters/criteria required for the question e.g. inform if the symptoms occurred in the previous week; inform on how the symptoms impacted on the resident; provide a description of the symptom (what is seen or heard).
Incorrect scoring is a common error with PAS-CIS, CSDD, Continence & Behaviour Records.

ACFI Tips

The CSDD cannot be validated without notes about the claimed items e.g. did it occur in the last week, how does it impact, has the exclusion criteria been addressed.
The cognitive and depression assessments when appropriately completed provide a rich source of information for care planning, and objective information for ACFI purposes.
ACFI 12.4: Does the pain assessment support a claim for complex pain?
ACFI 12.12: Tubular elasticised support bandages are not compression garments. There should be a clinical assessment undertaken to determine the treatment. Recommended Reference: *Australian and New Zealand Clinical Practice Guideline for the Prevention and Management of Venous Leg Ulcers: http://www.woundsaustralia.com.au/publications/2011_awma_vlug.pdf*

ACFI Tips

ACFI 12.14 Palliative care program - end of life care involving very intensive clinical nursing and/or complex pain management in the residential care setting. It is appropriate when the resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently.
Assessment/Appraisal Triggers • After an event (wound, procedure, infection, fall, medical event, grief, CI data, medication change, incident report, adverse event) • Change identified from a 3/12 or annual review of progress notes (staff, AHP, medical), clinical reports, Care Plan, PRN medications. Document the review. • Consider a case review with staff, communicate to staff what to document, commence re-assessments, check ACFI calculator, lodge if appropriate.

BCBA Training

- The BCBA training has been designed to demonstrate how to achieve good CARE practices and inform on the ACFI items using the EBCAT.

- The EBCAT is a research based process and set of resources that result in **objective and accountable documentation, based on evidence-informed assessments, as the foundation for innovative care planning, for delivering quality care outcomes, improved resident QOL and robust ACFI claims.**

- The e-learning package contains all of the EBCAT and BCBA resources, including assessment videos (case studies) for users to expand and test their skills and knowledge on assessments and care planning.

Summary and Close

- Questions?
- Evaluation form
- Thank you