Participant Workbook

Day 1

PSRAC LEADERSHIP
PUBLIC SECTOR RESIDENTIAL AGED CARE

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Barwon Health funded through the Department of Health Victoria engaged Applied Aged Care Solutions (AACS), to develop an evidence based clinical assessment Toolkit (EBCAT) for public sector residential aged care services (PSRACS). Applied Aged Care Solutions (AACS), are ACFI experts, they were the original developers of the ACFI system and have extensive experience in designing assessment models and evidence-based tools for the aged care sector.

Academics from La Trobe and Monash University and other experts have contributed to this unique training resource.

La Trobe University

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

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PRACS Leadership Group

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Other Contributors

We would also like to thank Professor Rhonda Nay for her expert assistance in the EBCAT Complex Health Workbook.

GLOSSARY

4WF	4 Wheeled Frame
ABI	Acquired Brain Injury
ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ACFI Answer Appraisal Pack	The completed record of the ACFI appraisal or reappraisal
ACFI Appraisal submission date	Date of the application for classification
ACFI Assessments	Required to evidence the completed checklists. There are mandatory assessments for some questions, otherwise the appraiser can use a validated evidence-based tool of their choice.
ACFI Assessment Pack	Mandatory (prescribed) assessments for Continence (Continence Record); Cognition (PAS-CIS); Behaviours (Behaviour Record); and Depression (modified CSDD).
ACFI Checklists	Form a minimum data set
ACFI Domains (3)	Activities of Daily Living; Behaviours; Complex Health Care
ACFI Questions (12)	Nutrition; Mobility; Personal Hygiene; Toileting; Continence; Cognition; Wandering; Verbal Behaviour; Physical Behaviour; Depression, Medicines, Complex Health
ACFI Records	Behaviour Records, Continence Records are frequency-based recordings.
ACFI Source documents	Indicates which evidence sources support the rating in the diagnoses sections and ACFI questions 11 & 12.
ADL	Activities of Daily Living
AHP	Allied Health Professional
APAC Kit	Australian Pharmaceutical Advisory Council Kit
APMH/APATT	Aged Persons Mental Health/ Aged Psychiatry Assessment and Treatment Team
BAF	Behaviour Assessment Form
BCBA	Better Care Better ACFI (the training resources)
BCBA Workbooks	Participant Workbooks (provided for BCBA training)
BCOPE	Best care for older people everywhere
BPSD	Behavioural & Psychological Symptoms of Dementia
BMI	Body Mass Index
CAx	Comprehensive Assessment
CFA	Continence Foundation of Australia

CHA	Comprehensive Health Assessment (CHA) of the older person in health and aged care. Assessment template 2014.
CHAOP	Comprehensive Health Assessment of Older Person (CHAOP)
CHC	Complex Health Care
Clinical Reports	Are not mandatory, provide supporting evidence for ACFI 6 (Cognition) and ACFI 10 (Depression), completed by a registered health professional (within defined disciplines)
CMA	Comprehensive Medical Assessment
CNC/S	Clinical Nurse Consultant/ Specialist
COLDSPA	Character, Onset, Location, Duration, Severity, Pattern, Associated factors
Contemporaneous	Information completed no greater than 6 months prior to the appraisal submission date
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence-Based Clinical Assessment Toolkit
EBCAT Assessment Packs	Contain the recommended tools for each EBCAT domain
EBCAT Domains (6)	ADL, Continence, Cognition, Behavioural Expressions, Medicines, Complex Health
EBCAT Workbooks	EBCAT Reference Workbooks
IPA	International Psychogeriatric Association
NATFRAME	National Framework for Documenting Care in Residential Aged Care Services
NSAF	National Screening and Assessment Form (replaces the ACCR)
PCC	Person-Centred Care
PEG	Percutaneous Endoscopic Gastrostomy
PSRACS	(Victorian) Public Sector Residential Aged Care Service
QOL	Quality of Life
SCP	Standardised Care Processes: Choking; Constipation; Dehydration; Oral and Dental Hygiene; Physical restraint; Unplanned Weight Loss. From the SCORE initiative (Strengthening Care Outcomes for Residents with Evidence)
SMART Goals	Specific, Measurable, Action-oriented, Realistic, Time-based Goals
STML	Short Term Memory Loss

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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

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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

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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

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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

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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

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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 ○ Based on evidence-informed clinical practices and tools ○ ACFI is integrated with the broader care documentation

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Background

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

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Background

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

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The approach

- The assessment tools were systematically reviewed and selected mainly from Australian Toolkits which collated evidence-informed assessment tools for the aged care sector.
- Selected evidence-informed assessment tools that meet both the ACFI requirements and provide a comprehensive assessment approach to the ACFI topics.
- Provides a process to apply the tools (prepare, identify, implement, evaluate).
- Provides accountable documentation for good care.
- Provides accountable documentation for government regulators.
- Provides sound information to base care planning around.
- Provides an evaluation framework for quality assurance.
- Shows how accurate and robust ACFI claiming flows ***from*** the systematic use of evidence-informed tools and practices.
- Flexible access to educational training resources through the BCBA E-learning portal
- Videos demonstrating critical aspects of assessment and care planning
- Quizzes to test understanding of the content
- Educator materials
- Reference materials

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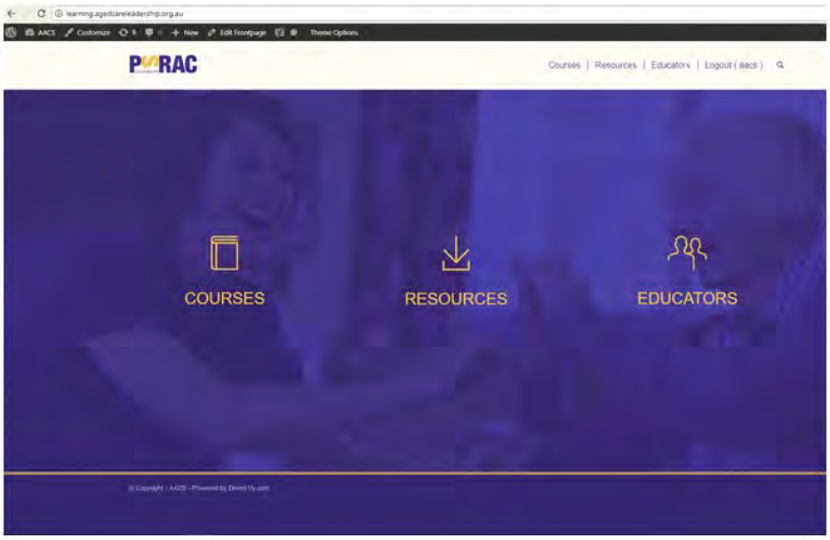
BCBA E-learning

http://learning.agedcareleadership.org.au

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



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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

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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)

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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

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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*

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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 Refresher: ACFI Evidence Types

	Domain	Diagnoses	Required evidence	Supporting Evidence Progress Notes, Other Assessments
	Source Documents	ACCR; MP notes/letters		Clinical Reports
1-4	ADLs	Physical, Sensory, Cognition, Behav'l (BPSD, ABI) /Medical	Evidence-based $A_{x:}$ e.g. MNA, FRAT, PMS, ROM,	Physiotherapist Assessment; Impairments – Cognition, Physical, Sensory, BPSD
5	Continence	Incontinence dx	Continence Records;	Comprehensive Assessment Prior evidence required when using Scheduled Toileting code
6	Cognition	As supporting evidence -Dementia dx, Mental Health dx	PAS-CIS	Clinical Report
			Q6 Checklist	Memory, personal care, orientation, communication. Cognitive assessment.
7-9	Behaviours	As supporting evidence -Dementia dx, Mental Health dx	Behaviour Records;	Documentation of behaviours, Comprehensive Assessment
10	Depression	Depression/Mood (C or D Rating)	Cornell (CSD)	Clinical Report
11	Medication		Medication Chart	
12	Complex Health	For some items e.g. dysphagia, catheter, wounds, oedema, DVT, $O_{2,}$	Pain/Skin/Swallowing/ Wound Assessments; Directives for all items; (ongoing) Records of Treatment for some items.	

ACFI Refresher: ACFI Evidence Lifespan

#	Evidence Type	Details	Timeframe
1-4	Evidence-based assessment e.g. NATFRAME	Nutrition; Mobility; Personal Hygiene; Toileting	6 months
5	ACFI Assessment	Continence Record	6 months
6	ACFI Assessment	PAS-Cognitive Impairment Scale	6 months
7-9	ACFI Assessment	Behaviour Records	6 months
10	ACFI Assessment	Cornell Depression Scale for Dementia	6 months
11	Source Documents	Medication Chart Medication administration time (not mandatory)	Reflect status of resident at time of appraisal
12	Source Documents	Directives; Assessments (Pain; Skin Integrity; Swallowing; Wound); Records; Diagnoses	Reflect status of resident at time of appraisal
	Source Documents	Medical Diagnoses	Reflect status of resident at time of appraisal
	Source Documents	Mental & Behavioural Diagnoses: 540, 550A, 550B, 560, (including provisional d_x)	12 months
	Source Documents	Mental & Behavioural Diagnoses; other	Reflect status of resident at time of appraisal

ACFI 12: Complex Health Care Requirements

#	Item	Dx/ACCR	Directive	Ax	RECORD
1	Blood pressure daily		MP		Yes
2	Blood glucose daily		MP		Yes
3	Pain management weekly		RN/MP/AH	Pain	Yes
4a	Complex Pain by RN/AHP - weekly		RN/MP/AH	Pain	Yes
4b	Complex Pain by AHP – 4/week		MP or AH	Pain	Yes
5	Complex Skin Integrity – 4/day		RN/MP/AH	Skin	
6	Special feeding by RN daily for dysphagia	✓	RN/MP/AH	Swallowing	
7	Suppositories and enemas weekly		RN or MP		Yes
8	Ongoing Catheter care	✓	RN or MP		
9	Chronic infectious conditions	✓	RN or MP		
10	Chronic wounds	✓	RN/MP/AH	Wound	Yes
11	Intravenous fluids etc.		Auth NP/ MP		
12a/b	Arthritis & Oedema, Oedema, Chronic skin	✓	RN/MP/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/MP/AH		
18	Technical equipment for continuous monitoring [CPAP]		RN or MP		Yes

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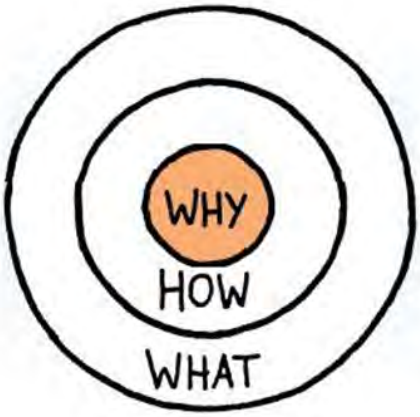
Documentation & Evidence

The Purpose of Documentation

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



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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.

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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

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Documentation & Evidence

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

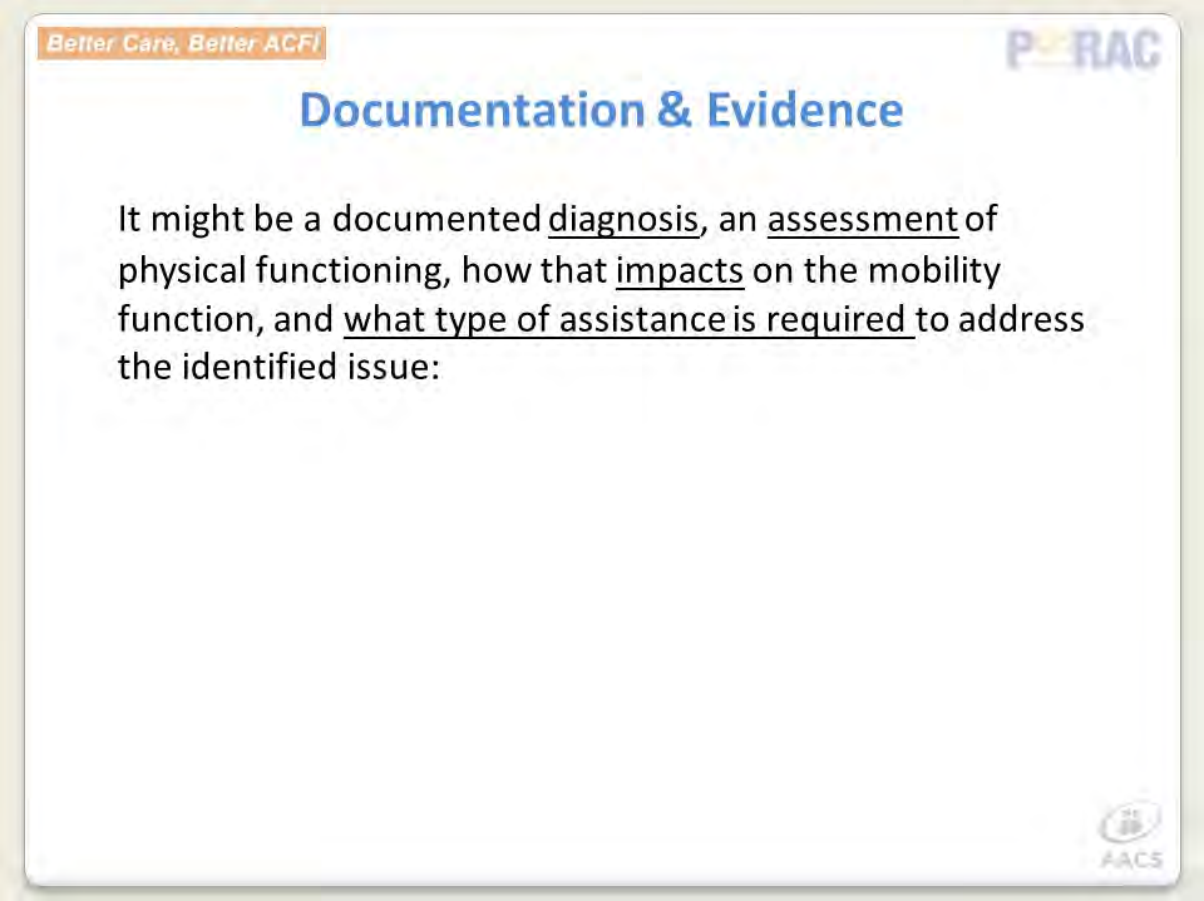
Is this describing

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

What should the 'evidence of a care need' look like?

❖ ACTIVITY: DOCUMENTATION OF A CARE NEED

Your example:



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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".

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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

This is an example of the type of documentation from various sources of information about a resident's care need in the **Topic of Nutrition**.

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

The facility's documentation:
Care Plan: *"Normal diet. Resident needs to be encouraged and helped to get ready for mealtimes"* *"Check during meal times and prompt to eat."*
Progress Notes: *At 9:12am "Meals are required to be **cut up**."* *At 9:35am on the same day, "The resident does not require meals to be cut up."*
Functional Assessment: "*The resident requires assistance in positioning self for eating."* The description, *"requires meals to be cut-up"* had been crossed out. *" General decline, tired at times, doesn't feel like eating. Needs encouragement and **help** from staff."*
Nutritional Assessment: *Dietary Details* *"Normal consistency for meals."* *"The resident prefers to take his meals in his bedroom."*
Physical Self-care ability / preference assessment: *"Resident is independent with eating"*

ACFI 1 Nutrition

Description

This question relates to the person's usual day to day assessed care needs with regard to eating. This question also applies to people receiving enteral feeding if they receive some nutrition orally on a daily basis.

Notes

For tube feeding refer to ACFI 12 Complex Health Care.

For assisting a resident to the dining room or assisting residents who are unable to position their chair appropriately see ACFI 2 Mobility.

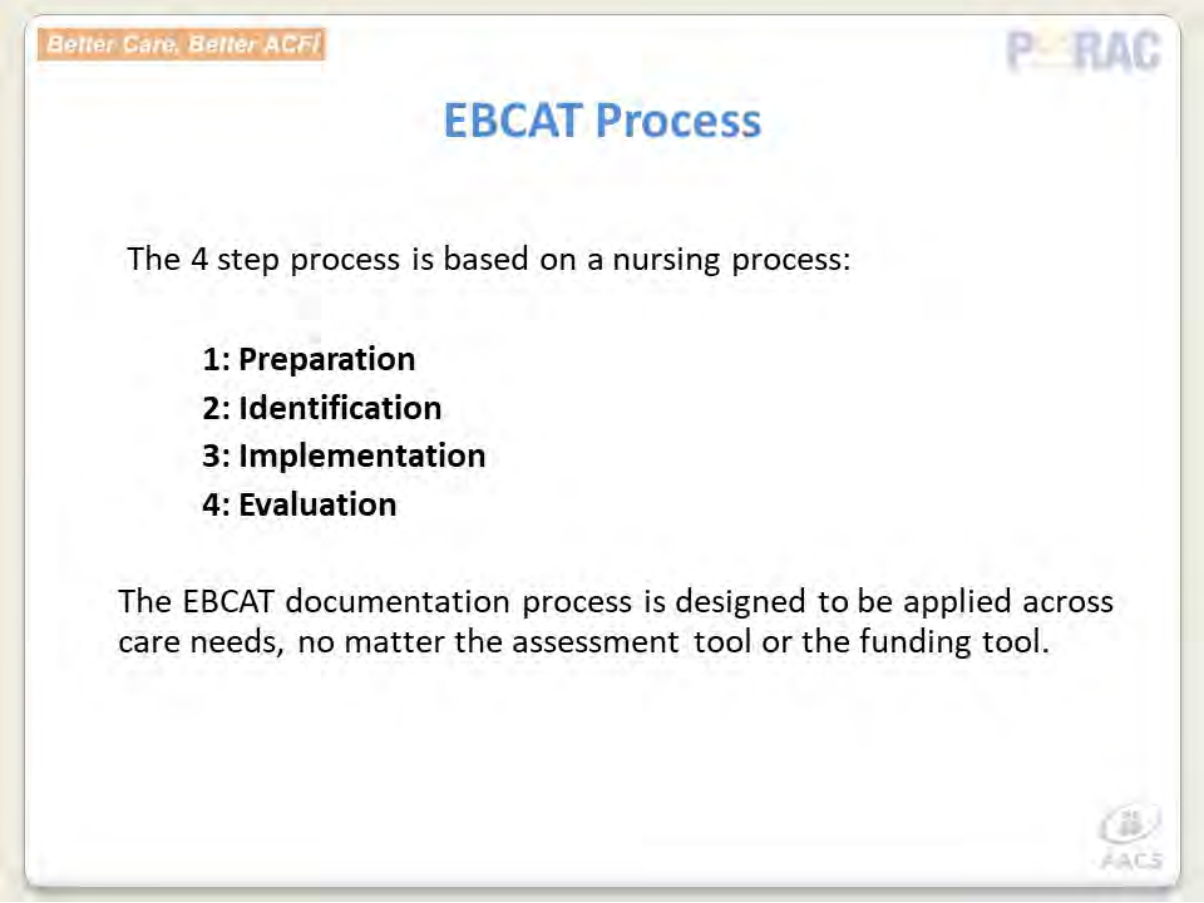
Physical assistance

Is the requirement for individual physical assistance from another person or persons throughout the specified activity. The activities that are taken into account are defined for each question.

Checklist

Rate the level of assistance (independent/ not applicable OR supervision OR physical assistance) required for each care need.

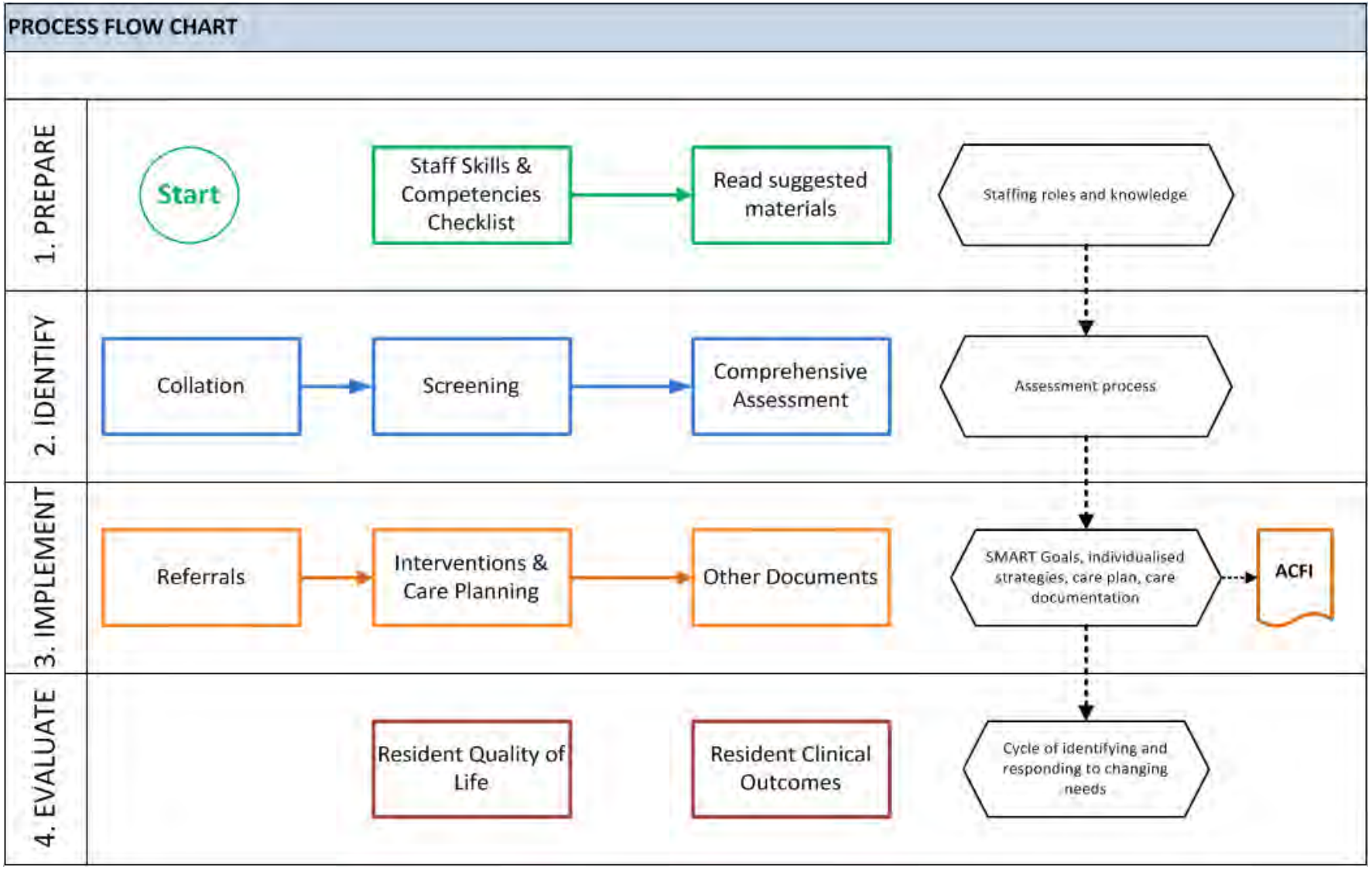
Nutrition Checklist	Assistance level (Tick one per care need)
1. Readiness to eat Supervision is: ▪ placing utensils in the resident's hand. One-to-one physical assistance is required for: ▪ cutting up food OR vitamising food.	☐ 0 (Independent/NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)
2. Eating Supervision is: ▪ standing by to provide assistance (verbal and/ or physical) OR providing assistance with daily oral intake when ordered by a dietitian for a person with a PEG tube. One-to-one physical assistance is required for: ▪ placing or guiding food into the resident's mouth for most of the meal.	☐ 0 (Independent/NA) ☐ 1 (Supervision) ☐ 2 (Physical assistance)



Following this process results in timely documentation and robust evidence for good care and ACFI. It also fits into a quality assurance approach.

The following flowchart gives “the big picture”.

EBCAT Process Flowchart



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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

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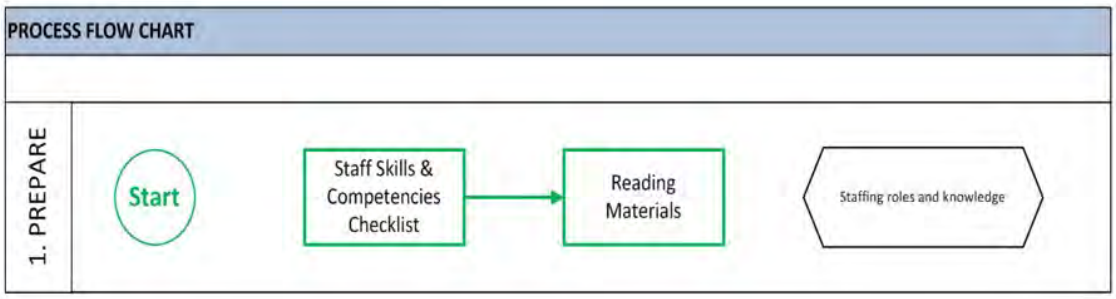
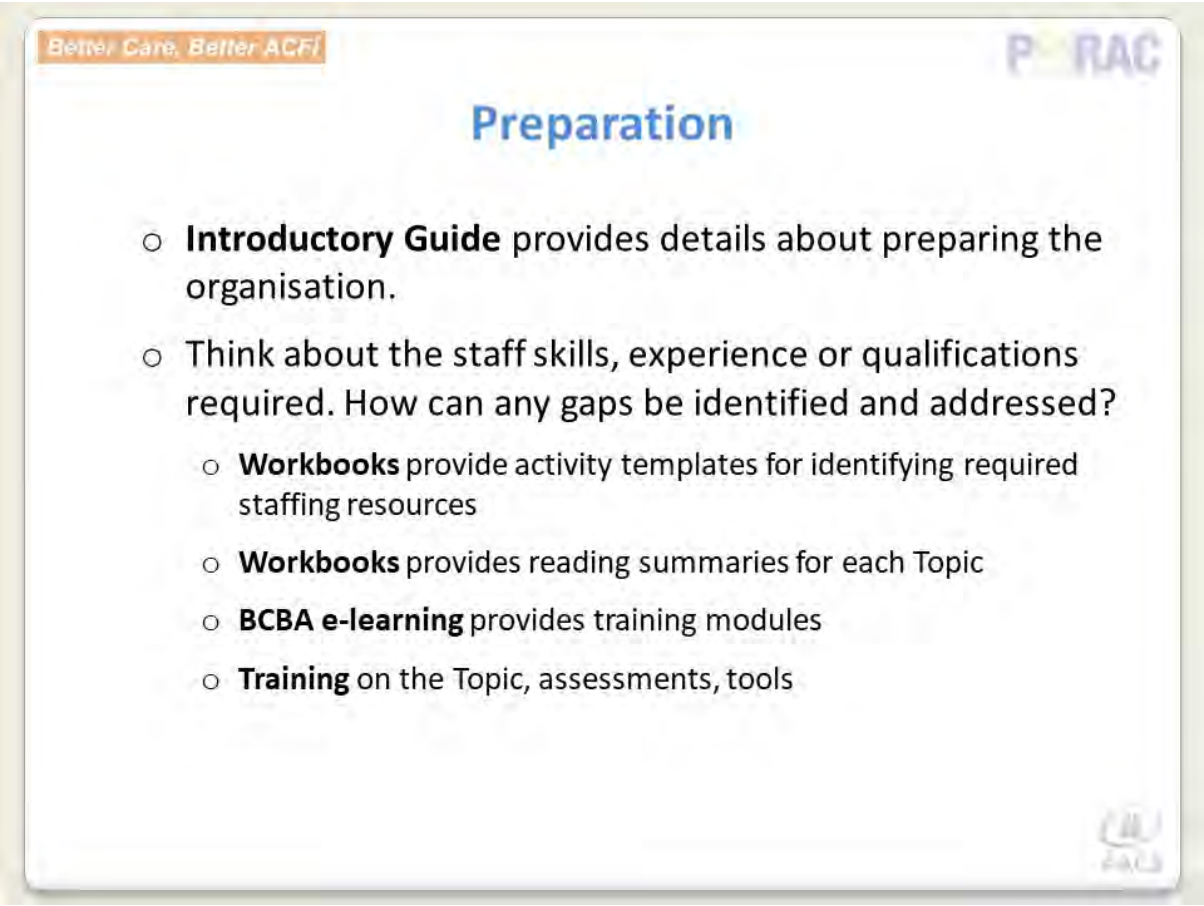
EBCAT Process Phase 1: Preparation

- Organisational Readiness
- Selecting team members
- Preparing team members





Organisational Readiness: The Introductory Guide provides guidelines and checklists for preparing the organisation – this is led by the person responsible for governance and change management and the person responsible for leading the care team.

Selecting team members: Lists are provided in each EBCAT Workbook to guide this process. To prepare for the assessment and care planning of a resident, you need to ensure that you have the right people to conduct the process, and that they have the right knowledge and experience. The facility might choose to address any gaps by providing training to staff, or by referring to a specialist or clinic.

The process includes:

- Identifying the required activities (examples are provided in the EBCAT Workbooks)
- Assessing staff competency to complete the activities
- Addressing identified gaps e.g. background reading, BCBA e-learning

Preparing team members: Ensuring that staff have the required qualifications or competencies and have completed background reading if required. Each EBCAT Workbook provides reading material for each Topic.

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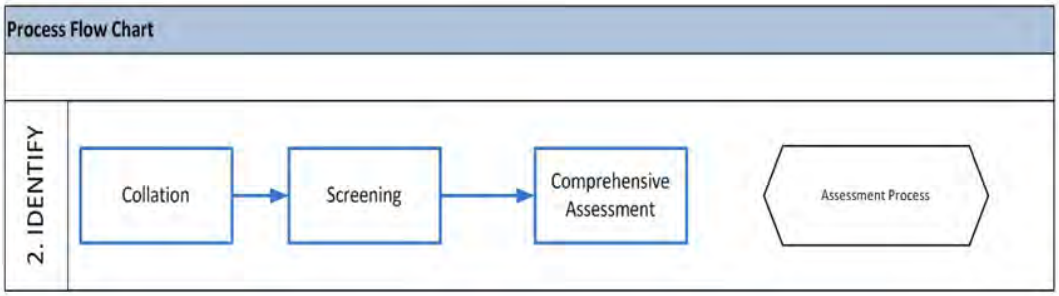
EBCAT Process Phase 2: Identification

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



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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?

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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.

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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

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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)

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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

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Where to find the Recommended Assessment Tools

Assessment Tool	Source/s
Abbey Pain Scale	EBCAT CHC Assessment Pack NATFRAME & The PMG Kit for Aged Care
ACFI Records (Behaviour; Continence)	ACFI Assessment Pack
CHA (Comprehensive Health Assessment of the older person in health and aged care. Assessment template 2014. The CHA is an example of an initial nurse assessment.	BCBA website resource
CHAOP (Comprehensive Health Assessment of Older Person)- how to undertake the CHA	BCBA website resource
Continence Resources for community and residential care - Recommended for the EBCAT Continence Assessment Pack (available soon from ACF)	Australian Continence Foundation (ACF)
DOMS (Dementia Outcomes Measures)	http://dementiakt.com.au/
FRAT (Falls Risk Assessment Tool)	EBCAT ADL Assessment Pack (physical functioning) NATFRAME
Grip Assessment	EBCAT ADL Assessment Pack (physical functioning)
KICA-Cog – Kimberley Indigenous Cognitive Assessment	EBCAT Cognition Assessment Pack DOMS website
Medication Self-Administration Assessment	EBCAT Medication Assessment Pack APAC
MNA short form (Mini Nutritional Assessment)- Recommended for the EBCAT ADL Assessment Pack	NATFRAME
Modified BAF (Behaviour Assessment Form)	EBCAT Behavioural Expressions Assessment Pack NATFRAME
CSDD (Modified Cornell Scale for Depression in Dementia)	ACFI Assessment Pack
M-RVBPI (Modified Residents Verbal Brief Pain Inventory)	EBCAT CHC Assessment Pack NATFRAME & The PMG Kit for Aged Care

Assessment Tool	Source/s
NATFRAME (National Framework for Documenting Care in Residential Aged Care Services)	http://webarchive.nla.gov.au/gov/20140802094457/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm
Observational Performance Assessment	BCBA website resource
PAINAD (Pain Assessment in Advanced Dementia)	EBCAT CHC Assessment Pack NATFRAME & The PMG Kit for Aged Care
Pain Intensity Tools	EBCAT Cognition Assessment Pack NATFRAME & The PMG Kit for Aged Care
PAS-CIS (Psychogeriatric Assessment Scales- Cognitive Impairment Scale)	ACFI Assessment Pack
PMS (Physical Mobility Scale)	EBCAT ADL Assessment Pack (physical functioning) NATFRAME
PMG Kit (Pain Management Guidelines Kit for Aged Care)	Prepared by Edith Cowan University © Commonwealth of Australia 2007 https://www.apsoc.org.au/publications
ROM (Range of Movement)	EBCAT ADL Assessment Pack CHAOP
Residential Care Services Skin Integrity Assessment	EBCAT CHC Assessment Pack NATFRAME
Residential Care Services Wound Assessment and Progress Chart	EBCAT CHC Assessment Pack NATFRAME
RNDC (Resident Nutrition Data Card)	EBCAT ADL Assessment Pack NATFRAME
RUDAS (Rowland Universal Dementia Assessment Scale)	EBCAT Cognition Assessment Pack DOMS
SMMSE (Standardised mini-mental state examination)- Recommended for the EBCAT Cognition Assessment Pack	Independent Hospital Pricing Authority website https://www.ihpa.gov.au/sites/g/files/net636/f/publications/smmse-tool-v2.pdf
Waterlow Pressure Ulcer Risk Scale	EBCAT CHC Assessment Pack NATFRAME

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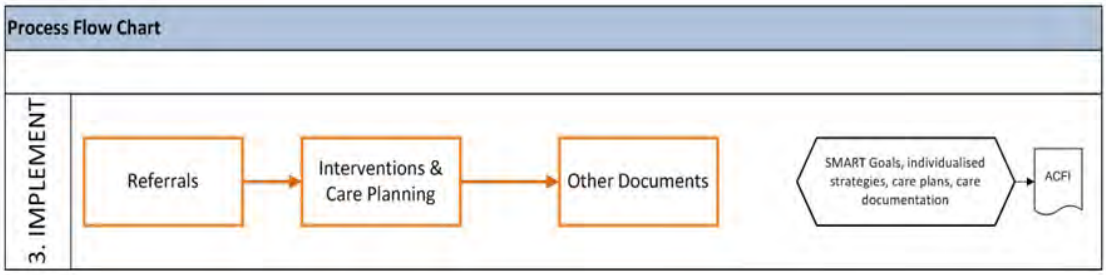
EBCAT Process Phase 3: Implementation

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



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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**.

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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.

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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.

Better Care, Better ACFI

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).

Better Care, Better ACFI

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)

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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.

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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

Quality of Life Questionnaire

The Quality of Life (QoL) questionnaire is not directed at any specific domain or Topic, it would be initially asked at the first care planning meeting with relatives and residents.

It can be revisited at set points, for example when evaluating resident goals that include one of the identified issues, or regularly (i.e. 6 monthly).

Example QOL Questions
a. Think about any recent problems that affect your quality of life
b. List the five most important problems
c. How would you rate each issue e.g. how badly you are affected by the problem? Rating scale: 1= Affected a little 2= Affected a fair amount 3= Affected quite badly 4= Affected very badly 5= Affected the worst possible amount
d. What would improve your situation?
e. If relevant, address the issues through a goal setting activity
f. 6 months later ask them to rate the issues again
g. Determine if the rating has improved (reduced) for any issues
h. Repeat the process to identify new issues

	Description of issue	Rating Time One	Rating Time Two
1.			
2.			
3.			
4.			
5.			

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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

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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.

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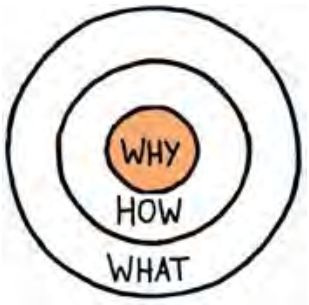
❖ ACTIVITY: SWALLOWING OBSERVATION

Why screen for swallowing?



Why	Why systematically screen for swallowing issues?
How	How would this fit into your current practices?
What	Does your facility systematically observe the resident's first meal?

From the video take notes about his swallowing and the food

Swallowing screen result

Question	How investigated
Do they have difficulty swallowing?	Is there a diagnosis e.g. dysphagia? History informs … Observation of the resident's first meal
Has a gag reflex?	CHAOP Module 4 page 11 shows how to test a gag reflex (not covered in video)
Have any difficulty swallowing food and fluid?	Is there a diagnosis e.g. dysphagia? History informs … Observation of the resident's first meal
Cough while eating and drinking?	Is there a diagnosis e.g. dysphagia? History informs … Observation of the resident's first meal
Require a texture modified diet?	Is there a diagnosis e.g. dysphagia? History informs …

❖ ACTIVITY: BUILD AN EVIDENCE PROFILE RELATED TO NUTRITION

- Build the evidence profile from the collation, screen, assessment and referral results
- Develop the Care Plan and an Evaluation
- Complete ACFI 1

An evidence profile provides a transparent rationale- the **underlying reason for why the resident needs a specific level or type of care.** It should provide a sound basis for care and accurate responses to the ACFI questions. Properly collated and maintained evidence gives easy access to the most current information as the resident's care needs are continually reviewed and updated.

Background notes	Source
Diagnosis of Parkinson's Disease and related dysarthria. Requires his meals to be prepared for him. Normal diet, has special cutlery Special cutlery due to limited ROM in hands (arthritis related). His speech is slow and he can only manage short sentences. *Dysarthria is a condition in which the muscles you use for speech are weak or you have difficulty controlling them. Dysarthria often is characterized by slurred or slow speech that can be difficult to understand [Mayo Clinic].*	**ACCR (Jan 2015)**
Resident has a sweet tooth, likes custard and ice cream, use to make a great apple pie. Enjoys having dinner with his son, due to work commitments his son often arrives at dinner time.	**Resident Interview (April 2015)**
Has been on normal diet since admission in April 2015. Care staff report that his appetite has decreased, he occasionally coughs while eating now. Soft diet to be commenced (meals to be monitored), and referral to a Speech Pathologist.	**GP (May 2015)**
[1] In last 3 months, moderate decrease in food intake [2] Weight loss in last 3 months between 1 and 3 kg [0] Requires assistance to get out of bed/chair [0] Psychological distress- recent admission to RAC [3] BMI 23 or greater	**MNA (June 2015)**
2 months ago, he was able to have a normal diet, he then progressed to a soft diet, with further deterioration in swallowing and more frequent coughing reported by care staff. Diagnosis of dysphagia (difficulty swallowing) related to his PD. Swallowing assessment- gag reflex is normal. Commenced on a modified textured diet with added thickener. Staff to closely monitor all meals and drinks, do not rush, and add extra thickener if any coughing.	**SP Report (June 2015)**

Identification Phase:

Evidence Profile (1): Add evidence from the File Notes / Interviews

Evidence	Source Document
	ACCR (Jan 2015)
	GP (May 2015)
	Resident Interview (April 2015)

Evidence Profile (2): Add evidence from the screen

Evidence	Source Document
	Swallowing Screen

Evidence Profile (3): Add evidence from the assessments

Evidence	Source Document
	MNA (June 2015)

Implementation Phase:

Evidence Profile (4): Add evidence from the referrals

Evidence	Source Document
	SP Report (June 2015)

Develop the Care Plan & the Evaluation Plan

Evidence ⇨ Actions	Source Documents
Care Plan *For example: there are diagnoses of Parkinson's Disease, dysarthria and dysphagia that impact on/will be addressed by …* *Referrals were made to …* *Referral recommendations …* *Other care recommendations …*	
Evaluation *For example,* *How often will you evaluate and using what methods?* *How will you demonstrate-* *If the nutritional status has improved or been maintained?* *If the Quality of life has improved or been maintained?* *If the family have been supported- does his son still visit at meal times?*	

Complete ACFI Q1 Nutrition

ACFI Question 1 Checklists	What checklist will you claim and what evidence do you have?
☐ Readiness to eat: Supervision - placing utensils in hand	
☐ Readiness to eat: Physical Assistance - cutting up food or vitamising food	
☐ Eating: Supervision - standing by to provide assistance	
☐ Eating: Supervision - daily oral intake for PEG feed	
☐ Eating: Physical assistance - placing or guiding food into the resident's mouth for most of the meal	

Better Care, Better ACFI

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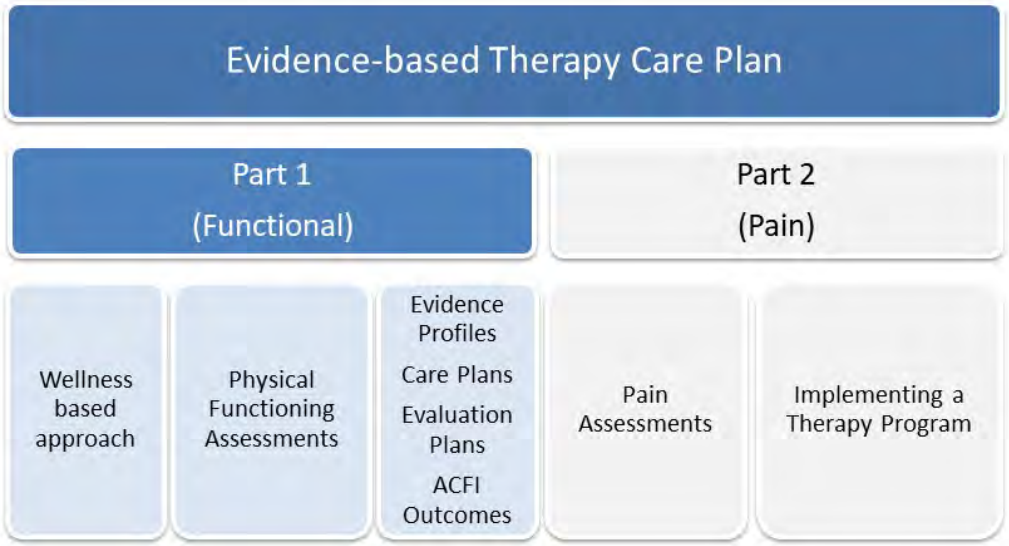
Developing an evidence-based Care Plan



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PCRAC

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)

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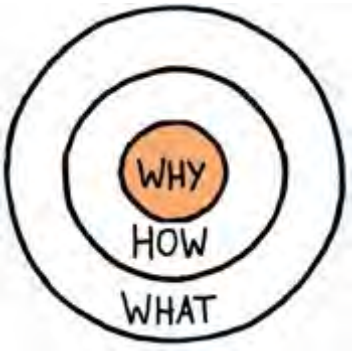
Developing an evidence-based Therapy Care Plan



Why	
How	
What	

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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)

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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).

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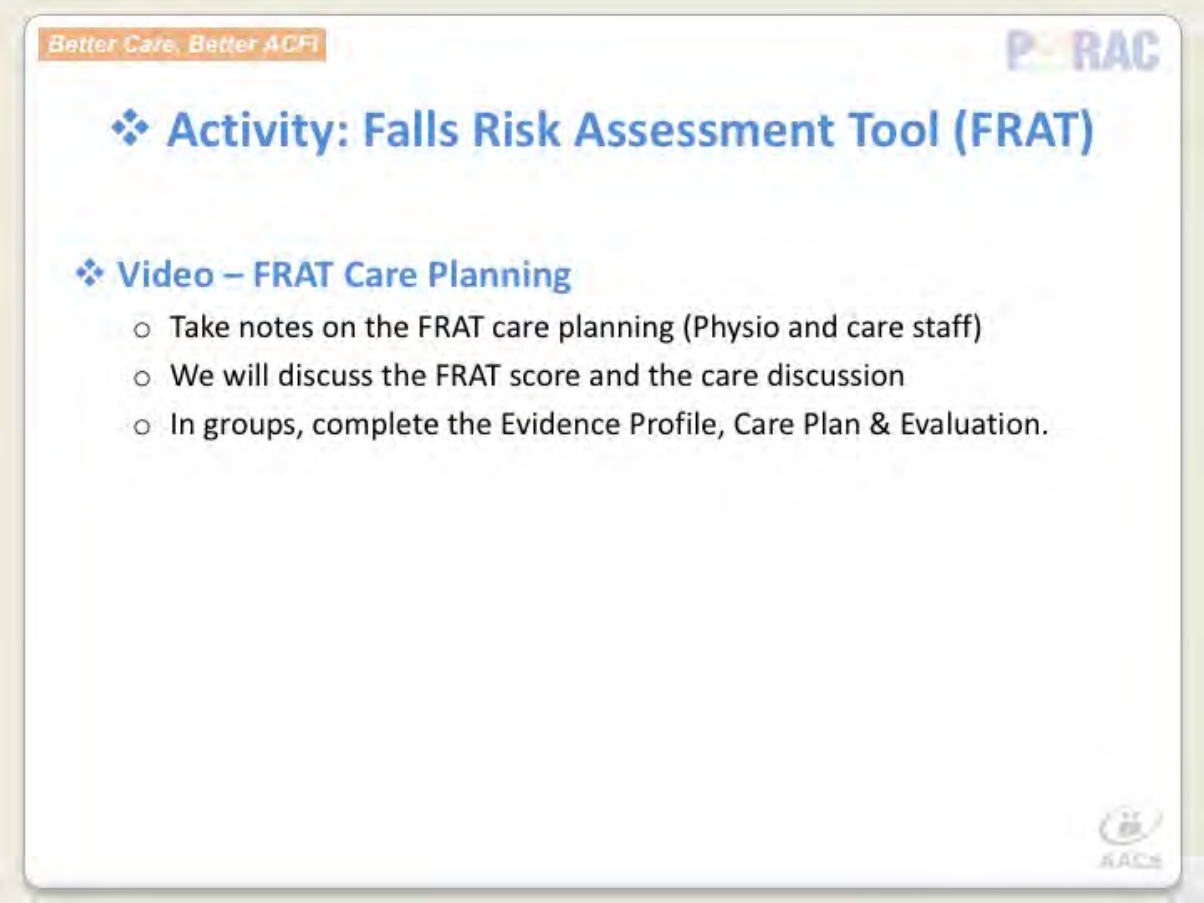
❖ Activity: ROM

❖ Video - ROM assessment

- Take notes on the ROM assessment
- Build the Evidence Profile

Scale	Range Of Movement (ROM) Level of Response
0	No evidence of movement (paralysis)
1	Barely detectable muscle contraction (flicker of muscle/tendon)
2	Full ROM or active body parts movement when gravity eliminated
3	Full ROM or active movement only against gravity, with no other resistance
4	Full ROM or active movement against gravity and some resistance
5	Full ROM or active movement against gravity and full resistance
	Notes



Activity: Score the FRAT

Risk factor	Level	Risk score
Recent falls	None in last 12 months	2
	One or more between 3-12 months ago	4
	One or more in last 3 months	6
	One or more in last 3 months whilst inpatient/resident	8
Medications (sedatives, anti-dep, anti-PD, diuretic, anti-hypertensive)	None	1
	One	2
	Two	3
	Taking more than two	4
Psychological (Anxiety, Depression, Co-operation, insight, judgement)	Has none of these	1
	Mildly affected	2
	Moderately affected	3
	Severely affected	4
Cognitive Status (MMSE, HAMS)	MMSE 9-10/10 OR Intact	1
	MMSE 7-8 OR Mildly impaired	2
	MMSE 5-6 OR Moderately impaired	3
	MMSE 4 or less OR Severely impaired	4
SCORE	LOW = 5-11; MED = 12-15; HIGH = 16-20	/20

❖ Activity: Notes for the Care Plan

Take notes on the risks/strengths that are discussed:

1	
2	
3	
4	
5	

Take notes on the care plan from the discussion:

1	
2	
3	
4	
5	

❖ Activity: Evidence Profile, Care Plan & Evaluation using the ROM and the FRAT

- Build the ROM evidence profile after watching the assessment video.
- Build the FRAT evidence profile after watching the assessment video.
- Then complete the Care Plan and Evaluation.

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

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P RAC

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

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P RAC

❖ 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 that are informed by the PMS

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❖ Activity: Score the PMS

Physical Functioning (PMS)	Level	Score
Supine to side lying (L)	No active participation in rolling Facilitation at shoulder & LL, actively turns head to roll Facilitation at shoulder or lower limb to roll Equipment (e.g. bedrail) to pull to side Verbal prompting to roll, does not pull to roll Independent- no assistance or prompting	**0** **1** **2** **3** **4** **5**
Supine to side lying (R)	Full assistance and slide sheet	**1**
Supine to Sit	Maximally assisted, no head control Fully assisted but controls head position Assistance with trunk and (LL or UL) Assistance with LL OR UL Supervision required Independent and safe	**0** **1** **2** **3** **4** **5**
Sitting Balance	Sits with total assistance, requires head support Sits with assistance, controls head position Sits using UL for support Sits unsupported for at least 10 seconds Sits unsupported, turns head & trunk to look behind to L & R Sits unsupported, reaches forward, touches floor and returns	**0** **1** **2** **3** **4** **5**
Sitting to Standing	Unable to weight bear Gets to standing with full assistance Equipment e.g. handrails Pushes to stand, weight unevenly distributed, stand by to assist Pushes to stand, weight evenly distributed, frame or bar when standing Independent, even weight bearing, hips & knees extended, no use UL	**0** **1** **2** **3** **4** **5**
Standing to Sitting (not seen)	Unable to weight bear To sitting with full assistance Initiates flexion, help to descend, uses arms of chair Poorly controlled descent, standby to assist Controls descent, holds arms of chair, weight evenly distributed Independent, does not use UL, weight evenly distributed	**0** **1** **2** **3** **4** **5**
Standing Balance	Unable to stand without hands-on assistance Able to stand safely using aid Stand independently for 10 seconds, no aid Stands, turns head & trunk to look behind L or R Able to bend forwards to pick up object from floor Single limb balance L …….seconds/ R …….seconds	**0** **1** **2** **3** **4** **5**
Transfers	Non-weight bearing, hoist Weight bearing, hoist Assistance of two persons Assistance of one person Standby assistance/verbal prompting Independent	**0** **1** **2** **3** **4** **5**
Ambulation/Mobility	Bed/chair bound Wheelchair mobile Ambulant with assistance of two persons Ambulant with assistance of one person Standby assistance/prompting Independent	**0** **1** **2** **3** **4** **5**

❖ Activity: Complete the Evidence Profile & the ACFI

PMS Evidence	Source
	Assessment: PMS **Item:** **Score:**
	Assessment: PMS **Item:** **Score:**
	Assessment: PMS **Item:** **Score:**
	Care Plan

Score these ACFI items from the PMS	PMS Items
ACFI Q2.1: Transfers (Independent, Supervision, PA, Lifting Machine)	
ACFI Q2.2: Locomotion (Independent, Supervision, PA)	
ACFI Q3.1: Dressing (Independent, Supervision, PA)	
ACFI Q3.2: Washing Hygiene (Independent, Supervision, PA)	
ACFI Q3.3: Grooming Hygiene (Independent, Supervision, PA)	
ACFI Q4.1: Toilet Use (Independent, Supervision, PA)	
ACFI Q4.2: Toilet Completion (Independent, Supervision, PA)	

Guidelines for Using the Physical Mobility Scale (PMS) 1

BACKGROUND

The Physical Mobility Scale (PMS) is a performance-based scale, requiring observation of the person and rating of functional movements by a physiotherapist or other health professional (Pike & Landers, 2010). The PMS was developed by physiotherapists to assess the mobility of residents in FRACs, and is endorsed by the Gerontology Group of the Australian Physiotherapy Association. It has been recognised as a comprehensive tool that quantifies the amount of assistance required and the equipment needed for a resident to perform mobility tasks.

Note: the guidelines have been developed by AACS in consultation with content matter experts. The guidelines are subject to modification (June 12, 2017).

PURPOSE OF THE PHYSICAL MOBILITY SCALE

The PMS aims to describe how a resident performs everyday mobility tasks, which can assist with the development of care plans and treatment interventions that reflect the resident's abilities and assistance needs.

QUALITY OF THE PHYSICAL MOBILITY SCALE

Studies have supported the use of the PMS by physiotherapists for people in RACFs. It has been demonstrated to have:

- High intra-rater reliability (Pike & Landers, 2010) and inter-rater agreement (Nitz & Hourigan, 2006; Barker, Nitz, Low Choy & Haines, 2008)
- Content (Nitz & Hourigan, 2006) and construct (Nitz & Hourigan, 2006; Barker et al., 2008) validity
- Responsiveness to changes in resident function (Pike & Landers, 2010).

WHO CAN USE THE PHYSICAL MOBILITY SCALE?

The PMS should be used by accredited physiotherapists and other health care staff (e.g. nurses) who are trained in its use within their scope of practice. Assessors should have sufficient anatomy knowledge and clinical observation skills and experience.

OUTCOMES OF THE PHYSICAL MOBILITY SCALE

Completion of the PMS will help the staff/facility to determine:

- The level of functional mobility and dependency of the resident
- The staff and equipment needed to assist the resident with each task Nitz & Hourigan, 2006; Barker et al., 2008)
- The need for physical therapy interventions (Pike & Landers, 2010; Barker, Nitz, Low Choy, & Haines, 2012).

Guidelines for Using the Physical Mobility Scale (PMS) 2

For subsequent assessments, the PMS may be used as an outcome measure to evaluate the effectiveness of therapy and changes in the resident's function over time (Pike & Landers, 2010). Please refer to the *'Understanding score changes'* section below for details.

ASSESSMENT PROCESS

The following is a guide to the preparation, execution and interpretation of the PMS, and considerations for therapy planning.

Preparation:

1. Review medical history/progress

a. Prior to performing the PMS, the assessor should review the resident's medical history, progress, and observation chart (if applicable) to aid their clinical judgements during the assessment. If a falls risk assessment (e.g. Falls Risk Assessment Tool) has been completed, the resident's risk score and risk factor checklist should also be reviewed.
b. Ensure that there are no contraindications to mobilising the resident (e.g. unstable fractures with restricted weight bearing orders from the doctor, unstable haemodynamic or cardiac status, deep vein thrombosis/pulmonary embolism, severe drowsiness/agitation/distress that compromises resident and assessor safety).
c. The assessor should exercise caution for residents with postural (orthostatic) hypo- or hypertension, vestibular disorders such as benign paroxysmal positional vertigo, dyspnoea due to respiratory disease, and significant pain. Clearance from the treating doctor should be sought if the assessor has concerns with mobilising the resident.

2. Review medication chart

a. Medication charts should be reviewed to consider the effects of recent medications on the residents' ability to mobilise. For example, outcomes may differ if the assessment is conducted before or after the administration of analgesia or sedatives.
b. Timing of the assessment should be adjusted in line with the effects of any medications to ensure safety for the resident and assessor. As a guide, an assessment conducted 30 minutes after oral paracetamol (depending on dose) may optimise pain levels when moving; ample time should pass (e.g. 1-2 hours, or depending on the type and dose) after the delivery of sedatives to consider proceeding with the assessment.

3. Date and time of the assessment

a. Variation in residents' ability to perform activities throughout the day has been recognised (Nitz & Hourigan, 2006). As a guide, the assessor should consider a suitable time to conduct the assessment that aligns with the resident's usual care needs (e.g. prior to, or within a reasonable period around scheduled toileting/showering/meal time when mobility is necessary).
b. All assessments must record the date and time completed, and name of the assessor.
c. Full assessment is encouraged to be completed in one setting to minimise variance. Items completed on separate days should clearly document the date and time conducted, with all tasks in the PMS assessed within 3 calendar days by the same assessor.
d. Repeat assessments should be completed at a similar time of day to the initial assessment, as far as possible, to improve consistency of the results.

4. Assessment environment

a. The assessment should be conducted in the resident's usual environment, using their familiar equipment (e.g. bed, chair, gait aid).
b. Ensure the assessment area and room is clear of obstacles and clutter to minimise the risk of injury.

Guidelines for Using the Physical Mobility Scale (PMS) 3

Completion

The PMS does not have formal instructions for each task. As the assessment can be completed through observation, it is not dependent on the resident being able to follow formal instructions (Barker et al., 2012) – this is particularly relevant for residents with cognitive deficits.

The PMS form, adapted from Pike & Landers (2010) and the PMS in the NATFRAME (Department of Health and Ageing, 2015), has information on starting positions, instructions and key considerations which may be used as a guide when conducting the assessment.

For 'Sitting Balance' and 'Standing Balance' the assessor should consider the safety risks when deciding to proceed to the more difficult components. Refer to the Considerations column in 'Physical Mobility Scale with guided instructions' below to guide decision making.

For residents who need total assistance with Sitting Balance (i.e. score of 0), it may be impractical and unsafe to continue with observing and assessing the subsequent tasks of Standing, Standing Balance, Transfers and Ambulation/Mobility. Therefore, considering the safety risks to the resident and assessor, it may be reasonable to cease the assessment if the resident scores a 0 for Sitting Balance. The assessor must score all remaining items using reasonable clinical judgement, and clearly document the rationale for the decisions. Other relevant comments for each task should also be documented – refer to the 'Guide for Documenting Relevant Comments in the Physical Mobility Scale' below.

Interpretation: **Item and Score Classification**

The PMS has nine mobility tasks (N.B. supine to side-lying as two tasks – left and right). A score is given from 0-5 for each item, yielding a total possible score of 45, where a higher score shows greater independence. The total summed score may be categorised into the following levels of functional impairment (Barker et al., 2012):

Total Score	Impairment Classification
0 – 9	Fully dependent
10 – 18	Severe mobility impairment
19 – 27	Moderate mobility impairment
28 – 36	Mild mobility impairment
37 – 45	Highest independence

Individual items will also inform on the level of independence for specific aspects of transfers and mobility. For example, items that score between 0 to 1 (and sometimes 2) usually show the need for physical/mechanical assistance. The scale follows a general pattern of maximum dependence to independence:

0 = Maximum physical assistance or no participation
1 = Requires physical assistance with some body part
2= Difficulties undertaking some of the actions requested
3 = Requires equipment
4 = Requires supervision/verbal prompting
5 = Independent

Guidelines for Using the Physical Mobility Scale (PMS) 4

1. **Relation to Care Delivery**
   It is important to understand how to interpret the PMS result to assist staff with planning and executing their delivery of care.

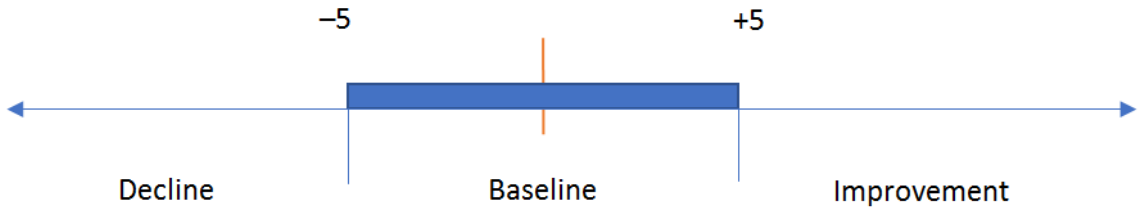
   Generally, a greater amount of assistance is indicated for lower scores. It is essential to review the assessor's comments for each task to ensure that appropriate staffing levels and equipment are being utilised when assisting the resident.

   > Important note: residents classified with a **mild mobility impairment** (score 28-36) have been reported to have the **highest risk of falls** (Barker et al., 2012).
   > It is recommended that PMS scores are reviewed together with the corresponding Falls Risk Assessment Tool score for all residents.

2. **Therapy Planning**
   Referral to a physiotherapist or exercise physiologist is recommended to ensure an appropriately tailored therapy plan is designed to maintain or improve a resident's functional mobility. In addition to other appropriate outcome measures, the PMS may be used to evaluate and monitor the effectiveness of the therapy plan.

3. **Understanding Score Changes**
   Previous research on the PMS in RACF residents showed that a change of 5 points is meaningful from a clinical and statistical perspective (Pike & Landers, 2010; Barker et al., 2008).

   This means that if the score in a repeat assessment, when compared to the earlier PMS score is:
   Five or more points higher indicates improvement in mobility
   Five or more points lower indicates deterioration in mobility



Changes in PMS scores can be used to evaluate the effectiveness of treatment that is designed to improve a resident's functional mobility performance. A decline in a resident's mobility, as reflected by a PMS score that has decreased by at least 5 points, may warrant a physiotherapy review and/or modification to the existing therapy plan.

Guidelines for Using the Physical Mobility Scale (PMS) 5

Functional Task	Documentation Guidelines
Supine to Side Lying	**Left** Equipment used: *e.g. uses bedrail with right hand to pull to roll (score=3)* Comments: *e.g. requires one person assist with bending right leg to facilitate roll, due to right knee weakness (score=2)*
	Right Equipment used: *e.g. uses bedrail with left hand to pull to roll (score=3)* Comments: *e.g. requires one person assist with bending left leg, due to left knee pain, and guiding left shoulder to facilitate roll (score=1)*
Supine to Sit	Equipment used: *e.g. bed triangle* Comments: *e.g. resident requires supervision to sit up from supine using bed triangle, due to occasional light-headedness when sitting up (score=4)*
Sitting Balance	Comments: *e.g. resident able to sit unsupported for 10 seconds without using hands – unsafe to assess turning left and right as resident intermittently sways when sitting, suggesting poor dynamic sitting balance; likely to require supervision from one person (score=3)*
Sitting to Standing	Description of assistance: *e.g. full assistance from two people required – one to support trunk and other to support left leg, due to lack of left hip and knee extension strength (score=1)* Equipment used: *e.g. resident uses 4WW to pull up to stand (score=2)*
Standing to Sitting	Description of assistance: *e.g. resident requires one person stand-by assistance and verbal prompting to use hands to control decent to sit (score=3)*
Standing Balance	Comments: *e.g. resident able to safely turn to look over left and right shoulders without aid – did not assess ability to pick up object from floor due to known bilateral knee pain, deemed unsafe to perform (score=3)*
Transfers	Description of assistance: *e.g. resident requires one person assist to support trunk to stand, and guide 4WW when turning near chair to position him/herself to sit down (score=3)* Equipment used: *e.g. resident able to weight bear in lower limbs, but unable to step to transfer due to pain and weakness in right hip and left knee – requires assistance from two people to transfer from bed to chair using standing hoist (score=1)*
Ambulation/ Mobility	Description of assistance: *e.g. resident requires one person assist at all times to support upper body to maintain balance when walking with SPS (score=3)* Gait pattern: *e.g. slow gait with slightly reduced stance time on left leg, likely due to known OA hip; adequate clearance both feet; intermittently rests after approx. 20m due to SOB (score=5)*

Physical Mobility Scale with Guided Instructions

Date: **Time**:	**Medication taken prior**: ☐ Y ☐ N If yes, **time taken**: **Specify medication**:

Item and Instructions	Scoring	Considerations
Supine to side-lying (Note: indicate left and right directions separately) *Instructions:* *-Please roll onto your left/right side.*	(0) No active participation in rolling (1) Requires facilitation at shoulder and lower limb but actively turns head to roll (2) Requires facilitation at shoulder or at lower limb to roll (3) Requires equipment (e.g. bedrail) to pull into side lying. Specify: (4) Requires verbal prompting to roll – does not pull to roll (5) Independent – no assistance or prompting	For (3) record any equipment used to roll left and right.
Supine to sit (Resident in supine) *Instructions:* *-Please sit up on the edge of the bed.*	(0) Maximally assisted, no head control (1) Fully assisted but controls head position (2) Requires assistance with trunk and lower limbs or upper limbs (3) Requires assistance with lower limbs or upper limbs only (4) Supervision required (5) Independent and safe	For all scores record any equipment used to sit up (e.g. bed triangle, bedrail)
Sitting balance (Resident sitting at edge of bed, feet on floor) *Instructions:* *(if safely performs preceding score)* *-Please turn and look over your shoulder.* *-Please reach forward and touch the floor.*	(0) Sits with total assistance, requires head support (1) Sits with assistance, controls head position (2) Sits using upper limbs for support (3) Sits unsupported for at least 10 seconds (4) Sits unsupported, turns head and trunk to look behind to left and right (5) Sits unsupported, reaches forward to touch floor and returns to sitting position independently	Consider testing (4) only if resident safely performs (3). Use clinical judgement and consider safety risks to test (5) only if resident safely performs (4).
Sitting to standing (Resident sitting at the edge of the bed) *Instructions:* *-Please stand up. Try not to use your hands for support.*	(0) Unable to weight bear (1) Gets to standing with full assistance from therapist. Describe: (2) Requires equipment (e.g. handrails) to pull to standing. Specify equipment used: (3) Pushes to stand, weight unevenly distributed, standby assistance required (4) Pushes to stand, weight evenly distributed, may require frame or bar to hold onto once standing (5) Independent, even weight bearing, hips and knees extended, does not use upper limbs	For (1) describe which body part/s and movement requires assistance (e.g. trunk support to initiate flexion, placement of hands on arms of chair). For (2) record equipment used to stand up.
Standing to sitting (Resident starts standing near edge of the bed) *Instructions:* *-Please sit down. Try not to use your hands for support.*	(0) Unable to weight bear (1) Gets to sitting with full assistance from therapist. Describe: (2) Can initiate flexion, requires help to complete descent, holds arms of chair, weight unevenly/evenly distributed (3) Poorly controlled descent, stand-by assistance required, holds arms of chair, weight evenly/unevenly distributed (4) Controls descent, holds arms of chair, weight evenly distributed (5) Independent and does not use upper limbs, weight evenly distributed	For (1) describe which body part/s and movement requires assistance (e.g. trunk support to initiate flexion, placement of hands on arms of chair).
Standing balance (Resident starts standing supported/unsupported) *Instructions:* *(if safely performs preceding score)* *-Please turn and look over your shoulder.* *-Please pick (the object) up from the floor.* *-Please stand on your left/right leg for as long as you can.*	(0) Unable to stand without hands-on assistance (1) Able to safely stand using aid. Specify aid used: (2) Able to stand independently for 10 seconds, no aid (3) Stands, turns head and trunk to look behind left or right (4) Able to bend forwards to pick up object from floor safely (5) Single limb balance Left _____ seconds Right _____seconds	This item has been recognised as the most difficult task[3] Use clinical judgement, include safety risks to test (3) -(5) only if resident safely performs the preceding score. e.g. Consider testing (3) only if resident safely performs (2).
Transfers (Resident starts sitting at the edge of the bed) *Instructions:* *-Please stand up and sit in your chair/wheelchair.*	(0) Non-weight bearing, hoist required. Specify: (e.g. full hoist) (1) Weight bearing, hoist required. Specify: (e.g. standing hoist) (2) Assistance of two persons required. Describe: (3) Assistance of one person required. Describe: (4) Stand-by assistance/prompting required (5) Independent	For (2) and (3) describe when the assistance is required, and which body part or aid needs assistance (e.g. upper/lower limb, trunk, guiding of assistive device).
Ambulation/mobility (Resident starts standing with or without assistive device or sitting in wheelchair *Instructions:* *-Please walk/push your wheelchair.*	(0) Bed/chair bound (1) Wheelchair mobile (2) Ambulant with assistance of two persons. Describe: (3) Ambulant with assistance of one person. Describe: (4) Stand-by assistance/prompting required (5) Ambulates independently. Gait pattern:	For (2) and (3) describe which body part/s needs assistance and why – e.g. poor balance, weakness. For (5) record any aid/equipment used.
Assessor Name:	**Signed:**	**Role/Profession:**

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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

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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

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Developing an evidence-based Care Plan

Evidence-based Therapy Care Plan

Part 1 (Functional)			Part 2 (Pain)	
Wellness based approach	Physical Functioning Assessments	Evidence Profiles Care Plans Evaluation Plans ACFI Outcomes	Pain Assessments	Implementing a Therapy Program

AACS

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PCRAC

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

AACS

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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

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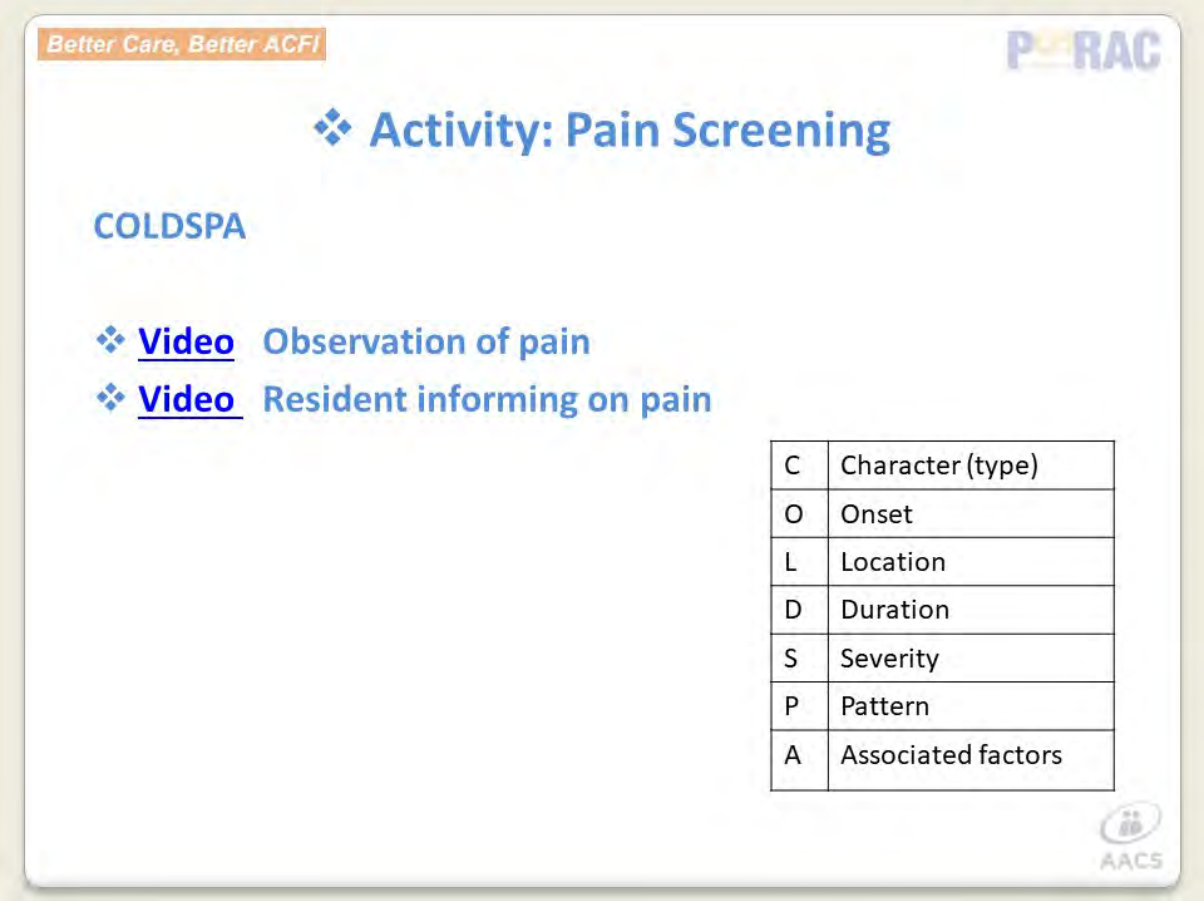
Pain Assessments

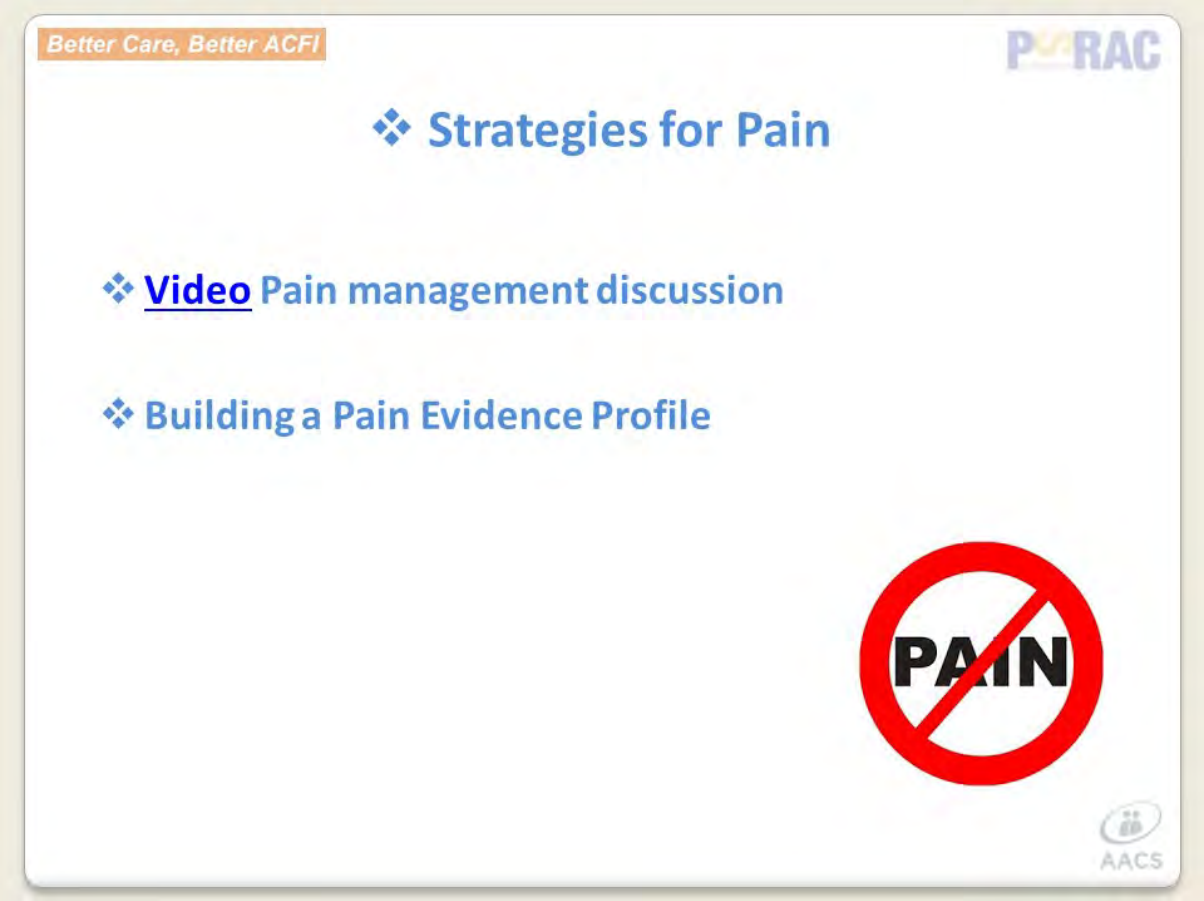
Pain assessments		
Screening	COLDSPA	CHA
Pain Assessment	Abbey/ PAINAD	PMG Kit
	M-RVBPI	PMG Kit
	Pain Intensity Tools	PMG Kit

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



Record any of the screening items that you can identify while you are watching the videos.

Character (type of pain) ***Describe symptoms***	
Onset ***When it starts***	
Location ***Where on body***	
Duration ***How long?***	
Severity ***How bad is it?***	
Pattern ***Is it constant, episodic?***	
Associated factors	
Observed signs Facial Expression; Vocalisation; Body Movement; Autonomic Pain	



Activity: Strategies for Pain

Note the care planning activities that were discussed:

1	
2	
3	
4	
5	
6	

❖ Activity: Building a Pain Evidence Profile

Evidence	Source
	Diagnoses
	COLDSPA
	Resident Interview
	Care Plan
	Evaluation

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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)

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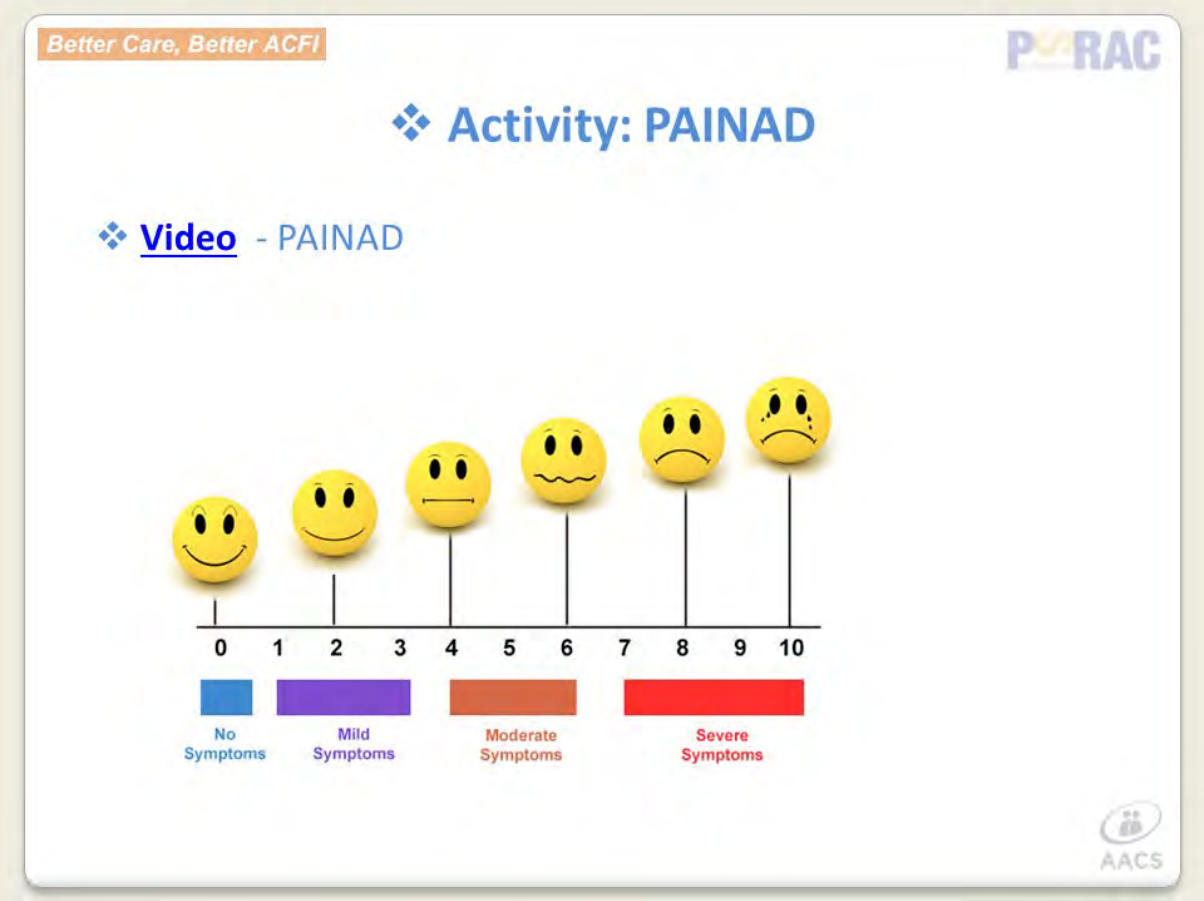
PAINAD

	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	

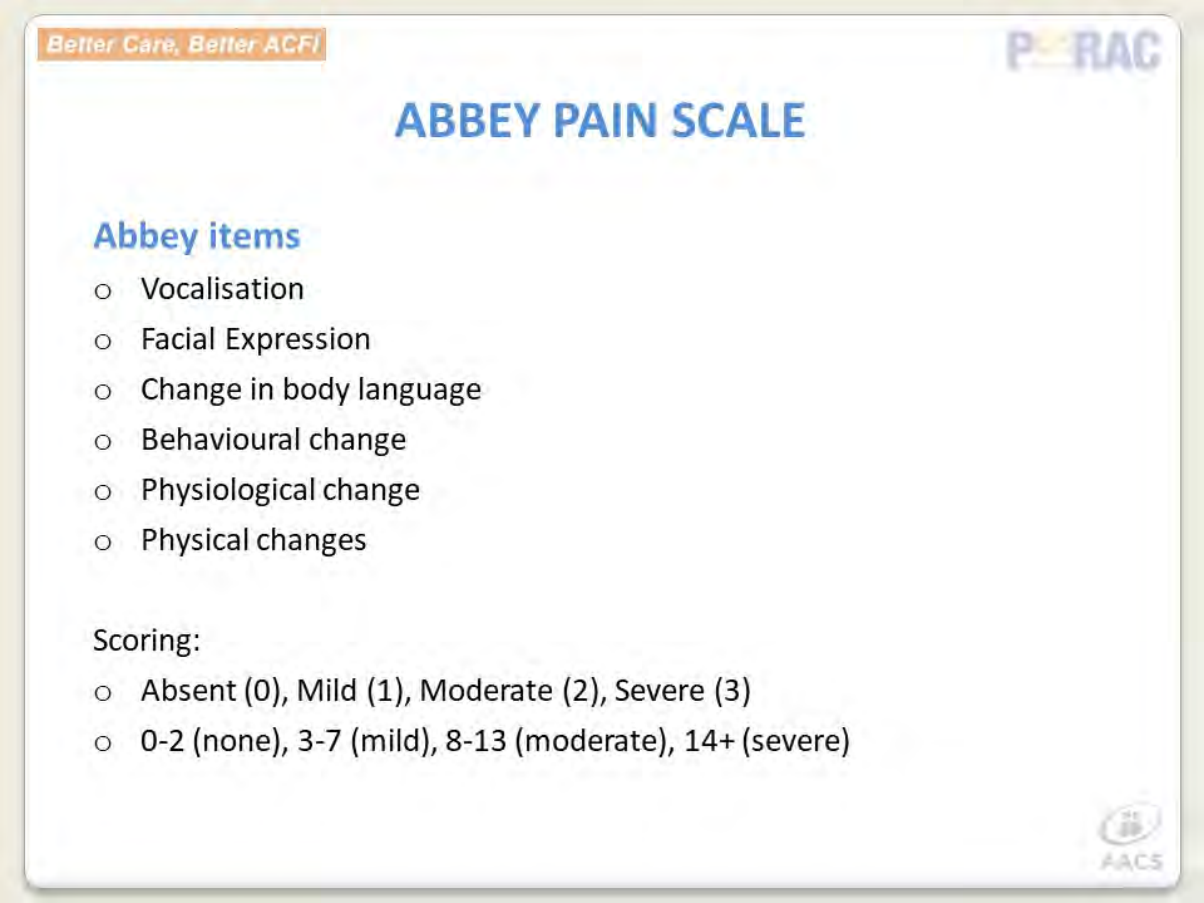


❖ **Activity: Note any observed pain symptoms from the PAINAD video**

Breathing	
Negative vocalisation	
Facial Expression	
Body Language	
Consolability	

❖ **Activity: Note the care planning activities that were discussed in the PAINAD video**

1	
2	
3	
4	
5	



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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

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Wellness/Therapy Program

Turning interventions into SMART goals

SMART Goals are:

- **Specific**
- **Measurable**
- **Action-oriented**
- **Realistic**
- **Time-based**

Resident Goals ≠ Clinical Goals

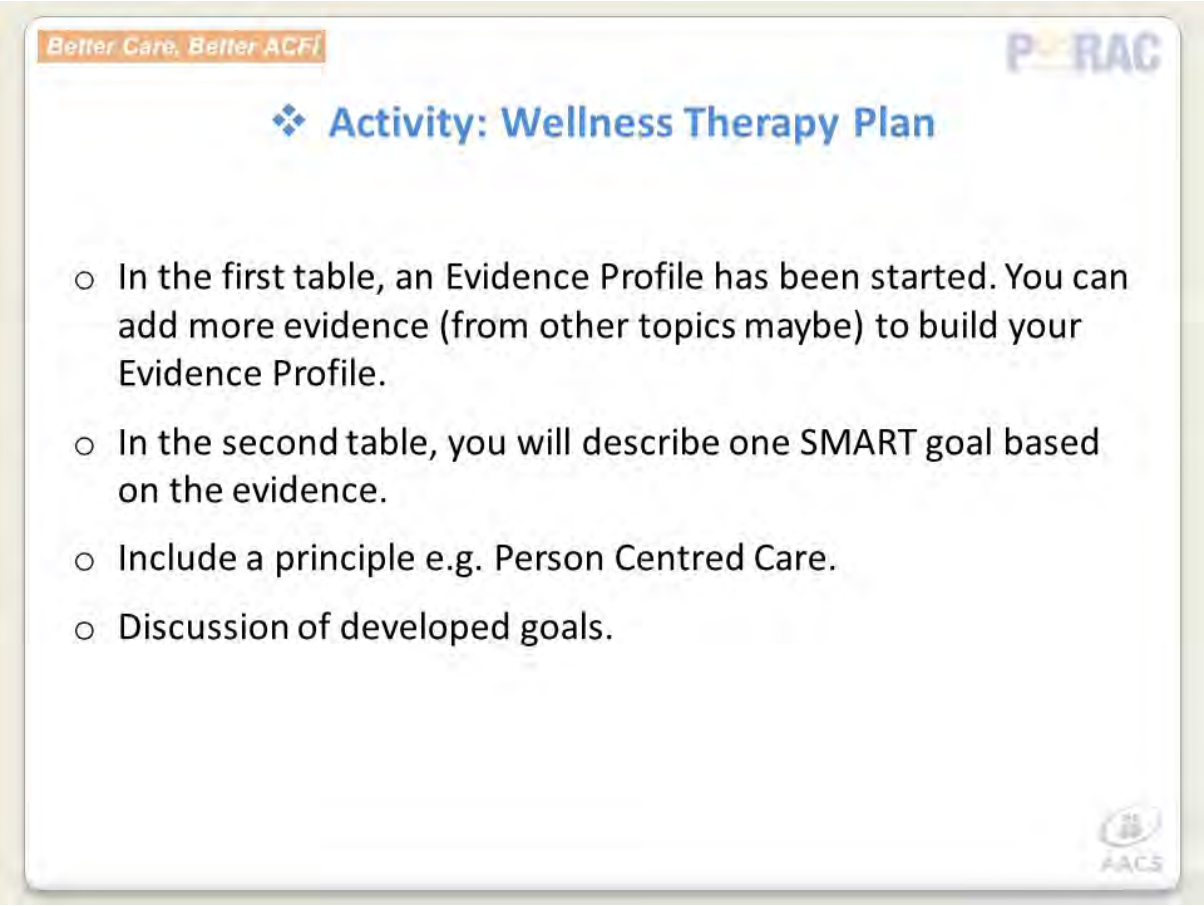
AACS

SMART Goals are an example of a standardised approach to goal setting with measurable outcomes. **SMART goals** are:

- **Specific –** they provide clarity, focus and direction.
- **Measurable –** objective measures demonstrate the effectiveness of the goal.
- **Action-oriented –** they provide a strategy to achieve goals.
- **Realistic –** so that they are achievable. Failure to achieve goals can impact on the resident's motivation, interest and participation.
- **Time-based –** they are current for a specific period of time. These goals can be measured at intervals, and re-evaluated on an ongoing basis (www.projectsmart.co.uk)

It is important to recognise that the resident's goals are not the same as clinical goals that are established by health professionals.

The resident's goals should be based on a person-centred approach that incorporates their physical, psychological and/or social needs. The clinical goal should be meaningful to the resident to achieve their own realistic goal. It is therefore important to include the resident/their family in the goal setting process, so that all interventions and therapies have a purpose.



❖ Activity: Evidence Profile

Evidence ***You can change or add evidence***	**Source Document**
Diagnoses- stroke, chronic pain	ACCR or Comprehensive Medical Assessment
Referral to CNC pain specialist	Initial Nurse Assessment
Impairment to left side upper and lower limbs, reduced dexterity in left hand.	Range of Movement (ROM)
High Falls Risk	FRAT or Physical Mobility Scale
Moderate but constant pain in left leg and arms, severe intermittent pain in left hand at night.	Pain
Recommendation for exercises to improve dexterity, upper and lower limbs.	Physiotherapist's Report
Recommendation for diversional therapy.	Clinical Nurse Consultant
A keen bird watcher at home would go into the garden every morning to observe the birds.	Add personalised information from a resident/family interview
Noted boredom in the morning and his pain is impacting quite badly on his quality of life.	Add personalised information from a resident QOL assessment

❖ Activity: SMART Goal

Describe one goal based on the developed evidence

Specific	A specific goal identifies exactly what is intended to be achieved, not just a general intention.
Measurable	These are things you can 'measure' as improvements rather than just having a hunch that things are improving.
Action orientated	Provide a strategy to achieve them.
Realistic	The goal must match with the known situation. They should be realistic. Achievement of small goals can provide motivation and pleasure.
Time-based	Goals need to have a time frame to determine the timing of the evaluation.

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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.**

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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: Documentation of a directive

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

What should the ‘Directive’ look like?

Your example:

Example of a Directive

ACFI 12.3. SIMPLE PAIN DIRECTIVE - <u>Therapeutic Massage</u> AND/OR <u>Application of Heat Packs</u>

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: ……

<u>Treatment Application of heat packs</u>

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

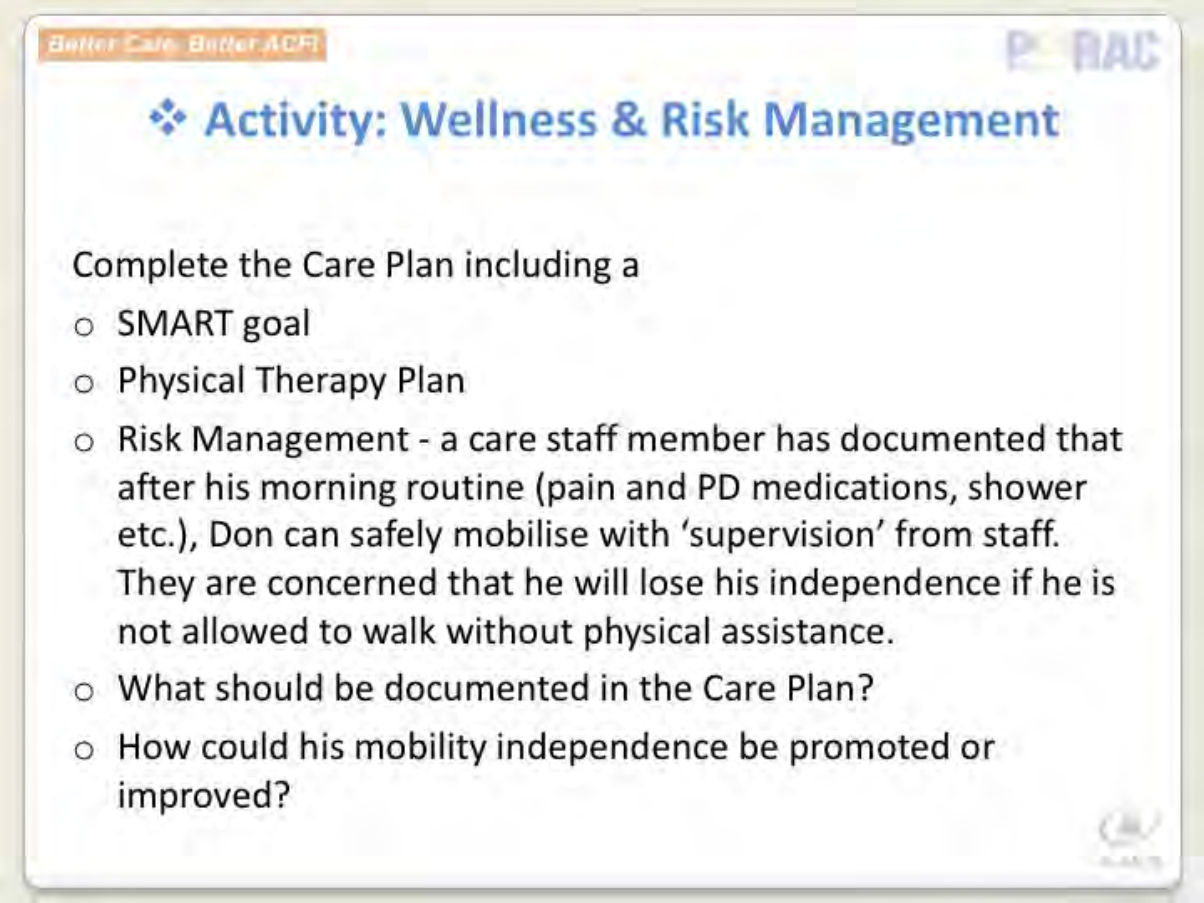
Treatment length: _____mins per session

By staff type (tick) PCW EN RN

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

Signature/Date

Name/Qualification



Background information and the functional assessment details have been provided.

Evidence Profile (Don)	**Source Document**
SMMSE = 9/10 (intact). Diagnosis of Parkinson's Disease. Independent with aid for mobility once up, needs assistance to get out of bed in the morning.	**ACCR (Dec 2016)**
Personal Interests: Long-time follower of the Tour de France. Cycled most of his life recreationally and to work (as projector operator at local cinema). Favourite film genre- Italian comedies. Great Italian cook, cooked for the family on weekends. Loves to participate in the cooking classes every Wednesday morning, but has missed it sometimes when his morning hygiene activities have been delayed.	**New Resident Interview (2 Jan 2017)**
Assistance of one person for transfers, independent with mobility. Uses 4WF.	**PMS (RN: 9 Jan 2017)**

Evidence Profile (Don)	Source Document
Multiple near falls reported, staff standing nearby and able to stop him falling with verbal assistance.	**Progress Notes (12-14 Jan 2017)**
Moderate pain in L knee on movement in last 24 hours. Interferes with his walking mildly, does not impact on other activity, has limited his interactions with other residents and activities.	**Pain Ax (RN: 14 Jan 2017)**
PAS-CIS = 4 (MILD). Scored on STML items.	**Cognition (EN: 15 Jan 2017)**
FRAT score =11. The FRAT rating was increased to medium because he has had three near falls while staff were walking next to Don when he nearly fell. He also has pain in his R knee which puts him at further risk.	**FRAT reviewed (RN: 15 Jan 2017)**
Fell at home before entry to care, tripped over a rug edge. This week he has had a number of near falls while walking, but staff have stopped him falling. He has since complained of L knee pain- Panadol commenced TDS and to be seen by the Physiotherapist.	**GP (15 Jan 2017)**
Left knee pain from strain caused by near fall, care staff to apply heat pack every morning for 5 minutes prior to rising from bed. Assess with pain intensity tool before and after heat pack every Monday morning. One staff member to physically assist (on his right-hand side) for transfers and mobility. Requires rails in shower and toilet. May need standing hoist when tired. Uses 4 WF. Physical exercise program in place to help assist with recovery from the knee injury and to promote a healthy gait and balance which is particularly at risk due to his PD	**Physio Report (16 Jan 2017)**
L knee joint issues (poor ROM, swelling, pain) L wrists and fingers (poor ROM, swelling, pain)	**ROM (Physio: 16 Jan 2017)**
A care staff member has documented: - That Don has requested to be allowed to be mobilise without assistance when he feels that he can. He values his independence. - That Don has been mobilising well after he has taken his morning medications for pain and PD this week. That he safely mobilises with his mobility aid and with distant supervision and has been getting to cooking class on time.	**Progress Notes (EN: 1 Feb 2017)**

Case Study: Don's functional assessment details

Falls Risk (FRAT)	Level	Risk Score
Recent falls	One or more in last 3 months (when not in care)	6
Medications	One, anti-PD	2
Psychological- judgement re mobility, depression	Does not appear to be affected, has safe mobility behaviour and is not depressed	1
Cognitive status	PAS-CIS = 4 (MILD)	2
	LOW RISK	**11/20**
Notes: The FRAT rating was increased to medium because he has had three near falls while staff were walking next to Don when he nearly fell. He also has pain in his R knee which puts him at further risk.		

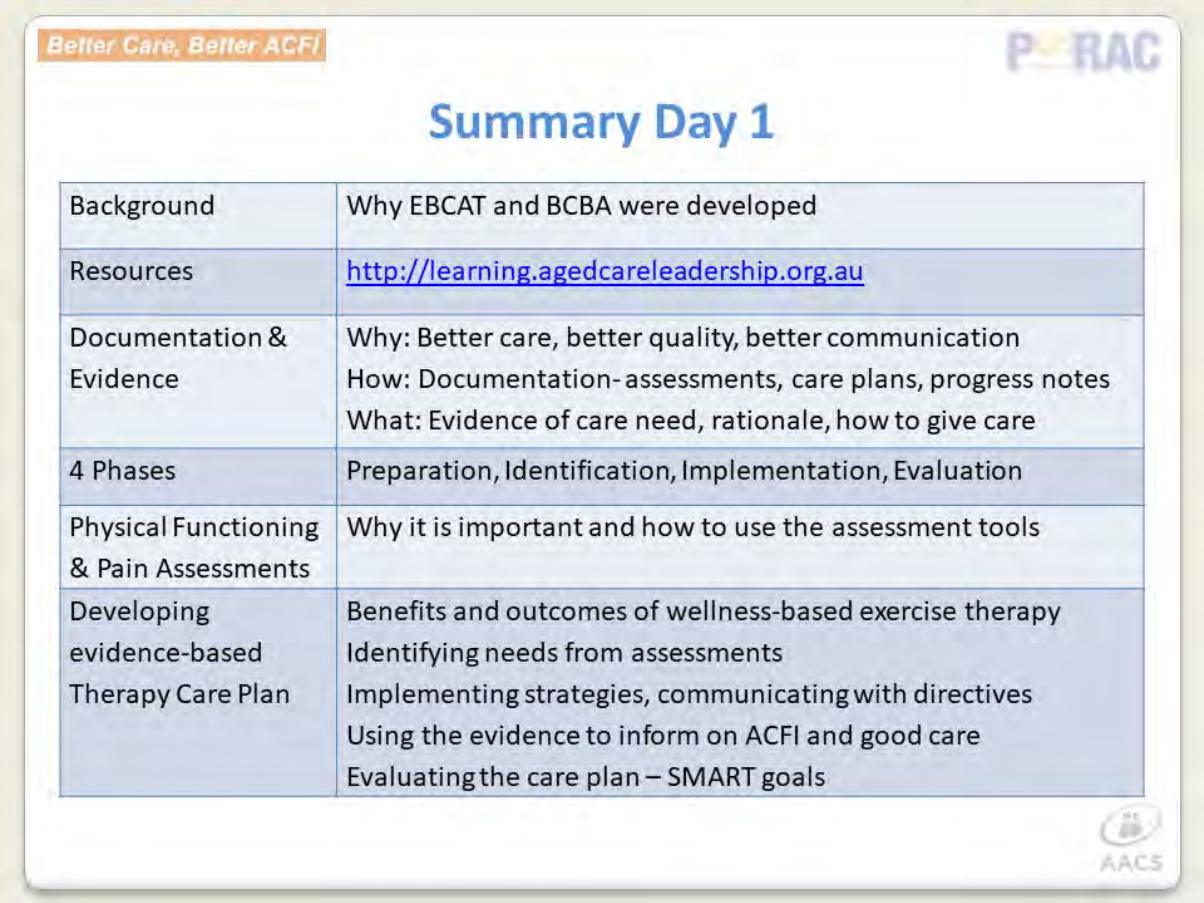
Physical Functioning (PMS)	Level	Score
Supine to side lying (L)	Requires equipment (bedrail)	3
Supine to side lying (R)	Requires equipment (bedrail)	3
Supine to Sit	Requires assistance with lower limbs or upper limbs only	3
Sitting Balance	Sits unsupported, turns head and trunk to look behind to left and right	4
Sitting to Standing	Requires equipment (4WF) to pull to standing	2
Standing to Sitting	Requires help to descent	2
Standing Balance	Able to safely stand using aid: 4WF	1
Transfers	Assistance of one person required (R side trunk)	3
Ambulation/Mobility	Ambulant with assistance of one person and 4WF	3

Range of Movement (CHA)	Response
Shoulder joints	Full active movement against gravity (3)
Elbow joints	Full active movement against gravity (3)
Forearms	Full active movement against gravity (3)
Wrist joints	Left- Poor ROM & Swelling (2)
Finger and thumb joints	Left- Poor ROM & Swelling (2)
Knee joints	L knee- Poor ROM & Pain & Swelling (2)

❖ Activity: Complete the SMART Goal & Physical Therapy Plan for Case Study Don

SMART Goal	***Specific**:* ***Measurable**:* ***Action orientated**:* ***Realistic:*** ***Time-based**:*
Physical Therapy Plan	
Risk Management	

Day 1: Summary



Day 2: Overview

Day 2 will focus on the Cognition and Behavioural Expression assessments to develop an evidence-based Behaviour Care Plan. We will use a case study to practice completing an ACFI claim based on assessments, and revisit the role of good documentation for good care and robust ACFI claims.