Participant Workbook

Day 2

PSRAC LEADERSHIP
PUBLIC SECTOR RESIDENTIAL AGED CARE

aacs
APPLIED AGED CARE SOLUTIONS

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

La Trobe University

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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

Better Care, Better ACFI

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

Better Care, Better ACFI

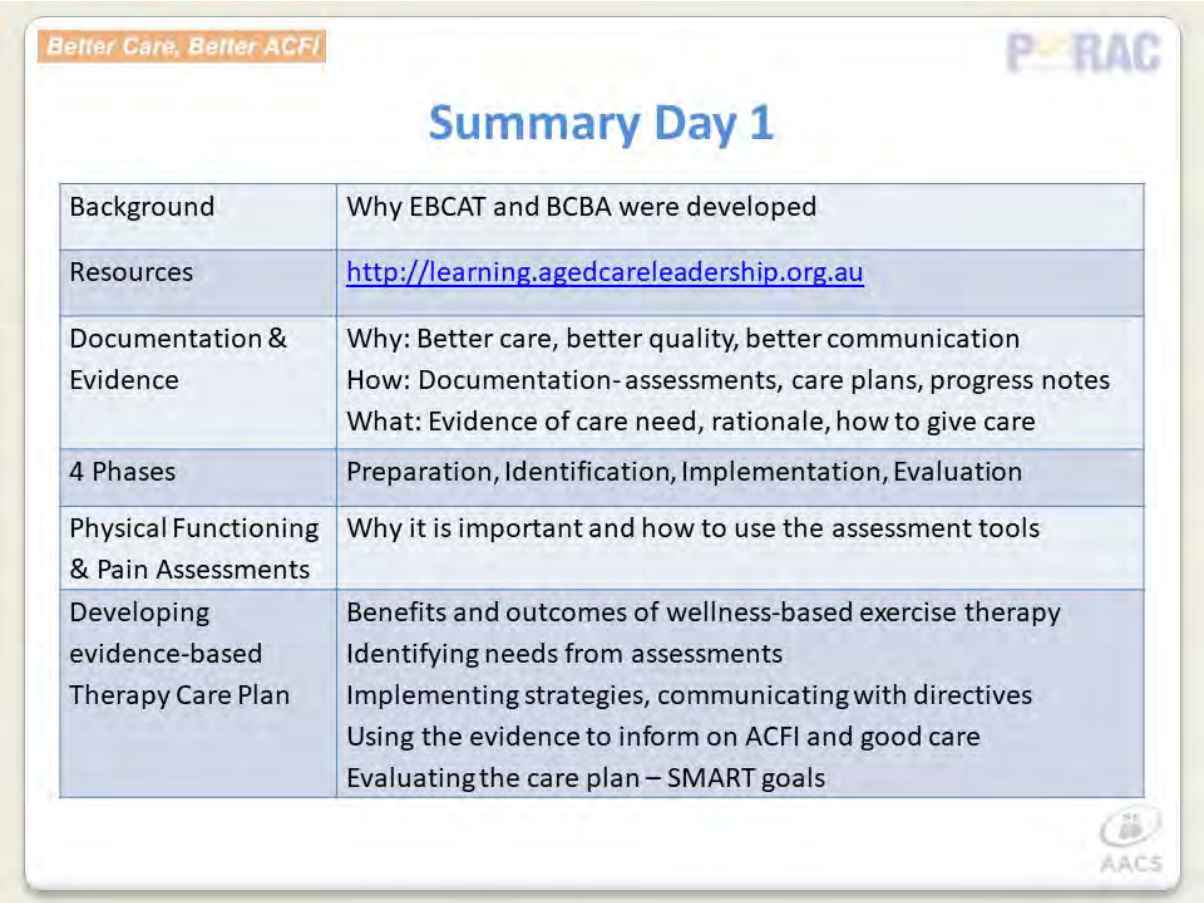
Objectives

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

Day 2: Overview

Having completed Day 1, participants will now be familiar with the process, the resources and the aims of the EBCAT and BCBA – to provide resources that will support Residential Aged Care Services to provide best care to residents and result in better ACFI outcomes. Day 1 practiced the process looking at an evidence-based Therapy Care Plan using Physical Functioning and Pain Assessments.



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.

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Program Day 2

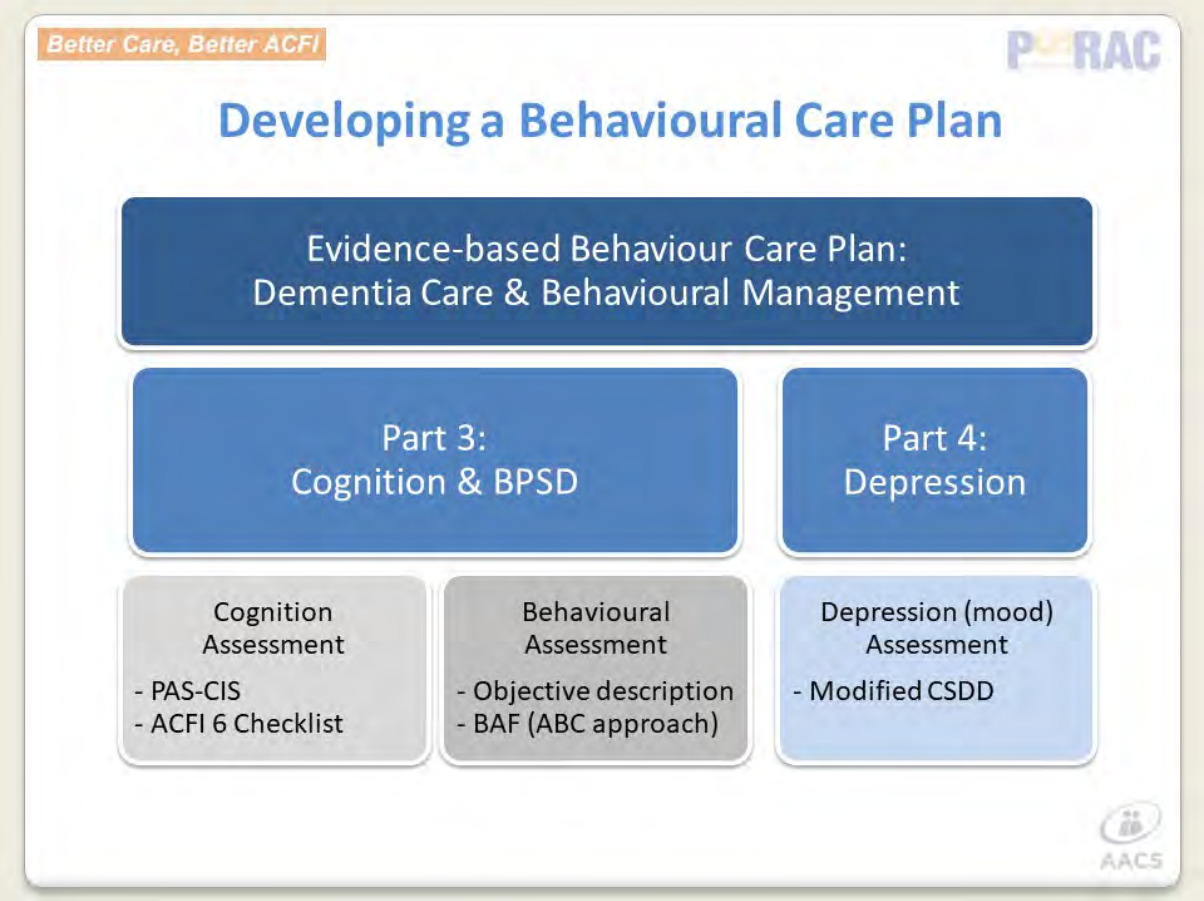
	Day 2
9.00 – 10.45am	Review of Day 1 and objectives Developing an evidence-based Behavioural Care Plan -Evidence for the Care Plan & ACFI (Part 3 Cognition & BPSD)
10.45 – 11.00am	BREAK
11.00 – 12.30pm	Developing an evidence-based Behavioural Care Plan -Evidence for the Care Plan & ACFI (Part 4 Depression)
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

Better Care, Better ACFI

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



What are the Behavioural Expressions

The investigation of behavioural expressions includes assessing cognition, behavioural and psychological symptoms (i.e. mood). A diagnosis of a cognitive impairment or mental health illness, link these topics:

- More than 50% of residents in Australian government-subsidised aged care facilities have dementia (85,227 out of 164,116 permanent residents with an ACFI assessment at 30 June, 2011)
- Almost half (44%) of permanent residents with dementia also had a diagnosis of a mental illness
- Dementia is the single greatest cause of disability in older Australians (aged 65 years or older) and the third leading cause of disability burden overall. (https://www.dementia.org.au/statistics)

Dementia is associated with a progressive cognitive decline, and behavioural and psychological symptoms of dementia (BPSD) - such as agitation, wandering, verbal and physical behaviours, depression, anxiety and psychosis. If not managed, it leads to a decreased quality of life for the resident. Good dementia care can be good care for any resident.

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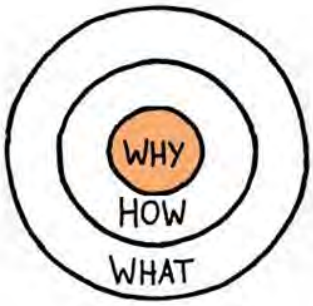
Developing a Behavioural Care Plan



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.

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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.*

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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

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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?

When the PAS assessment tool is not suitable and the resident **can be interviewed**, and depending on their cultural background and level of cognitive impairment, there are two further assessments provided to help inform on completing the ACFI 6 checklist.

- **Kimberley Indigenous Cognitive Assessment (KICA-Cog)** The KICA-Cog is the only validated screening tool for older Indigenous Australians.
- **Rowland Universal Dementia Assessment Scale (RUDAS).** This is a short cognitive screening tool designed to minimise the effects of cultural learning and language diversity on the assessment of cognitive performance.

When using the KICA-Cog or RUDAS, the assessor will still have to identify the level of cognitive impairment based on the ACFI 6 checklist. However, the alternative assessment may assist in that determination and provide valuable information for your care planning.

You will need to consider if the resident is suitable to be interviewed. If they have an adequate comprehension of English (e.g. can understand what is said to them and they can be understood) they may be suitable.

Also consider the following, for identifying when a resident **may not be suitable** to be interviewed or in particular when using the PAS-CIS:

- Have severe cognitive impairment or are unconsciousness
- Have a diagnosis of dementia in diseases such as Parkinson's, Picks, Huntington's
- Have a diagnosis of Intellectual Disability
- Have a diagnosis of other mental and behavioural disorders
- Have a speech impairment (cannot be understood), or are from a cultural or diverse linguistic background (their background does not inform on the questions), or have a sensory impairment (they may have difficulty with a number of items that are not suitable for hearing or sight impaired)
- They refuse to participate (that is their right).

Preparing for a cognitive assessment

- Ensure you have the competencies to undertake the assessment
- Set up an appropriate environment for conducting an interview (e.g. no distractions, quiet, suitable lighting)
- Familiarise yourself with background information about the person

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❖ 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

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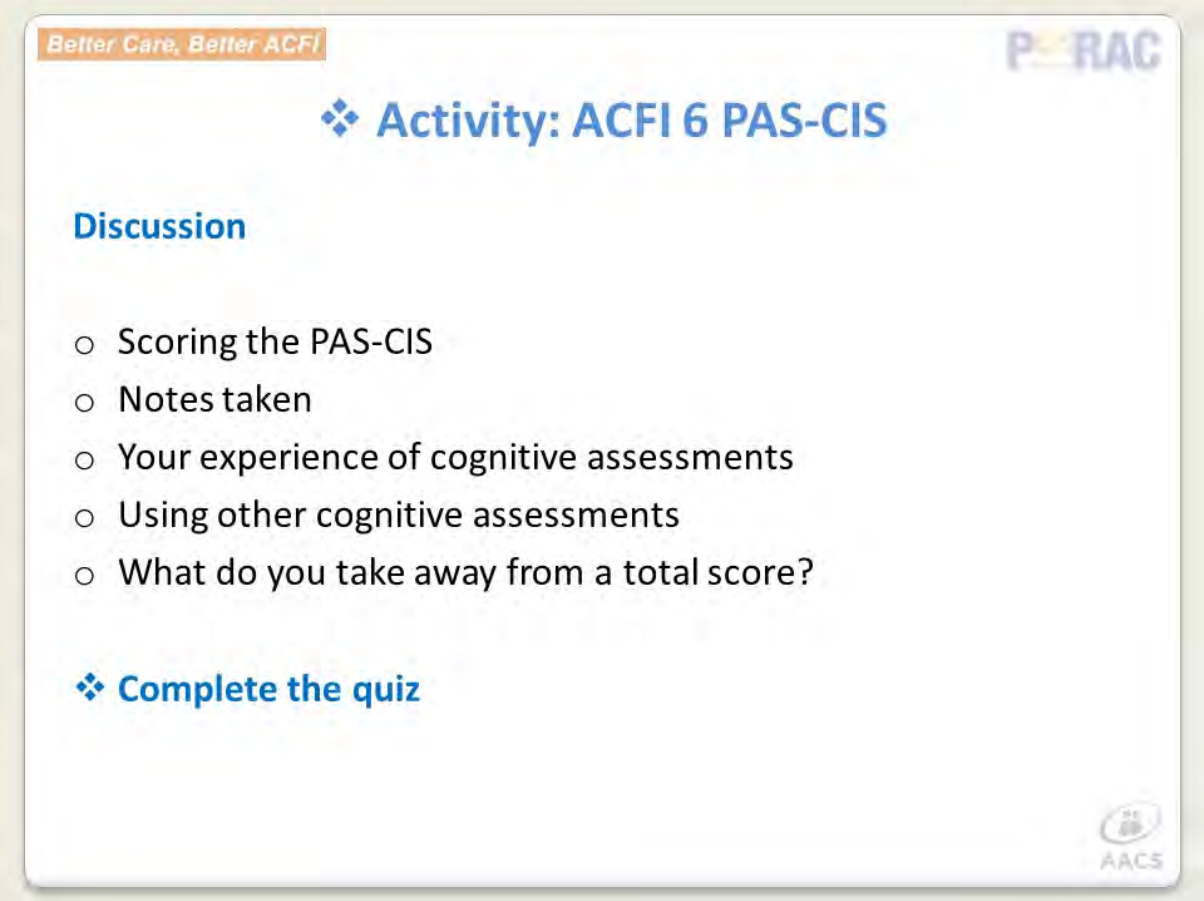
❖ Activity: ACFI 6 PAS-CIS

❖ 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: Video – ACFI 6 PAS-CIS

A short version of the PAS-CIS follows on the next page.

PAS-CIS assessment	This video shows: Psychiatrist interviewing the resident
While watching video take note of the steps	o Building rapport, to help put the person at ease o Informing when the assessment is commencing o Getting consent
PAS-CIS discussion	This video shows: Psychiatrist discussing ▪ The PAS-CIS interview process ▪ The scoring for each PAS-CIS item ▪ Common mistakes when scoring
While watching video take note of	o Why it was important to put the resident at ease o Why and how each item was scored o Which items require more detail to score correctly o Common mistakes when scoring

	PAS-CIS			
	I am going to name three objects. After I have said them I want you to repeat them. Remember what they are, because I am going to ask you to name them again in a few minutes… ***Apple, Table, Penny*** ***Repeat objects until all three are learned. Stop after five unsuccessful attempts***	0 Correct	1 Incorrect or refusal	? Not asked
1	*Would you please write any complete sentence on the piece of paper.*			
2	*Now what were the three objects I asked you to remember?*			
	Apple			
	Table			
	Penny			
	Please listen carefully to the following name and address, then repeat it: ***John Brown, 42 West Street Kensington*** *Please go on remembering this name and address as I will ask you about it later*			
3	*Tell me who they were or why they were famous in the past*			
	Charlie Chaplin (actor, comedian, film star, comic)			
	Joseph Stalin (soviet, Russian, WW2 leader, communist leader)			
	Captain Cook (explorer, sailor, navigator, discoverer)			
	Winston Churchill (British/English, prime minister, WW2 leader)			
4	*New Year's Day* falls on what date? *(first of January/first day of new year)*			
5	*What is the name and address I asked you to remember a short time ago?* (order is not important)			
	John			
	Brown			
	42			
	West Street			
	Kensington			
6	*Here is a drawing. Please make a copy of it here*			
7	*Read aloud the words on this page and then do what it says- close your eyes*			
8	*Read aloud the words on this page and then do what it says- cough hard*			
9	*Tell me what objects you see in this picture?*			
	Teapot, Kettle			
	Telephone			
	Scissors			
	Fork			

PAS-CIS Assessment Knowledge Quiz

Q1	What is a complete sentence?	☐ Has a subject ☐ Has a verb ☐ Makes sense ☐ All of the above
Q2	What shape do the two intersecting pentagons form?	☐ 5-sided figure ☐ 4-sided figure ☐ Pentagon ☐ Square
Q3	Is spelling and grammar considered when scoring the sentence?	☐ Yes ☐ No
Q4	Is a general indication about a famous person (e.g. he is a funny person) enough for the question to be scored as correct?	☐ Yes ☐ No
Q5	How many attempts at registration (e.g. the three objects) should be allowed?	☐ 1 ☐ 3 ☐ 5 ☐ As many as it takes to remember
Q6	If the sentence is illegible, should you ask them to read it out	☐ Yes ☐ No

Other cognitive tests: SMMSE

The Standardised Mini-Mental State Examination (SMMSE) is a 12-item cognitive impairment screening test which is commonly used across community health facilities, and universally used by the Aged Care Assessment Team. The My Aged Care report may comment on the SMMSE score or the items. While the SMMSE score can be mapped to the ACFI 6 Checklist, the items hold the depth of the information that can inform on care needs further.

Cognitive Skills Checklist	PAS-CIS	SMMSE	Rating
No or minimal impairment	0-3	25-30	1
Mild Impairment	4-9	21-24	2
Moderate Impairment	10-15	10-20	3
Severe Impairment	16-21	0-9	4

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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.

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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.

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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.

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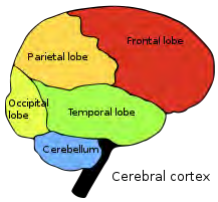

❖ Cognitive impairment related to the location in the brain

Frontal lobe	Executive functions such as planning, decision making, working memory, responding to feedback, error correction, mental flexibility, inhibition/regulation of social behaviour e.g. They may display socially inappropriate behavior.
Parietal lobe	Storing new information, short term memory, long term memory, distinguishing sounds and smells e.g. Be unable to follow more than one command at a time.
Temporal lobe	Language and reading, spatial perception, touch and pressure, judgement of size and shapes. e.g. Hand-Eye coordination
Occipital	Visual reception, recognition of colours and shapes e.g. Visual hallucinations
Cerebellum	The cerebellum receives information from the sensory systems, the spinal cord, and other parts of the brain and then coordinates voluntary movements such as posture, balance, coordination, and speech, resulting in smooth and balanced muscular activity.

❖ 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**

Transfer into the Evidence Profile (Checklist) on page 101

Cognitive Skills Checklist

Consists of 4 levels of impairment, with a description that looks at the impact of cognition on the following aspects:

- Memory loss
- Everyday activities/ Personal care
- Orientation (time, place and person)
- Communication

ACFI 6. Cognitive Skills Checklist	Tick one
None or minimal impairment PAS-CIS = 0-3 (decimal under 4) / SMMSE = 25-30 No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care.	☐ 1
Mild impairment PAS-CIS = 4-9 (decimal fraction under 10) / SMMSE = 21-24 May appear normal but on investigation has some problems in everyday activities. Memory: 3 item recall orientation (time then place) IADL: Problems with driving, finances, shopping Not independent in chores/ interests requiring reasoning, judgement, planning etc. (i.e. cooking, use of telephone). Personal care: Memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance) Orientation: Disorientation in unfamiliar places Communication: Word finding, repeating, goes off topic, loses track	☐ 2
Moderate impairment PAS-CIS = 10-15 (decimal fraction under 16) / SMMSE = 10-20 Has significant problems in the performance of everyday activities, requires supervision and some assistance. Memory: WORLD spelling, language and 3 step commands. New material rapidly lost, only highly learned material retained Personal care: Requires physical assistance with some ADLs (e.g. dressing, washing body, toileting) Orientation: Disorientation to time and place likely Communication: Possibly sentence fragments, empty speech, vague terms (i.e. this, that)	☐ 3
Severe impairment PAS-CIS = 16-21 / SMMSE = 0-9 Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions. Memory: All areas show obvious deficits. Only fragments of past events remain Personal care: Requires full assistance with most or all ADLs related to cognitive impairment Orientation: Orientation to person only Communication: Speech disturbances (i.e. slurring, stuttering) are common	☐ 4

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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.*

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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

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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

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Behavioural Description

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

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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**

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❖ Activity: Behavioural Descriptions

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

❖ Activity: Behavioural Descriptions

Complete the following: Look at the descriptions of Behavioural Expression Type in the first column and think of an occasion in your experience when you have witnessed an example of these behaviours. In the second column provide an **objective** description of those events.

Can you describe the most difficult behaviour to manage?

Behavioural Expression Type	**Your objective description example**
Mr. Gray interferes with others while wandering	
Verbal refusal to participate in daily care	
Socially inappropriate	
Physically agitated	
What is the most difficult behaviour?	

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❖ Activity: Behavioural Assessment

- ❖ Video – Describing Behaviours A
- ❖ Video – Describe Behaviours B
  - Complete the modified Behaviour Assessment Form (BAF)
  - Discussion
  - Complete the Evidence Profile
  - Discussion

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Modified Behaviour Assessment Form

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

Disruptiveness Scale:

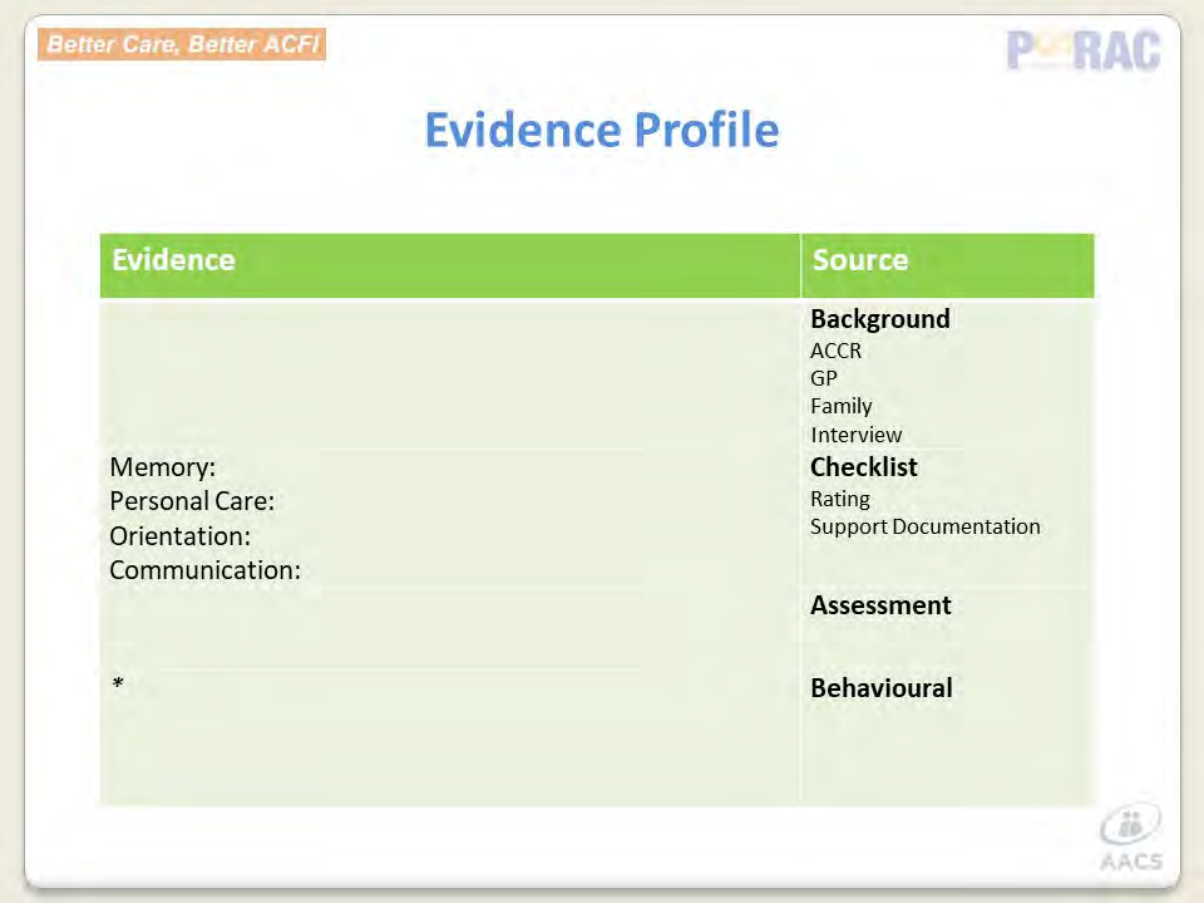
(0) None (Not disruptive no intervention by staff)

(1) Mild (A little disruptive co-operative response to intervention, not disruptive to other residents or visitors)

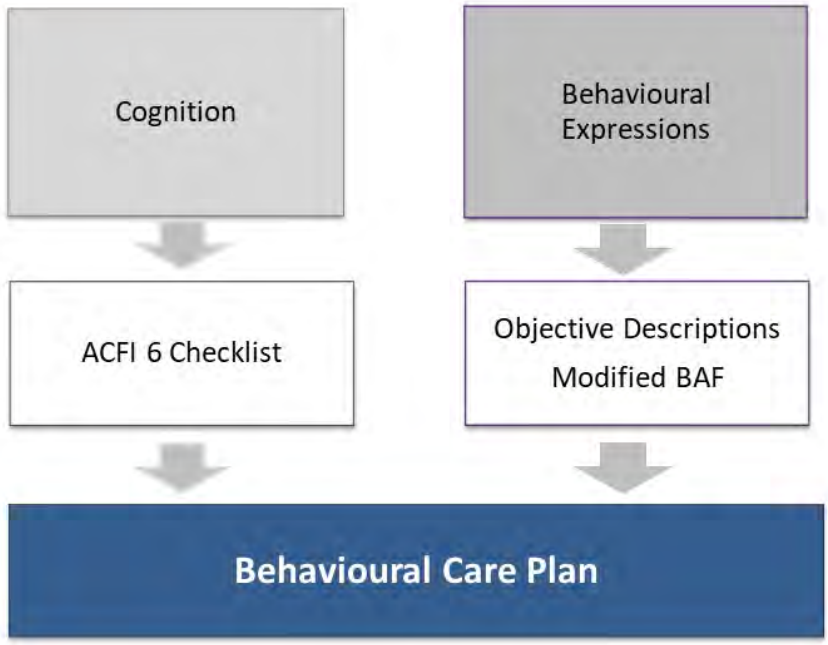
(2) Moderate (Moderately disruptive not always co-operative, but can be resolved with intervention, sometimes disruptive to other residents or visitors)

(3) Severe (Very disruptive sometimes requires immediate intervention, interferes with others, their belongings or visitors, asocial behaviour)

(4) Extreme (Extremely disruptive always requires immediate intervention, wakes others at night, disruptive to others during the day, requires one or more staff, attention or constant attention)



Transfer into the Evidence Profile (Behaviour) on page 101



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❖ Activity: Behavioural Care Plan

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

Dementia Care Planning

Good dementia care can be good care for any resident. Interventions that include a relaxed social environment, access to meaningful activities, and positive staff- resident relationships should be considered for all residents. A behaviour Care Plan should consider a range of non-pharmacological approaches, such as:

Person Centred Care	Taking into account the cultural, family values, interests and likes of the person. Looking after the whole of the person, their quality of life and their health needs.
Built Environment	The physical environment should be calm and supportive- small, homelike, with ready access to staff, and an arrangement of shared areas, single bedrooms with ensuites and access to safe garden walks. Noise and lighting should also be considered.
Relationships	Staff, other residents and the community should engage with the person as far as possible and encourage social interaction.
Activity and recreation	Meaningful activities that the person can relate to, even if they have memory loss.
1-1 interaction	Engaging the person in their surroundings, in conversation. Using daily interactions to engage the person.
Care routines	How can the care routines can be modified?
Physical activity	Exercise, incidental activity is good for the body and the brain.
Pleasant Events	Provides an opportunity to improve or maintain mood.
Broader health needs	Sleep- allowing people to sleep in and awake naturally. Pain- assess and manage pain
Communication	Effective verbal and non-verbal messages. Simple, short, slow down.
Referrals to specialist support services	Residential Support Program, DBMAS, Severe Behaviour Response Team, APMH/APATT, private services
Specific instructions for staff	Provides a consistent approach. Specialist care plans for severe BPSD can provide detailed instructions for staff to avoid triggers or how to respond to an escalating situation.

❖ Activity: Behavioural Care Plan

Evidence Profile (Background)

Evidence	Source Document
Diagnosis of dementia.	**ACCR (Jan 2015)**
Requires staff to physically assist with all activities of daily living due to cognitive impairment, does not initiate eating or personal hygiene activities.	**GP (Feb 2015)**
Mum had six children, and always seemed to have a baby in her arms, hers or her grandchildren. She loved her garden, helping and talking to others and was always busy.	**Family Interview (Feb 2015)**

Evidence Profile (Checklist – see p92)

Evidence	Source Document

A person with moderate or severe cognitive impairment or dementia will have a limited ability to make a rational or logical interpretation of the stimuli or how to communicate an unmet need.

Example: Evidence Profile (Behavioural – see p98)

Evidence	Source Document

The behavioural expressions can be considered a form of communication (Kozman et al, 2006) but in the case of a person with dementia it will not form a volitional, deliberate or rational course of actions designed to produce a particular outcome.

Evidence ⇨ Actions (Care Plan, Training Requirements)	**Source Documents**
Care Plan: e.g. How would you develop a strategy for undertaking the resident's personal hygiene activities or for diversional activities? e.g. What activities would you plan for the resident?	
Evaluation (how often?) **SMART Goal:** Specific: Measurable: Action-oriented: Realistic: Time-based:	

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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)

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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?

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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

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❖ Activity: How to document for CSDD

❖ **Video - CSDD Assessment**

- Take note of the three items that were scored and score the items
- 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

❖ Activity: How to document for the CSDD

Refer to the ACFI Assessment Pack, for details on how to complete the Modified Cornell Scale for Depression.

Part 1: Complete the Anxiety item

Anxiety (is an anxious expression of emotional discomfort, worrying, frowning) **Note: Anxiety is about mood, facial expressions and feelings. Agitation refers to physical symptoms of restless.**	
Tick, if the following observations/questions were addressed, and record the evidence.	
☐ Observed the resident ☐ Have you been feeling anxious in the last week? ☐ Have you been worried about things more than other people? Can you give me an example? ☐ Does this happen occasionally or often? ☐ How much does it interfere with your everyday life?	
☐ Staff interview ☐ Other	☐ Resident Interview ☐ Observation
Notes taken about his anxiety	

Part 2: How would you score the items

	Unable to score	Absent	Mild	Severe
Mood- Chronic Anxiety				

Frequency: Occasionally is intermittent (some days) / Often is persistent (nearly every day)
Interference: Minor is requires regular encouragement/ Major is limited or no participation
Mild is Minor interference + often or Major interference + occasionally
Severe is Major interference + often

Part 3: Strategies

Note one suggestion that you think would improve his Quality of Life?

❖ ACFI Case Study: Frank

Read the background and assessment information provided below, and complete the requested information for ACFI 1-4, ACFI 6, ACFI 7-9, ACFI 10, ACFI 12.

Admission History

Frank is 89 years old. He has been living with his wife Olive in an RSL village, he was receiving a Community Aged Care Package, but his condition has deteriorated. Frank served in the Korean War. He had maintained close ties to the ex-service community and was very active in the RSL up to 2 years ago. Frank was admitted to permanent care one month ago.

Personal History

Olive was asked to describe a typical day

Olive wakes Frank about 9am, helps him sit up and put on his robe and slippers. Frank would take himself to the toilet. He relied on Olive to help him get out of bed and out of chairs. He moved around the home quite safely using his frame. He would then have breakfast with Olive in the kitchen. Olive had some special cutlery and plates to help Frank with meals, and she followed a soft diet as directed by the hospital after his stroke. Olive stayed nearby when Frank was eating in case of any swallowing difficulties.

After breakfast Olive would set out his clothing for the day, and physically assist Frank with washing at the basin, gently encouraging him to do what he could reach. Frank had hand rails to assist him on and off the toilet and wore pads because he moved quite slowly and often could not get to the toilet on time. Usually he was continent with bowels with a daily toileting routine after breakfast. But Olive had to help him with completing toileting activities (e.g. using the toilet paper). He was still able to shave using an electric shaver. Olive found cardigans with zippers easier than jumpers for Frank, she could help him put them on without causing any pain in the shoulders. Three days a week a carer would come to shower and dress Frank. The carer reported that Frank had become increasingly confused and resistive when dressing and undressing, Olive wondered if it was due to pain or if his dementia was worse. Olive never rushed Frank in the mornings.

Frank would fill his day with sitting near the kitchen or in the garden, looking through the paper, listening to the radio, sometimes pottering down to his shed which was 2 metres from the backdoor and in a very safe and small backyard. He use to love repairing and recycling items, but it had been a good two years since Frank could do that, due to the arthritis in his hands and shoulder. Olive would always be nearby busy doing housework and gardening, and neighbours often dropped in. The village would transport Frank up to the community room most weekdays for a couple of hours for group activities so Olive could have some time to herself. Frank's son had set up skype on a computer (which Olive could use) so they could talk every night after tea and Frank could see the grandchildren. Although he did not always follow the conversations and said very little, he loved to watch his family and listen to their banter.

He also enjoyed watching slapstick comedy in the community TV room, where he could have a laugh with familiar faces.

He usually had an afternoon nap for 1 hour, and was in bed by 9pm. He was becoming restless at night, wanting to get up a couple of times a night to go to the toilet. Because Olive had to help him out of bed, she had found this very tiring. He had two falls at the community centre in the month prior to admission when he tried to get up without his 4W frame.

Since admission, Frank has had a noticeable lowered mood, he looks sad all of the time and he does not look interested in the activities going on around him in his surroundings, his appetite and weight has reduced, but his mood picks up when Olive visits.

Documented History

Diagnoses

ACCR and CMA: CVA, Vascular dementia, Double incontinence, Type 2 Diabetes, Osteoporosis, High Blood Pressure, Arthritis and Mild Dysphagia.

CMA: Frank's doctor completed a Comprehensive Medical Assessment and reported that Frank had been re-assessed by a local Memory Clinic in the week before admission and they reported he now had moderate to severe dementia, where a year ago he had completed the assessment process, but now was not able to complete pen and paper assessments. They reported he had a dressing dyspraxia and also noted a lowered mood.

Care Related Issues

ACCR indicated

- Frank requires soft food or his food to be cut up, Frank will eat his meal with the use of special cutlery, but requires supervision during mealtimes due to his swallowing risk.
- Frank requires full physical assistance with Personal Care - he has limited ability to shower, he can assist with some small parts of showering and drying. Frank has a dressing dyspraxia (difficulty planning the sequence of each activity) and becomes very frustrated with himself, also he cannot manage buttons or zips. He can shave if it is set up for him, he has upper and lower dentures but he does not clean them.
- Frank walks short distances around his home with a 4W frame, but is forgetting to use his frame at the community centre. Due to the recent falls he needs supervision when walking.
- Frank is doubly incontinent and wears pads. Due to his dementia he needs physical assistance and prompting with the pads, with positioning onto the toilet or commode, with adjusting his clothing and attending to all toilet hygiene aspects.
- His last fall resulted in a wound on his left leg (a re-occurring leg ulcer);
- Frank requires close monitoring with medications (he needs reminding to take all of his pills) and he needs to be given plenty of time due to his swallowing risk.

- Unable to test his cognition due to the severity of his impairment. States he is disorientated to place (when away from home), and time, but not person. His short-term memory is poor.

Assessment Results

The collated history combined with assessments undertaken at the home, will be used to assist with understanding Frank's needs and for completing the ACFI.

Below are some examples of relevant information that was identified from the Initial Nurse Assessment (CHA), the Resident Nutrition Data Card (RNDC), the Falls Risk Assessment Tool (FRAT) and the Physical Mobility Scale (PMS).

Initial Nurse Assessment	**Response**
Mood	Sad, withdrawn, agitated when attending to personal care Recommend Depression Assessment
Pain	Identified in shoulders and hands Recommend Pain Assessment
Cognition	Moderate to severe dementia, agitated when attending to personal hygiene care, hits out at staff. Recommend referral to DBMAS for assistance with strategies to assist with ADLs

Dietary Assessment (RNDC)	**Response**
Type of diet	Diabetic
Texture	Soft, Cut up
Food likes	Ice cream, soup, porridge
Food dislikes	Spices, artificial sugar
Chewing and Swallowing Ability	Mild dysphagia (ACCR)
Dexterity	Limited dexterity (Physiotherapist ROM)
Eating Assessment (RNDC)	**Response**
Require assistance to be fed?	No
Require special utensils	Yes, Angled spoon and plate surround
Weight Assessment (RNDC)	**Response**
Weight	72 kgs and has lost 4 kgs in last 6 months
Height	6 foot/ 184 cms
Within healthy weight range?	Yes; BMI = 21
Malnutrition Risk	Medium

Swallowing Screen	Response
Has difficulty swallowing?	YES
Has a gag reflex?	NO
Has any difficulty swallowing food and fluid?	YES
Coughs while eating and drinking?	NO
Requires a texture modified diet?	YES

Falls Risk (FRAT)	Level	Score
Recent falls	One or more in last 3 months	6
Medications- anti-hypertensive	One	2
Psychological- judgement re mobility, depression	Appears moderately affected by one or more	3
Cognitive status	Moderate impairment	3
	MEDIUM RISK	**14/20**

Physical Functioning (PMS)	Level	Score
Supine to side lying (L)	Independent	5
Supine to side lying (R)	Independent	5
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 to pull to standing e.g. handrails	2
Standing to Sitting	Poorly controlled descent, stand-by assistance required	3
Standing Balance	Able to safely stand using aid: 4WF	1
Transfers	Assistance of one person required	3
Ambulation/Mobility	Stand-by assistance/prompting required	4
		30/45

Range of Movement (Nurse)	Response
Shoulder joints	Poor ROM (2) & Crepitus & Pain
Elbow joints	Full active movement against gravity (3)
Forearms	Full active movement against gravity (3)
Wrist joints	Poor ROM (2) & Swelling
Finger and thumb joints	Barely detectable muscle contraction (1) & Swelling & Pain

Complete the requested information for ACFI 1-4; ACFI 6; ACFI 7-9; ACFI 10; ACFI 12

Score ACFI Q1-4: Activities of Daily Living

	ACFI 1 Nutrition Checklists *Describe the evidence for a claim and the documents that support the claim.* *e.g. Which document provides the evidence and what is the evidence and what does it inform on Diagnoses, Assessment outcomes; Impact on body structure/ function; Activity Impairments*	
	Readiness to eat	
☐	Independent (0)	
☐	Supervision (1) o placing utensils in hand	
☐	Physical assistance (2) o cutting up food or vitamising food	
	Eating	
☐	Independent (0)	
☐	Supervision (1) o Standing by to provide assistance OR o Providing assistance with daily oral intake when ordered by a dietitian for a person with a PEG tube	
☐	Physical assistance (2) placing or guiding food into the resident's mouth for most of the meal	

	ACFI 2 Mobility Checklists *Describe the evidence for a claim and the documents that support the claim.* *e.g. Which document provides the evidence and what is the evidence and what does it inform on -. Diagnoses, Assessment outcomes; Impact on body structure/ function; Activity Impairments*	
	Transfers	
☐	Independent (0)	
☐	Supervision (1) o Locking wheels on a wheelchair to enable a transfer AND adjusting/removing foot plates or side arm plates OR o Standing by to provide assistance (verbal and/or physical)	
☐	Physical assistance (2) o Moving to and from chairs or wheelchairs or beds	
☐	Mechanical Lifting o Requiring physical assistance with the use of mechanical lifting equipment for transfers	
	Locomotion	
☐	Independent (0)	
☐	Supervision (1) o Handing the resident a mobility aid OR o Fitting of callipers, leg braces or lower limb prostheses OR o Standing by to provide assistance (verbal and/or physical)	
☐	Physical assistance (2) o Staff to push wheelchair OR o Assistance with walking	

	ACFI 3 Personal Hygiene Checklists *Describe the evidence for a claim and the documents that support the claim.* *e.g. Which document provides the evidence and what is the evidence and what does it inform on -. Diagnoses, Assessment outcomes; Impact on body structure/ function; Activity Impairments*	
	Dressing and undressing	
☐	Independent (0)	
☐	Supervision (1) o choosing and laying out appropriate garments OR o undoing and doing up zips, buttons or other fasteners including Velcro OR o standing by to provide assistance (verbal and/or physical).	
☐	Physical assistance (2) o dressing AND undressing i.e. putting on or taking off clothing AND footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings) OR o fitting and removing of hip protectors, slings, cuffs, splints, medical braces and prostheses other than for the lower limb.	
	Washing and drying	
☐	Independent (0)	
☐	Supervision (1) o setting up toiletries, or turning on and adjusting taps, OR o standing by to provide assistance (verbal and/or physical).	
☐	Physical assistance (2) o washing and/ or drying the body.	
	Grooming	
☐	Independent (0)	
☐	Supervision (1) o setting up articles for grooming, OR o standing by to provide assistance (verbal and/or physical).	
☐	Physical assistance (2) o dental care OR hair care OR shaving	

	ACFI 4 Toileting Checklists *Describe the evidence for a claim and the documents that support the claim.* *e.g. Which document provides the evidence and what is the evidence and what does it inform on - Diagnoses, Assessment outcomes; Impact on body structure/ function; Activity Impairments*	
	Use of toilet	
☐	Independent (0)	
☐	Supervision (1) o setting up toilet aids, or handing the resident the bedpan or urinal, or placing ostomy articles in reach OR o stand by to provide assistance with setting up activities (verbal and/ or physical)	
☐	Physical assistance (2) o positioning resident for use of toilet or commode or bedpan or urinal	
	Toilet completion	
☐	Independent (0)	
☐	Supervision (1) o standing by while the resident toilets to provide assistance (verbal and/ or physical) with adjusting clothing or peri-anal hygiene OR o emptying drainage bags, urinals, bed pans or commode bowls	
☐	Physical assistance (2) o adjusting clothing AND o wiping the peri-anal area.	

Score ACFI Q6: Cognitive Skills Checklist

ACFI 6. Cognitive Skills Checklist	Tick one
None or minimal impairment PAS-CIS = 0-3 (decimal under 4) / SMMSE = 25-30 No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care.	☐ 1
Mild impairment PAS-CIS = 4-9 (decimal fraction under 10) / SMMSE = 21-24 May appear normal but on investigation has some problems in everyday activities. Memory: 3 item recall orientation (time then place) IADL: Problems with driving, finances, shopping Not independent in chores/ interests requiring reasoning, judgement, planning etc. (i.e. cooking, use of telephone). Personal care: Memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance) Orientation: Disorientation in unfamiliar places Communication: Word finding, repeating, goes off topic, loses track	☐ 2
Moderate impairment PAS-CIS = 10-15 (decimal fraction under 16) / SMMSE = 10-20 If SMMSE assessment is inappropriate: Has significant problems in the performance of everyday activities, requires supervision and some assistance. Memory: WORLD spelling, language and 3 step commands. New material rapidly lost, only highly learned material retained Personal care: Requires physical assistance with some ADLs (e.g. dressing, washing body, toileting) Orientation: Disorientation to time and place likely Communication: Possibly sentence fragments, empty speech, vague terms (i.e. this, that)	☐ 3
Severe impairment PAS-CIS = 16-21 / SMMSE = 0-9 Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions. Memory: All areas show obvious deficits. Only fragments of past events remain Personal care: Requires full assistance with most or all ADLs related to cognitive impairment Orientation: Orientation to person only Communication: Speech disturbances (i.e. slurring, stuttering) are common	☐ 4

Score ACFI Q7-9: Describe any noted behaviours

Behavioural Expression Type	Your description

Score ACFI Q10: Complete one CSDD item - Q2

Q2: Sadness (in expression, voice, tearfulness)	
Interviewing staff or other informant: • Has X/ she/ he been sad or down in the last week? • Has X/ she/ he had a sad, unhappy appearance? • Has X/ she/ he cried? What was the cause? • Does this happen occasionally or often? • How much does it interfere with her/ his everyday life?	Interviewing the care recipient or observation: • Observe care recipient • Have you been sad or down in the last week? • Have you cried? What was the cause? • Does this happen occasionally or often? • For how long each time? • How much does it interfere with your everyday life?
Staff:	❑ Interview
Other:	❑ Observation
Notes: Since admission, Frank has had a noticeable lowered mood, he looks sad all of the time and he does not look interested in the activities going on around him in his surroundings, his appetite and weight has reduced, but his mood picks up when Olive visits. **Score**	
unable to score = a absent = 0 minor interference with everyday life and/ or symptoms occur occasionally = mild = 1 major interference with everyday life and symptoms occur often = severe = 2	

Score ACFI Q12: Complex Health Care

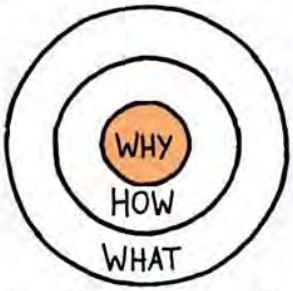
Identify any possible CHC claims

Item #	Procedure	Indicators and requirements

Write one example Directive

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)

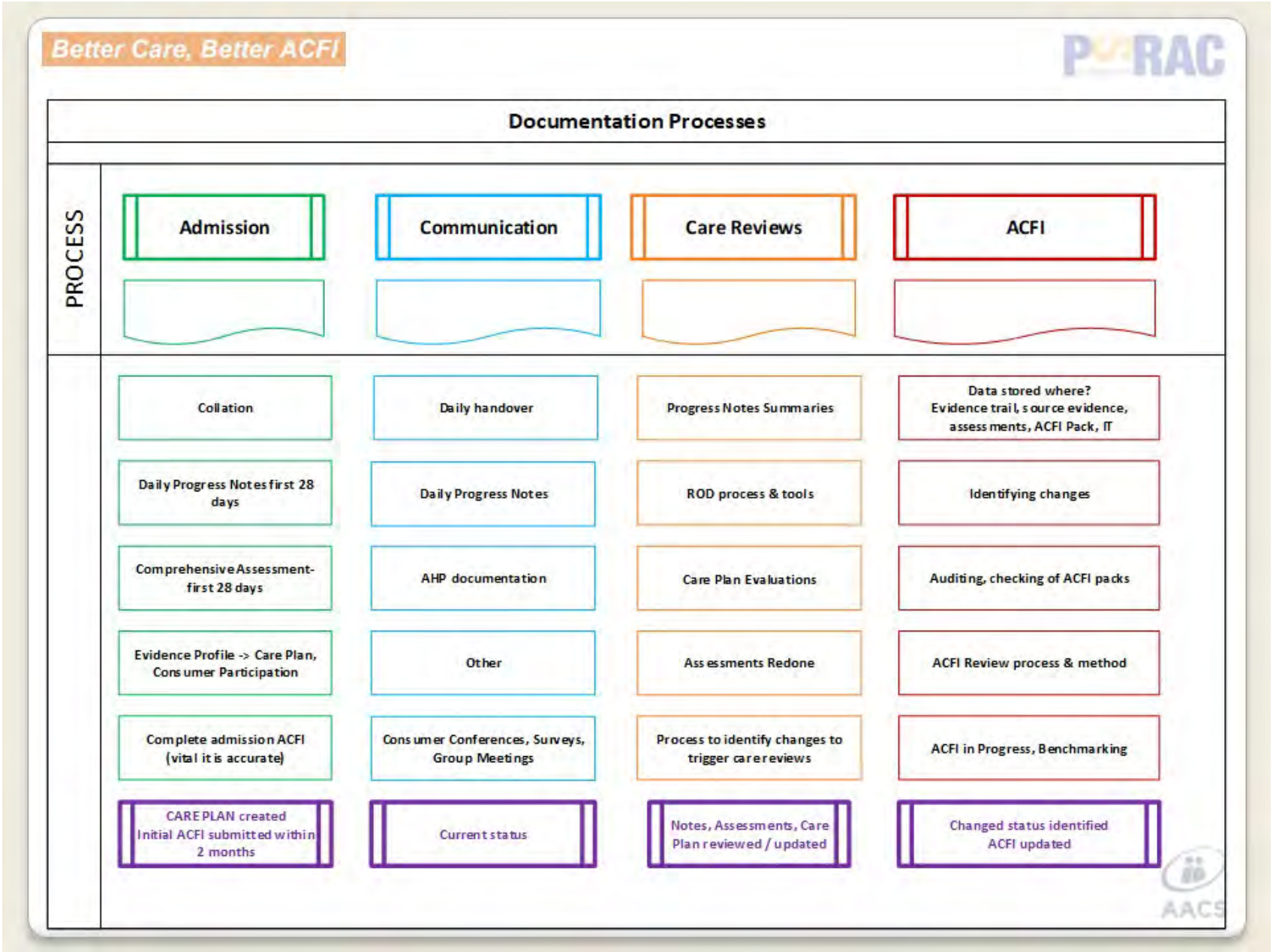


Better Care, Better ACFI

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?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RAC
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
AACS

ACFI Pack Check List

Please tick each item provided as evidence.

Resident Name & Location

	Mandatory Assessments ✓ Tick if made available	Supporting Evidence ✓ Tick if made available	Name of document/s
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

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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

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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.

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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)

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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

Better Care, Better ACFI

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.

Better Care, Better ACFI

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*

Better Care, Better ACFI

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.

Conclusion

That concludes this workshop program. Thank you for your participation.

Please assist us by completing the Evaluation Sheet and handing it to the facilitator.

Contacts

Access to the e-learning package is restricted to PSRACS personnel, staff wishing to access the e-learning package will need to arrange access to the training portal via a request to VHA.

To **register** for the training portal, email VHA: pscracsecretariat@vha.org.au

Applied Aged Care Solutions (AACS) is the developer of the e-learning package and provider of the BCBA training.

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