REVIEW OF THE AGED CARE FUNDING INSTRUMENT REPORT

PART 3: REFERENCES & APPENDICES

June 2017

Applied Aged Care Solutions Pty Ltd

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Appendix A: Chapter 2

Chapter 2.1: Mapping Assessment tools

Table A2.1: Broad comparison of ACFI, InterRAI and NSAF methods

DOMAIN	ACFI	INTERRAI	NSAF
OVERVIEW	ACFI User Guide & ACFI Assessment Pack & ACFI Answer Appraisal Pack Australian Government DoH Fact Sheets **Information for Aged Care Providers Newsletter**	**InterRAI Long Term Care Facilities (LTCF)** **Section A to Section S.** **Sections not allocated:** **Section A.** Identification Information **Section B.** Intake and Initial History **Section M.** Activity Pursuit **Section P.** Responsibility and Directives **Section Q.** Discharge Potential **Section R.** Discharge **Section S.** Assessment Information Very limited use of tools, is based on interview with person/staff and observation. Covers what is being provided not capability. Useful for ratings. Reviewing interRAI to see how they approach items, not as tool	Screening by MyAgedCare staff (telephone). Home support Ax by RAS (face to face). Comprehensive Ax by ACATs (face to face) Supplementary Assessment Tools for RAS & ACATs Useful for (i) assessing fit of tools to RACF setting for external/independent assessor; (ii) mapping modified ACFI to Australian Aged Care framework. Reviewing NSAF to see how they match to ACFI
DIAGNOSES	List of Medical diagnoses List of Mental & Behavioural diagnoses	**Section I.** Disease Diagnoses **Section J.** Health Conditions – falls, recent falls, problem frequency (balance, cardiac, psychiatric, neurological, GI status, sleep, other), Dyspnoea (SOB), Fatigue, Pain symptoms, instability of conditions	**CA: Health Conditions** Condition, Diagnosis status, impact, health observations

DOMAIN	ACFI	INTERRAI	NSAF
NUTRITION	ACFI 1: Nutrition **NSAF misses (1.1=1; 1.1=2; 1.2=1).** **EBCAT: RNDC misses (1.1=1)** 1.1 =1 (no match) 1.1=2 (Dexterity issue; Texture) 1.2=1 (some assistance) 1.2=2 (total assistance)	**Section K.** Oral and Nutritional Status	**Screening:** Function across IADLs and ADLs; weight loss/nutrition **CA: Health** Oral Health, Appetite, weight loss and fluid intake, Skin conditions Medical Ax Tools- South Australian Oral Health Referral Pad, Oral Health Assessment Tool (OHAT) for Non-Dental Professionals Physical Ax Tools- Mini Nutritional Assessment The **Self-MNA®** Mini Nutritional Assessment is a simple tool that can be used by adults 65 years of age and older or their caregivers. This new tool has been scientifically validated and is as effective as the MNA® in identifying malnutrition. The Self-MNA® is available in six versions
FUNCTIONAL	ACFI 2: Mobility ACFI 3: Personal Hygiene ACFI 4: Toileting	**Section G.** Functional Status	**Screening:** Function across IADLs and ADLs; falls **CA: Physical Domain – Health and Lifestyle** Falls, Pain, Sensory **CA: Physical Domain – Function** Can the client… If difficulty, who assists Will assistance be required
CONTINENCE	ACFI 5: Continence	**Section H.** Continence	**CA: Health -** Continence Medical Ax Tools- Revised Urinary Incontinence Scale, Revised Faecal Incontinence Scale

DOMAIN	ACFI	INTERRAI	NSAF
COGNITION	ACFI 6: Cognition	**Section C.** Cognition	**Screening:** memory/confusion **CA: Cognitive** Assessment tools- SMMSE, RUDAS, IQCODE, KICA-Cog, KICA-Carer
BEHAVIOURS	ACFI 7: Wandering ACFI 8: Verbal behaviour ACFI 9: Physical behaviour	**Section E.** Mood and Behaviour 3. BEHAVIOUR SYMPTOMS	**CA: Personality and behaviour**
MOOD	ACFI 10: Depression	**Section E.** Mood and Behaviour 1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD 2. SELF-REPORTED MOOD	**CA: Psychosocial** Screening items Assessment tools- K10, GDS (short)
MEDICINES	ACFI 11: Medication	**Section N.** Medications LIST OF ALL MEDICATIONS (name, dose, unit, route, frequency, PRN, computer entered drug code)	**CA: Health Conditions** Medication details Allergies and sensitivities
HEALTH TREATMENTS	ACFI 12: Complex Health Care	**Section O.** Treatments and Procedures TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS **Section J.** Health Conditions – PAIN SYMPTOMS (frequency, intensity, consistency, breakthrough, pain control) **Section L.** Skin Condition - MOST SEVERE PRESSURE ULCER; PRIOR PRESSURE ULCER; PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER; MAJOR SKIN PROBLEMS, SKIN TEARS OR CUTS, OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION, FOOT PROBLEMS.	**Screening**- pain **CA: Physical Domain – Health and Lifestyle** Pain **CA: Health Conditions** Health checks, hospitalisations, aids & equipment Assessment tools- Brief Pain Inventory, Residents Verbal Brief Pain Inventory, Abbey Pain Scale, Alcohol Use Disorders Identification Test

DOMAIN	ACFI	INTERRAI	NSAF
THERAPY	NA	**Section O.** Treatments and Procedures PREVENTION THERAPY / NURSING SERVICES IN LAST 7 DAYS HOSPITAL AND EMERGENCY ROOM USE PHYSICIAN VISITS PHYSICIAN ORDERS RESTRICTIVE DEVICES	*No NSAF items were noted.*
SOCIAL	NA	**Section F. Psychosocial Well-Being** Social Relationships Sense of Involvement Unsettled Relationships Major life stressors in last 90 days Strengths	**CA: Social** Client as carer AX Tool: Caregiver Strain Index
COMMUNICATION	*NA*	**Section D. Communication and Vision** Making self-understood (expression) Ability to understand others (comprehension) Hearing Vision	**CA: Communication needs** Preferred language, communication issues, translating service **CA: Physical Domain – Health and Lifestyle** Sensory section (vision. sight, speech)

Table A2.2: Detailed comparison of ACFI, InterRAI and NSAF

Domain	ACFI	InterRAI	NSAF
Tools overview	**Non-mandated contemporaneous assessments** (ACFI 1-4, ACFI 12) ▪ ACFI 12.3, 12.4a/b, 12.10: Evidence-based pain assessment ▪ ACFI 12.5: Skin Integrity Assessment ▪ ACFI 12.6: Swallowing Assessment ▪ ACFCI 12.10 Wound Assessment **Mandated records** (ACFI 5, ACFI 7-9) **Mandated assessments** ▪ ACFI 6: PAS-CIS ▪ ACFI 10: Cornell Depression Scale	**Section G.** ▪ Functional Status [timed 4-metre walk]	**RAS tools** ▪ Caregiver Strain Index ▪ Mini Nutritional Assessment ▪ OARS-ADL ▪ Barthel index of ADL ▪ KICA-ADL ▪ Kessler-10 **ACATs tools** ▪ Caregiver Strain Index ▪ Kessler-10 ▪ Brief Pain Inventory (short) ▪ R-VBPI ▪ ABBEY ▪ AUDIT ▪ SA Oral Health Referral Pad ▪ OHAT for non-dental professionals ▪ Revised Urinary Incontinence Scale ▪ Revised Faecal Incontinence Scale ▪ Mini Nutritional Assessment ▪ OARS-ADL ▪ Barthel index of ADL ▪ KICA-ADL ▪ SMMSE ▪ RUDAS ▪ IQCODE ▪ KICA-COG ▪ Geriatric Depression Scale
Diagnoses	List of Medical diagnoses List of Mental & Behavioural diagnoses	**Section I.** Disease Diagnoses **Section J.** Health Conditions ▪ falls, recent falls, problem frequency (balance, cardiac, psychiatric, neurological, GI status, sleep, other), Dyspnoea (SOB), Fatigue, Pain symptoms, instability of conditions	**CA: Medical Domain** ▪ Health Conditions (condition, Dx status, primary) ▪ Relevant medical history. ▪ Health Checks in past 3 months ▪ Hospitalisation in past 3 months

Domain	ACFI	InterRAI	NSAF
Nutrition	**ACFI 1: Nutrition** ▪ Currently ACFI 1 does not cover oral hygiene. **EBCAT: NSAF preferred over MNA.** **NSAF misses (1.1=1; 1.1=2; 1.2=1).** **RNDC misses (1.1=1)** 1.1 =1 (no match) 1.1=2 (Dexterity issue; Texture) 1.2=1 (some assistance) 1.2=2 (total assistance) **1.1 Readiness to eat** Supervision is required for an assessed care need for: ▪ placing utensils in the care recipient's hand. One-to-one physical assistance is required for an assessed care need: cut up food OR vitamise food. **1.2 Eating** Supervision is required for an assessed care need for: ▪ 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 an assessed care need to:	**P 76:** Q1. Ask the person or family about weight changes over the last 30 to 180 days. subjective estimate of weight change from the person or caretaker can be used if no written records are available. Q2. Identifying dehydration can be difficult. Record your clinical judgement based upon signs and symptoms (for example, severe vomiting over a period of time). Alternatively, laboratory results indicating dehydration may be available (i.e., BUN/creatinine ratio of > 25 [note that the standard for this ratio value can be country specific]). Q3. Observe and talk with the person. If available, review the person's clinical record, including MD, dietitian, and speech-language pathology notes if applicable. **Section G: Functional Status** **1. ADL SELF-PERFORMANCE-***Eating* How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) scored (0,1,2,3,4,5,6,8) **Section K:** Oral and Nutritional Status (not in ACFI) 1. **HEIGHT AND WEIGHT** 2. **NUTRITIONAL ISSUES** a. Weight loss of 5 per cent or more in LAST 30 DAYS, or 10 percent or more in LAST 180 DAYS b. Dehydrated, or BUN / Cre ratio > 25 [Ratio, country specific] c. Fluid intake less than 1,000 ml per day (less than four 250 ml cups/day) d. Fluid output exceeds input 3. **MODE OF NUTRITIONAL INTAKE** **0 Normal**—Swallows all types of foods **1 Modified independent**—e.g., liquid is sipped, takes limited solid	**CA: Medical Domain (not in ACFI)** ▪ Oral Health, Appetite, weight loss and fluid intake. **CA: Physical Domain** ▪ Function- eating **CA: Medical Domain -** ▪ Appetite, weight loss and fluid intake, ▪ How is your appetite? ▪ Have you noticed any loss of taste? ▪ Have you been eating poorly as a result of decreased appetite? ▪ Have you lost any weight without trying, or had other nutritional concerns in the past 3 months? ▪ Do you regularly drink more than 8 cups of fluid a day? Medical Ax Tools: ▪ South Australian Oral Health Referral Pad ▪ Oral Health Assessment Tool (OHAT) for Non-Dental Professionals **CA: Physical Domain** **Eating** ▪ Independent (food provided within reach) ▪ Needs help cutting, spreading butter etc. (ACFI 1.1=2) ▪ Unable (1.2=2) ▪ Physical Ax Tools- Mini Nutritional Assessment

Domain	ACFI	InterRAI	NSAF
	▪ place or guide food into the care recipient's mouth for most of the meal. **EBCAT Recommendation: Resident Nutritional Data Card (RNDC)** ▪ Based on the items- it identifies special dietary needs, records assistance/aids required (checklist no rationale requested), checks for healthy weight range and has a malnutrition risk. ▪ Demographics (age, gender, medications, medical history) ▪ Dietary assessment (type, texture, allergies, likes, appetite, chewing and swallowing ability, dexterity) ▪ Eating Assessment (assistance level, utensils ▪ Weight assessment (weight, height) ▪ MAG (Malnutrition Risk Guidelines) ▪ Ideal Body Weight Chart ▪ MISSING: Nutritional, Swallowing, Dexterity. Resourced from NATRAME ▪ NATFRAME as a toolkit has statistical evidence and all tools are (said to be) evidence based. ▪ Eating Assessment could be improved re objectiveness. It is checklist based, not a robust assessment if user is not	food; need for modification may be unknown **2 Requires diet modification to swallow solid food**—e.g., mechanical diet (puree, minced, etc.) or only able to ingest specific foods **3 Requires modification to swallow liquids**—e.g., thickened liquids **4 Can swallow only pureed solids**—AND—thickened liquids **5 Combined oral and parenteral or tube feeding** **6 Nasogastric tube feeding only** **7 Abdominal feeding tube**—e.g., PEG tube **8 Parenteral feeding only**—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN) **9 Activity did not occur**—During entire period **4. PARENTERAL OR ENTERAL INTAKE** *The proportion of TOTAL CALORIES received through parenteral or tube feedings in the LAST 3 DAYS* **0 No parenteral / enteral tube** **1 Parenteral / enteral tube, but no caloric intake** **2 1–25 per cent of total calories through device** **3 26 per cent or more of total calories through device** **5. DENTAL OR ORAL** **0** No **1** Yes a. Wears a denture (removable prosthesis) b. Has broken, fragmented, loose, or otherwise nonintact natural teeth c. Reports mouth or facial pain / discomfort d. Reports having dry mouth e. Reports difficulty chewing f. Presents with gum (soft tissue) inflammation or bleeding adjacent to natural teeth or tooth fragments	**Mini Nutritional Assessment** Mini-Nutritional Assessment (MNA) Guigoz Y et al. 1994 (http://www.mna-elderly.com/). Mini nutritional assessment: A practical assessment tool for grading the nutritional state of elderly patients Facts, Research in Gerontology 1994; Suppl 2: 15-59 Setting: Acute, Community; Rehab; Long term care; Patient group: Geriatric25 Screening and Assessment component Includes diet history, anthropometry (weight history, height, MAC, CC), medical and functional status. Assessed based on numerical score as: - no nutritional risk - at risk of malnutrition or – malnourished. ▪ Lengthy ▪ Low specificity for screening section of tool in acute populations ▪ Can be difficult to obtain anthropometric data in this patient group ▪ Need calculator to calculate BMI.

Domain	ACFI	InterRAI	NSAF
	trained/qualified. For example, if the user does not have the expertise/knowledge in this domain to understand what underpins the assessment. 1. MNA review		
ADL	ACFI 1: Nutrition ACFI 2: Mobility ACFI 3: Personal Hygiene ACFI 4: Toileting ACFI 5: Continence **ACFI 1-4 assessments** ▪ Not mandated ▪ Contemporaneous in last 6 months ▪ Restricted to specified activities, usual care needs	**Section G: Functional Status** **1. ADL SELF-PERFORMANCE** ▪ Bathing ▪ Personal hygiene ▪ Dressing upper body ▪ Dressing lower body ▪ Walking ▪ Locomotion ▪ Transfer toilet ▪ Toilet use ▪ Bed mobility ▪ Eating	**CA: Physical Domain – Function** **Function section** ▪ Go to place outside walking distance ▪ Shopping for groceries ▪ Prepare own meals ▪ Housework ▪ Medicine ▪ Handle own money ▪ Walking ▪ Bath or shower ▪ Dressing ▪ Eating ▪ Transfers ▪ Toilet use **Supplementary Assessments** ▪ Older Americans Resources and Services (OARS) Activities of Daily Living ▪ Barthel Index of Activities of Daily Living ▪ Kimberly Indigenous Cognitive Assessment - Activities of Daily Living (KICA-ADL)
ADL (cont.)	Current and usual care needs. ADL 1-4 is about daily needs.	**1. ADL SELF-PERFORMANCE** *Consider all episodes over 3-day period.* **0 Independent**—No physical assistance, set-up, or supervision in any episode **1 Independent, set-up help only**—Article or device provided or	**CA: Physical Domain – Function** **For items:** ▪ Go to place outside walking distance ▪ Shopping for groceries ▪ Prepare own meals

Domain	ACFI	InterRAI	NSAF
	ACFI 1-4 scale is ▪ Independent ▪ Supervision (setting up and standing by with specified activities) ▪ Physical Assistance (one to one PA throughout the specified activities)	placed within reach, no physical assistance or supervision in any episode **2 Supervision**—Oversight / cuing **3 Limited assistance**—Guided maneuvering of limbs, physical guidance without taking weight **4 Extensive assistance**—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50 per cent or more of subtasks **5 Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ helpers—OR—Weight-bearing support for more than 50 per cent of subtasks **6 Total dependence**—Full performance by others during all Episodes **8 Activity did not occur during entire period**	▪ Housework ▪ Medicine ▪ Handle own money ▪ Walking ▪ Bath or shower ▪ Can the client…? Without help, with some help, completely unable? If difficulty, who assists? - list Will assistance be required- episodic, not episodic, no, yes/unable to determine **For items:** ▪ Dressing ▪ Eating ▪ Transfers ▪ Toilet use Independent, Needs some help, dependent If difficulty, who assists? Will assistance be required?
ADL (cont.)	**ACFI 1-4** ▪ Based on evidence from a contemporaneous assessment completed in last 6 months (of the required needs) ▪ Must reflect current needs ▪ Restricted to specified activities ▪ Reflects usual care needs	**Page 50** ▪ The scales in Items G1 are used to record the person's actual level of involvement in self-care and the type and amount of support received during the last 3 days. ▪ DO Engage direct care staff from all shifts who have cared for the resident over the last 3 days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last 3 days only. ▪ To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.) ask probing questions, beginning with the general and proceeding to the more specific.	**CA: Physical Domain – Function** ▪ Eating ▪ Transfers ▪ Walking ▪ Bath or shower ▪ Dressing ▪ Toilet use Independent, Needs some help, dependent Without help, with some help, completely unable.

Domain	ACFI	InterRAI	NSAF
		▪ DO NOT record your assessment of the resident's capacity for involvement in self-care — that is, what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes.	
Functional	No items titled function. ACFI 2 Transfers and Locomotion is similar to InterRAI item G2. Requires contemporaneous assessment in last 6 months (note does not state evidence-based assessment, it is about assessing for need, not recording what is done)	**Section G: Functional Status In last 3 days** **P52:** Ask the person and direct care staff about the person's movement in the unit and outdoors during the last 3 days. Record the farthest distance travelled without a prolonged stop. 2. Locomotion/Walking a) mode b) timed 4-metre walk (timed 4-metre walk ax) c) distance walked	**CA: Physical Domain – Function** ▪ Can the client walk? ▪ Transfers
Functional (cont.)	**1. Transfers** Supervision is: ▪ locking wheels on a wheelchair to enable a transfer AND adjusting/ removing foot plates or side arm plates OR ▪ commitment of one staff member **standing by** to provide assistance (verbal and/ or physical). One-to-one physical assistance is required for: ▪ moving to and from chairs or wheelchairs or beds. Mechanical lifting equipment: requiring physical assistance with the use of mechanical lifting equipment for transfers.	**2. LOCOMOTION / WALKING** **a. Primary mode of locomotion** **0** Walking, no assistive device **1** Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair **2** Wheelchair, scooter **3** Bed-bound **b. Timed 4-metre walk** ▪ Lay out a straight, unobstructed course. Have person stand in still position, feet just touching start line. Then say: "When I tell you, begin to walk at a normal pace (with cane / walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. ▪ Is this clear?" Assessor may demonstrate test. Then say: "Begin to walk now." Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-metre mark. Then say: "You may stop now." Enter time in seconds, up to 30 seconds **30** or more seconds to walk 4 metres **77** Stopped before test complete **88** Refused to do the test **99** Not tested—e.g., does not walk on own	**CA: Health and Lifestyle domain** ▪ Falls section **CA: Physical Domain – Function** ▪ Transfers **CA: Physical Domain – Function** ▪ Can the client walk?

Domain	ACFI	InterRAI	NSAF
	2. Locomotion Supervision is: ▪ handing the care recipient a mobility aid; OR ▪ fitting of calipers, leg braces or lower limb prostheses; OR ▪ commitment of one staff member **standing by** to provide assistance (verbal and/ or physical). One-to-one physical assistance is required for: ▪ staff to push wheelchair; OR assistance with walking	**c. Distance walked** ▪ Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed). **0** Did not walk **1** Less than 5 metres **2** 5–49 metres **3** 50–99 metres **4** 100–999 metres **5** 1 kilometre or more **d. Distance wheeled self** ▪ Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair) **0** Wheeled by others **1** Used motorized wheelchair / scooter **2** Wheeled self less than 5 metres **3** Wheeled self 5–49 metres **4** Wheeled self 50–99 metres **5** Wheeled self 100+ metres	
Continence	ACFI 5 assessments ▪ Mandated Records Frequency determines Rating ▪ No episodes of urinary incontinence or self manages ▪ Incontinent urine < or = 1/day ▪ 2-3 episodes daily of urinary incontinence or passed urine during scheduled toileting ▪ > 3 episodes daily of urinary incontinence or passed urine during scheduled toileting ▪ No episodes of faecal incontinence or self manages ▪ Incontinent faeces 1 or = 2/week ▪ 3-4 episodes weekly of faecal	**Section H: Continence** **P57-** To determine and record the person's pattern of bladder continence (control) over the last 3 days. Review clinical records and flow/bowel charts, ask the person, validate with care staff, observation where inconsistent information. **1. BLADDER CONTINENCE** **0 Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device **1 Control with any catheter or ostomy over last 3 days** **2 Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes **3 Occasionally incontinent**—Less than daily **4 Frequently incontinent**—Daily, but some control present **5 Incontinent**—No control present **8 Did not occur**—No urine output from bladder in last 3 days	**CA: Domain** ▪ Continence **Assessments** ▪ Revised Urinary Incontinence Scale- not suitable ▪ Revised Faecal Incontinence Scale- not suitable

Domain	ACFI	InterRAI	NSAF
	incontinence or passed faeces during scheduled toileting ▪ > 4 episodes per week of faecal incontinence or passed faeces during scheduled toileting	**2. URINARY COLLECTION DEVICE (Exclude pads / briefs)** **0 None** **1 Condom catheter** **2 Indwelling catheter** **3 Cystostomy, nephrostomy, ureterostomy** **3. BOWEL CONTINENCE** **0 Continent**—Complete control; DOES NOT USE any type of ostomy device **1 Control with ostomy**—Control with ostomy device over last 3 days **2 Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes **3 Occasionally incontinent**—Less than daily **4 Frequently incontinent**—Daily, but some control present **5 Incontinent**—No control present **8 Did not occur**—No bowel movement in the last 3 days **4. OSTOMY** **0** No **1** Yes	
Cognition	**ACFI 6** **PAS-CIS** (validated assessment of cognition) or Checklist when interview not suitable.	**Section C.** Cognition **1. COGNITIVE SKILLS FOR DAILY DECISION MAKING** *Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do* **0 Independent**—Decisions consistent, reasonable, and safe **1 Modified independence**—Some difficulty in new situations only **2 Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times **3 Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times **4 Severely impaired**—Never or rarely makes decisions **5 No discernible consciousness, coma [Skip to Section G]**	**CA: Psychological domain** ▪ Cognitive section ▪ Decision making ▪ Psychological (cog, behaviour, mood outcomes) **Complexity Indicators** ▪ Person has a memory problem or confusion that significantly limits self-care capacity, requires ▪ intensive supervision and/or frequent changes to support. **Supplementary Assessment Tools** ▪ Standardised Mini-Mental State Examination (SMMSE) - downloaded

Domain	ACFI	InterRAI	NSAF
		2. MEMORY / RECALL ABILITY *Code for recall of what was learned or known* **0** Yes, memory OK **1** Memory problem a. **Short-term memory OK**—Seems / appears to recall after 5 minutes b. **Long-term memory OK**—Seems / appears to recall distant past c. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues d. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room) **3. PERIODIC DISORDERED THINKING OR AWARENESS** *[Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behaviour over this time]* **0** Behaviour not present **1** Behaviour present, consistent with usual functioning **2** Behaviour present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago) a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse **4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—***e.g., restlessness, lethargy, difficult to arouse, altered environmental perception* **0** No **1** Yes	▪ Rowland Universal Dementia Assessment Scale (RUDAS) ▪ Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)-downloaded ▪ Kimberly Indigenous Cognitive Assessment (KICA-COG) ▪ Kimberly Indigenous Cognitive Assessment - Carer (KICA-Carer)

Domain	ACFI	InterRAI	NSAF
		5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT) **0** Improved **2** Declined **1** No change **8** Uncertain	
Behaviour	ACFI 7: Wandering ACFI 8: Verbal behaviour ACFI 9: Physical behaviour ▪ Mandated Records	**Section E.** Mood and Behaviour **3. BEHAVIOUR SYMPTOMS** *Code for indicators observed, irrespective of the assumed cause* **0** Not present **1** Present but not exhibited in last 3 days **2** Exhibited on 1–2 of last 3 days 3 **Exhibited daily in last 3 days** a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused d. **Socially inappropriate or disruptive behaviour**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or faeces, hoarded, rummaged through other's belongings e. **Inappropriate public sexual behaviour or public disrobing** f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating	**CA: Physical domain** ▪ Personality and behaviour (not asked of client) ▪ Psychological (cog, beh, mod outcomes)
Mood	ACFI 10: Depression **Cornell Depression Scale** (validated assessment of depressive symptoms)	**Section E.** Mood and Behaviour **1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD** *Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person.]* **0** Not present **1** Present but not exhibited in last 3 days **2** Exhibited on 1–2 of last 3 days **3** Exhibited daily in last 3 days	**CA: Physical domain** ▪ Psychosocial [nervous, depressed, lonely, stress, change in mental state] ▪ Psychological (cog, behaviour, mood outcomes) **Supplementary Assessment Tools** **K10** ▪ This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and

Domain	ACFI	InterRAI	NSAF
		a. **Made negative statements**—e.g., *"Nothing matters"*; *"Would rather be dead"*; *"What's the use"*; *"Regret having lived so long"*; *"Let me die"* b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions e. **Repetitive anxious complaints / concerns (non-health related)**— e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning g. **Crying, tearfulness** h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends j. **Reduced social interactions** k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., *"I don't enjoy anything anymore"*	depressive symptoms that a person has experienced in the most recent 4 week period. The use of a consumer self-report measure
Medication	ACFI 11 • Medication Chart	**Section N.** Medications ▪ LIST OF ALL MEDICATIONS (name, dose, unit, route, frequency, PRN, computer entered drug code)	**CA: Medical Domain** ▪ Medication Details (how many types)
Treatments	No Prevention items	**Section O: Treatments & Procedures** **1. Prevention No/Yes to** a. Blood pressure measured in LAST YEAR	**CA: Medical Domain** ▪ Skin Conditions **Assessments**

Domain	ACFI	InterRAI	NSAF
		b. Colonoscopy test in LAST 5 YEARS c. Dental exam in LAST YEAR d. Eye exam in LAST YEAR e. Hearing exam in LAST 2 YEARS f. Influenza vaccine in LAST YEAR g. Mammogram or breast exam in LAST 2 YEARS (for women) h. Pneumovax vaccine in LAST 5 YEARS or after age 65	▪ Brief Pain Inventory (downloaded) ▪ Residents Verbal Brief Pain Inventory (PMG Kit) ▪ Abbey Pain Scale (PMG Kit) ▪ Alcohol Use Disorders Identification Test (NA)
Treatments (cont.)	**ACFI 12** 12.1 Blood Pressure 12.2 BGL 12.5 Skin Integrity 12.6 Management of special feeding undertaken by an RN 12.7 Suppositories & enemas 12.8 Catheter care 12.9 Chronic infectious conditions 12.10 Chronic wounds 12.11 Ongoing IV, syringe drivers, dialysis, hypodermoclysis 12.12a Mgmt of Arthritic joints and oedema related to arthritis with tubular elasticised support bandages. 12.12b Mgmt. of non-arthritic oedema OR DVT with compression garments / bandages. 12.13 Oxygen therapy not self-managed 12.14 Palliative care (end of life) 12.15 Ongoing stoma care	**Section O: Treatments & Procedures** **2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)** **0** Not ordered AND did not occur **1** Ordered, not implemented **2** 1–2 of last 3 days **3** Daily in last 3 days ***Treatments*** a. Chemotherapy b. Dialysis c. Infection control—e.g., isolation, quarantine d. IV medication e. Oxygen therapy f. Radiation g. Suctioning h. Tracheostomy care i. Transfusion j. Ventilator or respirator k. Wound care ***Programs*** l. Scheduled toileting program m. Palliative care program **n.** Turning / repositioning program	*No NSAF items were noted.*

Domain	ACFI	InterRAI	NSAF
	12.16 Suctioning airways, tracheostomy care 12.17 Management of ongoing tube feeding 12.18 Technical equipment for continuous monitoring of vital signs including Continuous Positive Airway Pressure (CPAP) machine.		
PAIN	12.3 Pain (20 mins) 12.4a Complex Pain (20 mins by RN/AHP) 12.4b Complex Pain (80 mins by AHP over 4 days)	**Section J: HEALTH Conditions** **6. PAIN SYMPTOMS** *[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]* a. **Frequency with which person complains or shows evidence of pain** (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain) **0** No pain **1** Present but not exhibited in last 3 days **2** Exhibited on 1–2 of last 3 days **3** Exhibited daily in last 3 days **b. Intensity of highest level of pain present** **0** No pain **1** Mild **2** Moderate **3** Severe **4** Times when pain is horrible or excruciating **c. Consistency of pain** **0** No pain **1** Single episode during last 3 days **2** Intermittent **3** Constant **d. Breakthrough pain**—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain **0** No **1** Yes	**CA: Health and Lifestyle domain** ▪ Falls section ▪ Pain section ▪ Sensory section (vision. sight, speech) **Assessments** ▪ Brief Pain Inventory (downloaded) ▪ Residents Verbal Brief Pain Inventory (PMG Kit) ▪ Abbey Pain Scale (PMG Kit)

Domain	ACFI	InterRAI	NSAF
		e. Pain control—Adequacy of current therapeutic regimen to control pain (from person's point of view) **0** No issue of pain **1** Pain intensity acceptable to person; no treatment regimen or change in regimen required **2** Controlled adequately by therapeutic regimen **3** Controlled when therapeutic regimen followed, but not always followed as ordered **4** Therapeutic regimen followed, but pain control not adequate **5** No therapeutic regimen being followed for pain; pain not adequately controlled **P70: PAIN** NOTE: Always ask the person about frequency, intensity, and control of the pain. Observe the person and ask others who are in contact with the person.	
Therapy	Not applicable	**Section O: Treatments & Procedures** **3. THERAPY / NURSING SERVICES IN LAST 7 DAYS** *e.g., therapist or therapy assistant under direction of therapist [Note: Count only postadmission therapies]* **A. # of days** treatment scheduled in the LAST 7 DAYS **B. # of days** administered for **15 minutes or more** **C. Total # of minutes** provided in LAST 7 DAYS (or *ordered* if days administered = 0 and days scheduled > 0) a. Physical therapy b. Occupational therapy c. Speech-language pathology and audiology services d. Respiratory therapy e. Functional rehabilitation or walking program by licensed nurse f. Psychological therapy (by any licensed mental health professional)	*No NSAF items were noted.*
SOCIAL	Not applicable	**Section F: Psychosocial Well-Being** • **Social relationships**	**CA- Social Domain** ▪ Client as carer ▪ Family, Community Engagement & Support

Domain	ACFI	InterRAI	NSAF
		• **Sense of involvement** • **Unsettled relationships** • **Major stressors in last 90 days** • **Strengths**	▪ Caregiver Strain Index
HEALTH	Not applicable	**Section J: Health Conditions** • **Falls** • **Balance, Cardiac, Psychiatric, Neurological, GI status, sleep, other** • **Dyspnoea** • **Fatigue** • **Pain** • **Instability of conditions** • **Self-reported health** • **Tobacco and alcohol**	**CA: Physical domain** ▪ Sleep section ▪ Alcohol and tobacco section ▪ Physical Activity **CA: Health and Lifestyle domain** ▪ Falls section
Communication	Not applicable Refer to TRG recommendations	**Section D. Communication and Vision** ▪ Making self-understood (expression) ▪ Ability to understand others (comprehension) ▪ Hearing ▪ Vision	▪ CA: Health and Lifestyle domain ▪ Sensory section (vision. sight, speech)
Complexity Indicators	Not applicable	*No InterRAI items were noted.*	▪ Person is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing and ability to remain living in the community. ▪ There is a risk of, or suspected or confirmed abuse. ▪ Person has emotional or mental health issues that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support. ▪ Person is experiencing financial disadvantage or other barriers that

Domain	ACFI	InterRAI	NSAF
			threaten their access to services essential to their support. ▪ Person has experienced adverse effects of institutionalisation and/or systems abuse (e.g. spending time in institutions, prisons, foster care, and residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing. ▪ Person is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others. ▪ Person is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others. ▪ Person has a memory problem or confusion that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.
Complexity Indicators (cont.)	Not applicable	*No InterRAI items were noted.*	**Risk of Vulnerability Cohort** ▪ Aboriginal or Torres Strait Islander ▪ Veteran ▪ Change in family/carer support arrangements ▪ Refugees, asylum seekers or recent migrants without support ▪ Lesbian, Gay, Bisexual, Transgender, Intersex or other gender diverse individuals ▪ Culturally and linguistically or ethnically diverse individual

Domain	ACFI	InterRAI	NSAF
			▪ Socially isolated individual

Chapter 2.2: Consultation Guide

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Discussion Guide

Applied Aged Care Solutions (AACS)

1. Welcome

2. Project Background

- Identify ACFI Issues
- Views on modifications
- Develop modified ACFI
- External / Independent Assessment Options
- Final Report

3. Discussion Points

- The ACFI Model
- Changing the basic model design
- Number of ACFI Questions
- Assessment tools & mandatory requirements
- Therapy program incentives
- ACFI question considerations
- Business Rules
- External / Independent Assessment
- Other Suggestions / Comments

4. Next Steps

1. The ACFI Model – Indicator Questions and Relative Care Needs

Background

- ACFI was designed to reduce paper work, limit questions and target a small set of indicators or markers related to broader resource needs
- ACFI does include some background assessments that can be used for care planning purposes as well as funding but it was not designed as a comprehensive assessment approach
- The ACFI funding provides a bundle of money to cover all care need areas - not just for areas covered in the specific ACFI questions
- The ACFI funding is to be used for the broader care need areas covered by (i) Specified Care and Services and (ii) the Quality of Care Principles
- The ACFI is a relative resource instrument – it divides up the available funding on a resident by resident basis based their relative cost of care
- The overall funding level is determined by Government and covers what they are prepared to pay in the overall budget for the care subsidy and the growth in funding due to changes in the cost of providing care

ACFI Funding Model Design

- The ADL Low level was designed as the base funding for entering residential care (eligibility) – everyone should get this level of funding to support their all day, every day care needs. This can be considered the "fixed" base layer.
- The ACFI funding model comprises additional layers (ADL medium and high) over the base (ADL low) which results in the ADL domain comprising three levels overall (base/low, medium, high) with two four level "supplements" (none to high)

2. Considerations – Basic Model Design

- The basic ACFI design can be adjusted to include a broader base layer (e.g. low + medium), with a determination only for high but this creates issues with ageing in place facilities and re-distributes funding to lower care levels in "competition" with community care
- The basic design can be adjusted to include only one, two or three level supplements but this creates compromises for higher care residents and it may reduce the incentive for providers to take on high care clients (as was the case before the RCI was introduced)
- Should we develop a very high ADL level to split the domain high category? Low (all = base) / Medium / High / Very High. Who would fit into Very High?
- Do we want the funding model based on assessed care need (e.g. validated assessments), care provided (e.g. care plans) or a combination of both?
- Should the model make sure that assessments used in the funding aspects can also be used for care planning or do you want two separate processes?

3. Considerations – Number of ACFI Questions

- Do you think the number of ACFI questions should be increased to cover areas currently not specified in the ACFI?
- Increasing the number of questions will not provide more funding but it might improve the discrimination of the system. It will increase the effort required to submit an appraisal.
- Do you think the number of ACFI questions should be reduced to remove items that are less discriminating?
- How directive do we want the funding model to be? Can it work with Specified Care and Services and the Quality of Care Principles or should ACFI cover off all care areas with multiple items?

4. ACFI Assessment Tools and Mandatory Requirements

- Currently some ACFI areas use only summary "assessments" - that records a care outcome (e.g. unable to participate in transfers) as evidence for a care need (requires physical assistance with transfers).
- Should we be recommending or mandating more objective assessment tools (validated), that assesses and records the reason/s why the care is needed, which can be linked to appropriate care planning to assist the resident to participate i.e. to encourage best practice and assist with the accuracy of claims?
- Can evidence based assessments be used for care and as evidence for the funding claim?
- Should the ACFI appraisal submission to DoH also include the provider number (for example) of the health professional undertaking or signing off on the mandated assessments?
- Should all ACFI assessments require a sign off by an RN or AHP?

5. ACFI Question Considerations

- Move items: Include Medication as a two-level item in ACFI Q12 and remove item 12.7 for suppositories and enemas (regular enemas not considered best practice). For example: Have two medicine levels- Needs assistance (with suppositories, patches, medicines) or needs daily injections?
- Should the MMSE replace the current PAS-CIS to allow for consistency between other parts of the aged care system?
- Consider dropping the Cornell and replace with simpler assessment tool? If keep Cornell, funding could be dependent on a diagnosis and treatment regime and require (e.g.) 12mthly review?

6. Therapy Program Incentives

Specified care and Services: already covers therapy, why include it in the ACFI?

If include Maintenance and Reablement "price signal" in the ACFI – How to structure this component? Package up Maintenance, Rehabilitation, Mobility, Pain interventions into a therapy aspect?

(i) Allow a range of therapeutic inputs from a variety of health professionals?
(ii) Determine funding levels by who provides the service?
(iii) How could the therapy aspect be audited? Records of treatment? Time based requirements?

Structure the therapy aspect into:

(a) single item or separate domain - but big money needs to come from BEH or CHC domains to fund

OR

(b) attach the funding to the ADL domain by providing additional funding (from pain management items in Q12) if an individualised, goals based CDC program is provided:
- individual time based therapy program (ITP) using range of allied health professionals providing physical therapy (design flexible, AHP flexible)
- need to allow for clients not wanting or benefiting from the ITP (how?)

7. Business Rules Considerations

- Leave current appraisal rules in place – no changes required (mandatory; two category change; re-appraise when care needs change for one category increase after 12 months)
- Expire all ACFI appraisals after (e.g.) 12 months? Benefits / Disadvantages?
- Expire some ACFI complex health items after set periods but allow non-chronic conditions? E.g. Complex Health Care domain items in the category such as (possible) short-term medical needs (e.g. IV therapy, wound management) would expire after a certain period (e.g. 6 months) unless the care need was still current. Is this required? Benefits / Disadvantages?
- Allow assessments to be commenced in the first 7 days but mandate further sign off by RN or Allied Health after 14-21 days to confirm they represent usual care needs

8. External / Independent Assessment

(i) Background

- What is the problem we are trying to fix?
- DoH audits are reducing funding in over 20 per cent of their ACFI reviews.
- In NSW 33 per cent of claims were reduced on audit in the May-June 2016 period.
- While these are mostly targeted audits, the penalties for claiming discrepancies have also been increased significantly and the audit program may be expanding
- Need to consider alternative approaches to provide more certainty of funding for providers and budget predictability for government.

- Will External / Independent assessment for the funding address extended claiming and funding growth beyond expectation? Provide more funding certainty?

(ii) What models are worth exploring? (could include variations on below)

***Fully External*:** Funding allocated pre-entry or post entry by external/independent assessor. Major change submissions requiring external assessment approval via electronic review or on-site visit. No site input and no audit program.

***Partial External*:** Partial funding allocated pre-entry by external assessor with aspects completed post entry by the facility. Post entry funding aspects subject to audits. Major change submissions completed by facilities and subject to audit.

***Joint Determination*:** Funding Approval Model

(i) Facility completes the funding application but it requires approval from an independent assessor before the full amount confirmed (entry and re-appraisals)

(ii) Facility software has a limited (and agreed) special access section to allow external access to a sub-set of the assessment records

(iii) independent assessor reviews pre-entry information, the facility assessment records, ACFI funding submissions and determines if they will:

- approve the appraisal after electronic review without further consideration (e.g. 70 per cent)
- be subject to further information provision request (e.g. 20 per cent)
- be subject to independent assessor visit to confirm the appraisal and who may review the documentation and assess the resident (e.g. 10 per cent)
- process to be concluded in a 3-month window or DoH accepts the submission? Then no audits.

Appendix B: Chapter 3

Chapter 3.1: The ACFI (R-ACFI) and Specified Care and Services

A comparison of the ACFI questions, the Specified Care and Services (2014) and Quality Agency Accreditation requirements is shown in Table A3.1. The ACFI questions link directly to the Specified Care and Services categories. The ACFI system provides the funding (issues about adequacy aside) to cover all care related areas and requirements as described in the Specified Care and Services (there are exclusions where fees can be charged) and the Quality of Care Principles legislation. The ACFI questions should be considered selective 'indicators' that provide the necessary resources to allow all of the required care related services to be delivered. It is not correct to interpret the ACFI funding as only covering areas targeted in the question set or that it only funds some care activities and not others or that it somehow restricts what can be done to assist residents. The ACFI funding is provided to cover the entire gamut of care areas as covered in the legislation. Providers are not restricted in what care can be provided with the ACFI funding and restrictions, if they do exist, are necessarily imposed by the provider model of care, not the ACFI funding model.

For example, funding provided in ACFI 2 - Mobility is linked to the Specified Care and Services requirement 2.1 Daily Living Assistance (Table A3.1).

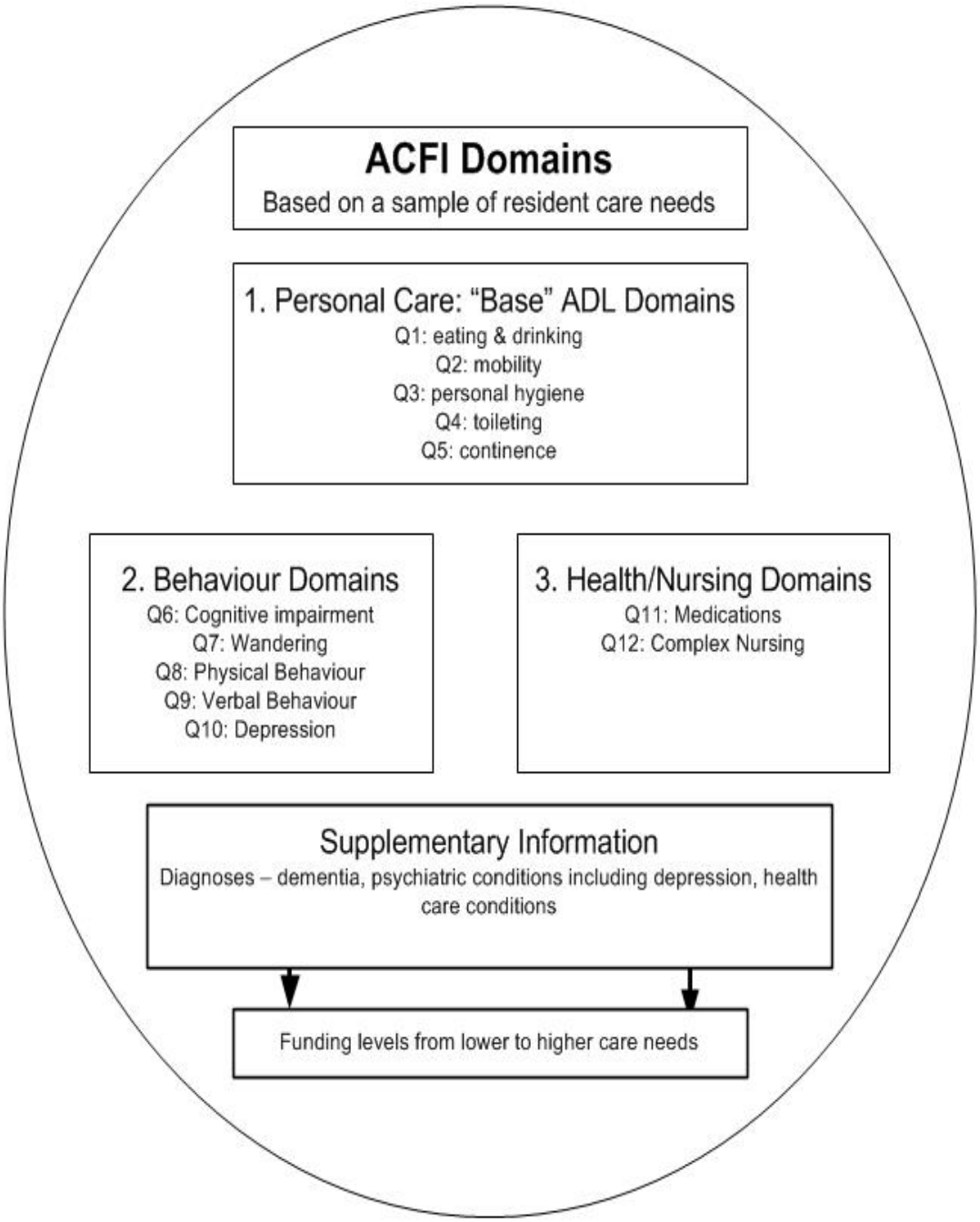
Daily living assistance covers:

- 2.1-Daily Living Assistance
- 2.1 (e) moving, walking, wheelchair use and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids.
- 2.6 Rehabilitation Support
  - Individual therapy programs aimed at maintaining or restoring
  - making arrangements for speech therapists, podiatrists, occupational or physiotherapy practitioners.
- 3.4 Goods to assist care recipients to move themselves
- 3.5 Goods to assist staff to move care recipients
- 3.6 Goods to assist with toileting and continence management
- 3.11 Therapy services such as, recreational, speech therapy, podiatry, occupational therapy, and physiotherapy services
- Maintenance therapy
- More intensive therapy designed to allow care recipients to reach a level of independence
- Excludes intensive, long term rehabilitation services.

The original ACFI was designed to not only detail the specific requirements in the ACFI User Guide but more broadly link directly to the Specified Care and Services applicable at the time (Figure A3.1).

Figure A3.1: ACFI Measurement Model

A. ACFI Payment Model: based on the measurement of resident care needs in regular higher frequency activities



B. SPECIFIED CARE & SERVICES: BASIC CARE & SUPPORT
[funding included in the base ACFI rates as applies to all residents]
- accommodation, meals, social & emotional support, recreation therapy, rehabilitation support.
Previous RCS questions focusing on social and human needs and therapy are not included in the ACFI but the associated funding is included in the ACFI funding pool

Table A3.1: ACFI, Specified Care and Services and the Accreditation Standards

ACFI Question	Specified Care and Services	Aged Care Accreditation Standards
ACFI 1 - Nutrition	**1.10 - Meals and Refreshments** a) Meals of adequate variety, quality and quantity for each care recipient b) Special dietary requirements having to either medical need or religious or cultural observance c) Food, including fruit of adequate variety, quality and quantity, and non-alcoholic beverages, including fruit juice **2.1 - Daily Living Assistance** ▪ 2.1(c) Eating and eating aids, and using eating utensils and eating aids (including actual feeding if necessary) **2.2 - Meals and Refreshment** ▪ Special diet not normally provided **3.8 - Nursing Services** ▪ Nursing services (NP, RN, EN), or other professional appropriate to the service (for example, speech pathologist ▪ Services may include; Special feeding for care recipient's dysphagia	**2.10 – Nutrition and Hydration.** Receive adequate nourishment and hydration
ACFI 2 - Mobility	**2.1 - Daily Living Assistance** ▪ 2.1 (e) Moving, walking, wheelchair use and using devices and appliances designed to aid mobility, including the fitting of artificial limbs and other personal mobility aids **2.6 - Rehabilitation Support** ▪ 2.6 Individual therapy programs aimed at maintaining or restoring ▪ 2.8 Making arrangements for speech therapists, podiatrists, occupational or physiotherapy practitioners **3.4 - Goods to assist care recipients to move themselves** **3.5 - Goods to assist staff to move care recipients** **3.6 - Goods to assist with toileting and continence management** **3.11 - Therapy services such as, recreational, speech therapy, podiatry, occupational therapy, and physiotherapy services** a. Maintenance therapy b. More intensive therapy designed to allow care recipients to reach a level of independence c. Excludes intensive, long term rehabilitation services	**2.6 – Other health and related services** Are referred to appropriate health specialists **2.14 – Mobility, dexterity and rehabilitation** Optimum levels of mobility and dexterity.
ACFI 3 – Personal Hygiene	**2.1 - Daily Living Assistance** ▪ 2.1 (a) Bathing, showering, personal hygiene and grooming ▪ 2.1 (d) Dressing, undressing and using dressing aids **2.7 - Assistance in obtaining health practitioner services** ▪ Arrangements for aural, community health, dental appointments	**2.11 – Skin care** **2.15 – Oral and dental care**

ACFI Question	Specified Care and Services	Aged Care Accreditation Standards
ACFI 4 – Toileting	**3.6 - Goods to assist with toileting and continence management** ▪ Absorbent aids, commode chairs, disposable bedpans and urinal covers, disposable pads, over toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas	*No standard for this item*
ACFI 5 – Continence	**2.1 - Daily living assistance** ▪ Maintaining continence or managing incontinence, and using aids and appliances designed to assist continence management **3.6 - Goods to assist with toileting and continence management** ▪ Absorbent aids, commode chairs, disposable bedpans and urinal covers, disposable pads, over toilet chairs, shower chairs and urodomes, catheter and urinary drainage appliances, and disposable enemas	**12.12 – Continence management** Care recipients' continence is managed effectively
ACFI 6 – Cognitive skills	**2.7 - Assistance in obtaining health practitioner services** ▪ Arrangements for medical, psychiatric and other health practitioners to visit care recipients **2.9 - Support for care recipients with cognitive impairment** ▪ Individual attention and support to care recipients with cognitive impairment (for example, dementia and behavioural disorders) including individual therapy activities and specific programs	*No standard for this item*
ACFI 7 – Wandering	**2.7 - Assistance in obtaining health practitioner services** ▪ Arrangements for medical, psychiatric and other health practitioners to visit care recipients	**2.13 – Behavioural management** The needs of care recipients with challenging behaviours are managed effectively
ACFI 8 – Verbal Behaviour	**2.7- Assistance in obtaining health practitioner services** ▪ Arrangements for medical, psychiatric and other health practitioners	**2.13 – Behavioural management** The needs of care recipients with challenging behaviours are managed effectively
ACFI 9 – Physical Behaviour	**2.7 - Assistance in obtaining health practitioner services** ▪ Arrangements for medical, psychiatric and other health practitioners	**2.13 – Behavioural management** The needs of care recipients with challenging behaviours are managed effectively
ACFI 10 – Depression	**2.3 - Emotional Support** ▪ Emotional support to, and supervision of, care recipients **2.7 - Assistance in obtaining health practitioner services** ▪ Arrangements for medical, psychiatric and other health practitioners	**2.13 – Behavioural management** The needs of care recipients with challenging behaviours are managed effectively **3.4 – Emotional support.** Receives support to adjusting to life in the new environment and on an ongoing basis
ACFI 11 – Medication	**2.4 - Treatments and procedures** ▪ Treatments and procedures including supervision and physical assistance with taking medications, and ordering and reordering medications	**2.7 – Medication management.** Medication is managed safely and correctly

ACFI Question	Specified Care and Services	Aged Care Accreditation Standards
ACFI 12 – Complex Health Care	**2.4 - Treatments and procedures** ▪ Including supervision and physical assistance with bandages, dressings, swabs and saline **3.8 - Nursing Services** ▪ Initial assessment and care planning and ongoing management and evaluation ▪ Nursing services carried out by a, for example, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a Palliative Care Team ▪ Services may include, but are not limited to the following: **1.** Establishment and supervision of complex pain management or palliative care program, including monitoring and managing any side effects **2.** Insertion, care and maintenance of tubes, including intravenous and naso-gastric tubes **3.** Catheter care program **4.** Stoma care program **5.** Complex wounds **6.** Insertion of suppositories **7.** Risk management of chronic infectious conditions **8.** Special feeding for care recipient's dysphagia **9.** Suctioning of airways **10.** Tracheostomy care **11.** Enema administration **12.** Oxygen therapy **13.** Dialysis treatment	**2.4 – Clinical care** Care recipients receive appropriate clinical care **2.5 – Specialised nursing care needs by appropriately qualified nursing staff**. **2.6 – Other health and related services.** Are referred to appropriate health specialists **2.8 – Pain management** **Care recipients are as free as possible from pain**. **2.9 – Palliative care** **The comfort and dignity of terminally ill care recipients is maintained.** **2.11 – Skin care**

Chapter 3.2: How the ACFI Domains and Question Weightings were Developed

The development of the ACFI used a sophisticated analytical approach which calculated the relative funding to be allocated to each care domain (ADL, Behaviour, Complex Health Care) from the:

- RCS costing study
- ACFI National Trial
- Analysis of Care Costs Study which used the Pricing Review facility costing data

It should be noted that the underlying ACFI structure and weightings were derived from the traditional statistical methods (factor analysis, regression analysis etc). For the R-ACFI update, AACS has used IRT methods, which have become more recently available and are considered current 'best practice', on the ADL scale.

3.2.1. Developing the ACFI Care Domains

The ACFI care domains (ADL, BEH, CHC) were developed from questions used in the ACFI National Trial. The National Trial data was analysed, using factor analysis, to combine the most highly correlated questions into domains and a single factor in each care domain was determined to reflect the overall care needs underlying the group of correlated questions. The factor analyses used principal component factors.

The ratio of the first to second first eigenvalues in the factor analysis provided an indication of care domain (scale) uni-dimensionality. That is, all the questions reflect the same underlying dimension. Table A3.2 shows the mean factor score (transformed to the range 0 to 100 to facilitate interpretation and comparison), the eigenvalue, the ratio of the first to second eigenvalues, and the scale alpha statistic. The results indicated the unidimensional nature of each ACFI domain scale (care domain) indicating that the component ACFI questions can be statistically combined to generate a single construct such as ADL, BEH and CHC domains.

Table A3.2: Results of Factor Analysis used to determine ACFI Care Domains

Care Domain	Mean Factor Score	SD	Eigenvalues ½	Ratio of 1st/2nd Eigenvalue	Scale alpha
All questions	58.2	19.3	5.90 / 1.79	3.29	0.85
ADL	59.1	22.3	3.63 / 1.11	3.28	0.81
BEH	48.9	19.7	2.49 / 1.05	2.36	0.67
CHC	53.8	20.9	1.80 / 0.94	1.91	0.57

The relationship between the ACFI care domains is described in Table A3.3. While the scales are correlated to the total score at a significant level, the correlations were less between the scales themselves. This confirmed that the scales are together measuring aspects related to care needs or dependency but they were covering different aspects of the latent dimension of 'aged care needs'.

Table A3.3: Correlations between ACFI Care Need Domains

Correlation	Total	ADL	Behaviour (BEH)	Complex Health Care (CHC)
All questions	1.000			
ADL	0.955	1.00		
BEH	0.721	0.552	1.00	
CHC	0.788	0.694	0.381	1.000

3.2.2. Establishing ACFI Domains Funding Relativities

To identify the relative contribution of the three domains (ADL, BEH, CHC) to the overall score and funding, a regression analysis across all cases in the dataset was conducted. The criterion was the total factor score and the predictors were the scale scores for the three domains. Table A3.4 shows the beta coefficients (standardised regression coefficients) for the three domains, and their relative contribution as was determined as percentages.

Table A3.4: Total Funding by Care Domain

Funding/person	Coef.	Std. Err.	t	P>|t|	Beta coeff.	Relative Contribution %
ADL	0.868	0.002	364.7	0.00	0.519	58.5
BEH	0.246	0.002	124.8	0.00	0.130	14.6
CHC	0.427	0.002	193.6	0.00	0.239	26.9

Note: Partition based on domains using dollar funding per person as the criterion.

The relative percentages for the domains to the total funds available (the current RCS recurrent funding total) were applied to the analysis, based on the RCS funding. Table A3.5 shows the funding by care domain and the questions that distributed the funding in the ACFI funding model.

Table A3.5: Percentage ACFI Funding by ACFI Care Domains

ADL Care Domain	Funding per day %	Component Questions
ADL Scale	58.5%	Q1: Eating & Drinking
		Q2: Mobility
		Q3: Personal Hygiene
		Q4: Toileting
		Q5: Continence (bladder & bowel)
BEH Care Domain	**Funding per day %**	**Component Questions**
BEH Scale	14.6%	Q6: Cognitive ability
		Q7: Wandering
		Q8: Verbal Behaviour
		Q9: Physical Behaviour
		Q10: Depression
		Q12: Complex nursing procedures
CHC Care Domain	**Funding per day %**	**Component Questions**
CHC Scale	26.9%	Q11: Medication

3.2.3. Determining the ACFI Scales Weightings

The ACFI factor scores were obtained by factor analysis on the ACFI National Trial sample. The importance of the individual ratings for the ACFI questions within each scale was determined using dummy regression analysis on the ACFI factor scores. For each care domain the scale score was regressed on to dummy variables (A to B, A to C, A to D) for the constituent scale items to show the contribution of each rating in each variable to the total scale score. The factor score for a person equals the sum of the dummy variable coefficients. The coefficients are only relevant within the domain in question (e.g. ADL) and distribute the funding available in that domain. The calculation of the domain funding relativities was described in the previous section (Table A3.5).

The relative importance of the revised nursing questions (ACFI 11, 12) was investigated by regressing the Nursing factor total score against the constituent domains (ACFI 11, 12). As there are only two questions in the 'scale' it was not possible to derive accurate factor weights using dummy variable regression. The relative importance of the levels within the domains (A, B, C, D) was determined using the overall domain relativities.

3.2.4. Calibrating the ACFI Scales to Recurrent Resident Subsidies

As the ACFI scales have been developed as separate 'independent' measures of care need, the coefficients are only relevant within the scale in question, as the amount of funding associated with each care domain (ADL, BEH, CHC) was calibrated separately. While the scales within the domains are comprised of questions whose importance is calculated 'in combination', the funding amounts determined by the domains can then be added as they are components of the latent 'related' domain of 'aged care needs'.

This was in contrast to the RCS where the question weights were determined relative to all other questions in the scale. This (RCS) approach is less specific and will tend to significantly overweight the main factor related to the latent domain of 'aged care needs'. This (RCS) approach is more suitable to hospital or sub-acute care funding models where there is typically a single overall major reason for the care.

The ACFI methodology of partitioning the care needs into three main areas also meant that the ACFI funding models were flexible for future developments as the various components (ADL, BEH, CHC) could be adjusted with additional or modified questions, funding amounts can be differentially applied to the scale domains (e.g. a future cost calibration study may indicate a change in the funding relativities between or within the scales) and particular resident 'types' can be further targeted with the ACFI models at a more resident specific level.

Appendix C: Chapter 4

Chapter 4.1: Rationale for new R-ACFI Nutrition Question

The following gives the rationale for changing the current ACFI Nutrition question:

4.1.1. Relevant Assessment Tools Review

The NSAF approach is to ask questions of the resident about their oral health, appetite, weight loss and fluid intake. The resident's need for assistance with eating is rated on a

3-point scale (Independent; Needs help- cutting, spreading butter etc.; Unable); and if there is difficulty, it clarifies who assists and if episodic assistance is needed. The Mini Nutrition Assessment (MNA) is a supplementary tool.

The interRAI assesses eating (how eats and drinks, intake of nourishment by other means) and rates the resident on a detailed 7-point scale:

- Independent
- Set up help only
- Supervision – oversight
- Limited assistance - guiding with no weight bearing
- Extensive assistance - weight bearing assistance for less than 50 per cent of subtasks
- Maximal assist - weight bearing assistance for more than 50 per cent of subtasks or more than two helpers
- Total dependence - full performance by others.

BMI, nutritional issues (weight loss, dehydrated, fluid intake and output), parenteral and enteral intake, and modes of intake are also assessed. This approach requires a broad and detailed assessment of the person.

4.1.2. Description

- Added: Include content changes to cover nutritional needs and assistance with eating.
- Removed: "This question also applies to people receiving enteral feeding if they receive some nutrition orally on a daily basis". This is covered in ACFI 12.17, and is not a high frequency item.

4.1.3. Recommendations:

- Mandated assessment tool Mini Nutrition Assessment (MNA-Short Form) be introduced.
- That the MNA-Short Form has been completed within the 3 months prior to assessment and reflects the resident's nutritional needs at the time of appraisal.

4.1.4. Assessments - recommended Nutrition assessment tool

The MNA (short form) was selected because:

- It records a BMI and has a screening score which informs on nutritional status, which fits contemporary nursing practice requirements

- It is used by the broader Australian aged care sector (NSAF includes the MNA as a supplementary nutrition tool)
- It gives outcomes for a BMI which can inform on underweight, obesity, bariatric care needs, and a nutritional status that informs on the need for monitoring of nutritional issues
- The Screening score confirms the need for nutritional monitoring
- MNA-short is quick to complete
- Six of the seven items have outcomes that are objectively measured (A, B, C, E, F1, F2). This reduces the level of subjectivity in deciding the outcomes
- The set of questions give an understanding of the reason why monitoring is needed i.e. to monitor food intake for weight loss
- The MNA tools are freely available

4.1.5. Nutrition Assessment Summary

- An Assessment Summary has been added, as the new question now has a mandated assessment
- Records if there are Medical Practitioner or Speech Pathologist (SP) notes that confirm evidence of a swallowing issue (which supports the need for at least partial assistance with eating and drinking i.e. checklist item 2)
- There may be several reasons that help to explain why the resident needs assistance related to this question. To identify those other needs the user must record, at the end of the set of the first four ADL questions (ACFI 1 to ACFI 4), if there is an issue that impacts on any of the ADL items (ACFI 1 to ACFI 4) which explains the requirement of some (partial or full) assistance. The user is also requested to identify the evidence source to support this claim. The reasons for assistance are:
    - physical impairment
    - sensory (vision/hearing) impairment
    - cognitive impairment
    - behavioural issue.

4.1.6. Checklist Content

- Reduced from two checklists covering (Readiness to Eat, and Eating) to one checklist covering the activity of Eating and drinking (Eating).
- Includes a more contemporary approach that covers monitoring of nutritional issues which will be assessed by the MNA short form. This also removes outdated wording such as ‘vitamised’.
- Setting-up activities classed as minimal assistance e.g. taking lids off, cut up food, specialised plates and cutlery, special diets, placing food in front of resident etc.

4.1.7. New Rating Scale

- Rating scale changes from a 3-point scale to a 4-point scale, giving a consistent 4-point scale across the ACFI ADL questions 1 to 4.

- Standby assistance and setting up activities moves from supervision and physical assistance to the standard care level.
- Mandated assessment increases objectivity of the evidence.
- Request for supporting evidence increases the objectivity of the evidence and the rationale for why assistance is needed.

4.1.8. Assessors

- This tool is suitable for external assessment (completed pre-entry or post-entry) and provider assessment (completed at entry) – it is short, and six out of the seven items (A, B, C, E, F1, F2) have outcomes that are clearly defined and therefore can be objectively validated.
- External Assessor could review the claim or complete the MNA-Short assessment using evidence from
    - Diagnoses e.g. dysphagia for swallowing issues, sensory loss, dementia for cognitive loss
    - Documentation by Speech Pathologist, Dietitian or Medical Practitioner
    - Informants e.g. resident, carer, Speech Pathologist, Dietitian or Medical Practitioner.

Chapter 4.2: Rationale for new R-ACFI Mobility Questions

The following gives the rationale for modifying the current ACFI Mobility question.

4.2.1. Relevant Assessment Tools Review

The NSAF collects information about walking and transfers:

For walking the person is:

(i) rated on a 3-point scale (Without help -except for walking stick or similar; With some help from a person or with the use of a walker or crutches etc.; Completely unable to walk). If there is difficulty, it then asks:
(ii) who assists, and
(iii) is the assistance episodic.

For transfers the person is:

(i) rated on a 4-point scale of (Independent; Minor Help -verbal or physical; Major help - one or two people, physical, can sit; Unable- no sitting balance); If there is difficulty, it then asks:
(ii) who assists, and
(iii) will assistance be needed.

Further comments on the physical domain are collected (not mandatory, with prompts) - why does the person need assistance, what is the underlying problem, what activities can they do themselves and what do they have difficulty with, is the person likely to benefit from reablement, in what area, referral to allied health/aids and equipment?

The supplementary functional tools are OARS-ADL, Barthel Index of ADL, and KICA-ADL. These supplementary tools primarily record assessment outcomes – they do not explain the reason why the care is needed. The NSAF items do not give a rationale for the ADL assessment outcome, which is both clinically important and would also strengthen the objectivity of the assessment.

The **interRAI** mobility items cover two mobility items in the ADL self-performance section:

(i) Walking (how the person walks between locations on same floor indoors)

(ii) Locomotion (how the person moves between locations on same floor).

These two items rate the person on a detailed seven-point scale:

- Independent
- Set up help only
- Supervision-oversight
- Limited assistance - guiding with no weight bearing
- Extensive assistance - weight bearing assistance for less than 50 per cent of subtasks
- Maximal assistance - weight bearing assistance for more than 50 per cent of subtasks or more than two helpers
- Total dependence - full performance by others.

There is a transfer item (in the ADL self-performance section); however, it covers only toilet transfers. The scales are used to record the person's actual level of involvement in self-care and the type and amount of support received during the last 3 days.

The interRAI focuses on care provided, not the assessed care need.

4.2.2. Description

No changes.

4.2.3. Recommendations:

- Mandated assessment tools (PMS and FRAT).
- Assessment to have been completed within the past 3 months and continues to reflect the resident's mobility needs at the time of appraisal.

4.2.4. Assessments - recommended Mobility assessment tool:

The Physical Mobility Scale (PMS) was selected because it:

- Provides objective evidence for completing the ACFI 2, 3, 4 checklists and gives an understanding of why the resident needs assistance
- Provides scaled information on transfers and mobility, including balance and aids used.
- Describes 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.

- Will help the staff/facility to determine the level of functional mobility and dependency of the resident, the amount of staff and equipment needed to assist the resident with each task, and the need for physical therapy interventions.
- May also be used when developing a functional therapy plan.
- Can be used to evaluate performance over time, such as for evaluating a Therapy Program, using the overall score determined from the nine (9) PMS item scores.

Individual items of the PMS will inform on the level of independence for specific aspects of transfers and mobility, and can be used to validate the ACFI 2 checklist items. Guidelines have been developed to support the RAC users of this tool – the guidelines were developed by AACS and reviewed by industry and individual physiotherapists.

The FRAT is widely used in the residential sector, and was developed and tested for assessing falls risk in the older population.

The PMS and FRAT are freely available, and copies can be sourced from the NATFRAME (Department of Health, 2015). A review of the PMS and the FRAT is provided in the Appendices (Appendix 4).

4.2.5. Mobility Assessment Summary

- Records if a PMS and FRAT were undertaken – FRAT risk score and the nine item scores for the PMS.
- There may be several reasons that help to explain why the resident needs assistance related to this question. To identify those other needs, at the end of the set of the first four ADL questions (ACFI 1 to ACFI 4), the user must record if there is a:
    - Physical impairment
    - Sensory (vision/hearing) impairment
    - Cognitive impairment
    - Behavioural issue.

4.2.6. Checklist Content

- Two care needs (Transfers and Locomotion).
- Transfers refer to moving to or from chairs or wheelchairs or beds, or re-positioning of the body to perform an ADL (e.g. sitting upright for eating).
    - Setting up activities moved to standard care e.g. preparing wheelchair or other transfer aid.
- Locomotion is described as fitting of lower limb items to enable locomotion (callipers, leg braces, prostheses); moving around inside the facility; Physical Assistance includes pushing a wheelchair.
    - Setting up activities moved to standard care e.g. handing the resident the mobility aid.
- The description of the care need will sit above the ratings, rather than within the ratings. This will clarify and simplify the rating scale for users.

4.2.7. New Rating Scale

Recommendation: That the rating scale approach across the ADL R-ACFI questions be as follows:

- **Standard Care**: Independent or staff standing by for occasional assistance or provision of setting up activities.
    - Independent (with or without aids).
    - Standing by for occasional or episodic assistance.
    - Transfer Setting up activities
    - Verbal assistance, prompting, cuing.
- **Moderate Assistance**: Always providing physical assistance, on a one-to-one basis, for at least part of the activity, whenever the activity is needed.
- **Full Assistance**: Always providing physical assistance, by at least two staff, throughout the entire activity, whenever the activity is needed.
- **Mechanical lifting (Transfers)**: Always providing physical assistance by the use of mechanical lifting equipment, throughout the entire transfer activity, whenever the activity is needed.

4.2.8. Assessors

- This tool is suitable for external assessment (pre-entry or review) and internal assessment (new resident or re-appraisal).
- The External Assessor could review the claim or complete the PMS assessment using evidence from:
    - Diagnoses that support a physical impairment, sensory loss, dementia/ cognitive loss, behavioural issues
    - Documentation by Physical Therapists, Medical Practitioners
    - Informants e.g. Physical Therapist who has recently assessed the resident, Medical Practitioner, resident, carer
    - Direct assessment of the resident's functional performance.

Chapter 4.3: Rationale for new R-ACFI Personal Hygiene Questions

The following gives the rationale for modifying the current ACFI Personal Hygiene questions:

4.3.1. Relevant Assessment Tools Review

The NSAF collects information about Bath or shower and Dressing.

For **Bath or shower** the person is:

(i) rated on a 3-point scale (without help; with some help - need help getting into or out of the bath/shower; completely unable to bathe themselves). If there is difficulty, it then asks:

(ii) who assists, and

(iii) will assistance be needed.

For **Dressing** the person is:

(i) rated on a 3-point scale of (Independent - including buttons, zips, laces etc.; Needs Help but can do about half unaided; Dependent); If there is difficulty, it then asks:
(ii) who assists, and
(iii) will assistance be needed.

Further comments on the physical domain are collected (not mandatory, with prompts) - why does the person need assistance, what is the underlying problem, what activities can they do themselves and what do they have difficulty with, is the person likely to benefit from reablement, in what area, referral to allied health/aids and equipment? The supplementary functional tools are OARS-ADL, Barthel Index of ADL, and KICA-ADL.

The relevant **interRAI** items:
(i) Bathing - includes transfers, how each part of body is bathed;
(ii) Personal Hygiene - i.e. combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands;
(iii) Dressing Upper body - includes prostheses; and
(iv) Dressing lower body-includes prostheses.

All items are rated using the ADL self-performance rating - a detailed 7-point scale:
- Independent
- Set up help only
- Supervision-oversight
- Limited assistance - guiding with no weight bearing
- Extensive assistance - weight bearing assistance for less than 50 per cent of subtasks
- Maximal assistance - weight bearing assistance for more than 50 per cent of subtasks or 2+ helpers
- Total dependence - Full performance by others.

The scales are used to record the person's actual level of involvement in self-care and the type and amount of support received during the last 3 days.

4.3.2. Description

No changes.

4.3.3. Recommendations:

- Grooming item be removed based on ACFI data analysis & feedback from the consultations
- Three care needs reduced to two care needs (grooming removed)

4.3.4. Assessments

- No mandated assessment

4.3.5. Assessment Summary

- Not needed as no mandated assessment

4.3.6. Checklist Content

- Two care needs (Dressing & Undressing; Washing & Drying)
- Dressing & Undressing is Fitting and removing of hip protectors, slings, cuffs, splints, medical braces, and prostheses other than for the lower limb – and addition of tubular elasticised support bandage; Undoing and doing up zips, buttons or other fasteners including Velcro; Putting on or taking off clothing and footwear (e.g. Underwear, shirts, skirts, pants, cardigan, socks, stockings.
    - Setting up activities moved to standard care e.g. choosing and laying out clothes
- Washing & Drying is Washing & drying body.
    - Setting up activities moved to standard care e.g. setting up toiletries within reach, turning on or adjusting taps.
- The description of the care need will sit above the ratings, rather than within the ratings. This will clarify and simplify the rating scale for users.

4.3.7. Rating Scale

Recommendation: That the rating scale approach across the ADL R-ACFI questions be as follows:

- **Standard Care**: Independent or staff standing by for occasional assistance or provision of setting up activities.
    - Independent (with or without aids).
    - Standing by for occasional or episodic assistance.
    - Transfer Setting up activities.
    - Verbal assistance, prompting, cuing.
- **Moderate Assistance**: Always providing physical assistance, on a one-to-one basis, for at least part of the activity, whenever the activity is needed.
- **Full Assistance**: Always providing physical assistance, by at least two staff, throughout the entire activity, whenever the activity is needed.

4.3.8. Assessors

- This tool is suitable for external assessment (pre-entry or review) and internal assessment (new resident or re-appraisal)
- External Assessors could review the claim or complete the ACFI Checklist using evidence from:
    - Diagnoses that support a physical impairment, sensory loss, dementia/ cognitive loss, behavioural issues
    - Documentation by Physical Therapists, Medical Practitioners
    - Informants e.g. Physical Therapist who has recently assessed the person, Medical Practitioner, resident, carer.

Chapter 4.4: Rationale for new R-ACFI Toileting Questions

The following gives the rationale for modifying the current ACFI Toileting questions:

4.4.1. Relevant Assessment Tools Review

The **NSAF** collects information about Toilet use.

For **toilet use** the person is:

(i) rated on a 3-point scale of (Independent on and off, dressing, wiping.; Needs some help, but can do some things alone; Dependent); If there is difficulty, it then asks:

(ii) who assists, and

(iii) will assistance be needed.

Further comments on the physical domain are collected (not mandatory, with prompts) - why does the person need assistance, what is the underlying problem, what activities can they do themselves and what do they have difficulty with, is the person likely to benefit from reablement, in what area, referral to allied health/aids and equipment? The supplementary functional tools are OARS-ADL, Barthel Index of ADL, and KICA-ADL.

The relevant interRAI items:

(i) Transfer toilet - how the person moves on and off toilet or commode;

(ii) Transfer use - how the person uses, cleanses self after, changes pads, manages ostomy/ catheter, adjusts clothes.

All items are rated using the ADL self-performance rating - a detailed 7-point scale:

- Independent
- Set up help only
- Supervision-oversight
- Limited assistance - guiding with no weight bearing
- Extensive assistance - weight bearing assistance for less than 50 per cent of subtasks
- Maximal assistance - weight bearing assistance for more than 50 per cent of subtasks or 2+ helpers;
- Total dependence - Full performance by others.

The scales are used to record the person's actual level of involvement in self-care and the type and amount of support received during the last 3 days. Information about type of Urinary Collection devices and use of Ostomy are collected under Continence.

4.4.2. Description

No changes.

4.4.3. Requirements

Changes

- Minor word/format changes

4.4.4. Assessments

- No mandated assessment

4.4.5. Assessment Summary

- Not required as no mandated assessment

4.4.6. Checklist Content

- Two care needs (Toilet Use, and Toilet Completion)
- Toilet Use is positioning resident for use of toilet or commode or bedpan or urinal
    - setting up activities moved to minimal assistance e.g. setting up toilet aids or handing the resident the bedpan or urinal, or placing ostomy articles in reach
- Toilet completion is adjusting clothing & wiping the peri-anal area
    - setting up activities moved to standard care e.g. emptying drainage bags, urinals, bed pans or commode bowl
- The description of the care need will sit above the ratings, rather than within the ratings. This will clarify and simplify the rating scale for users.

4.4.7. Rating Scale

Recommendation: That the rating scale approach across the ADL R-ACFI questions be as follows:

- **Standard Care**: Independent or staff standing by for occasional assistance or provision of setting up activities.
    - Independent (with or without aids).
    - Standing by for occasional or episodic assistance.
    - Transfer Setting up activities
    - Verbal assistance, prompting, cuing.
- **Moderate Assistance**: Always providing physical assistance, on a one-to-one basis, for at least part of the activity, whenever the activity is needed.
- **Full Assistance**: Always providing physical assistance, by at least two staff, throughout the entire activity, whenever the activity is needed.

4.4.8. Assessors

- This tool is suitable for external assessment (pre-entry or review) and internal assessment (new resident or re-appraisal).
- External Assessors could review the claim or complete the ACFI Checklist using evidence from:
    - Diagnoses that support a physical impairment, sensory loss, dementia/ cognitive loss, behavioural issues
    - Documentation by Physical Therapists, Medical Practitioners
    - Informants e.g. Physical Therapist who has recently assessed the person, Medical Practitioner, resident, carer

Chapter 4.5: Rationale for new R-ACFI Continence Question

The following gives the rationale for modifying the current ACFI Continence question:

4.5.1. Relevant Assessment Tools Review

The NSAF collects information to identify continence issues: Do you have bladder or bowel issues that affect your lifestyle? Bladder issues; Bowel issues; Have you discussed these problems with anyone (e.g. GP, continence advisor)? Would you like to discuss continence issues with a continence advisory service?

The supplementary functional tools are Revised Urinary Incontinence Scale and Revised Faecal Incontinence Scale. These tools rate responses on 5 questions, and then give a mean score for identifying incontinent male/female patients.

The relevant interRAI items are (i) Bladder Continence and (ii) Bowel Incontinence.

Both items use a rating scale to score frequency over the last 3 days (Continent; Control catheter or ostomy; Infrequent incontinent - none in last 3 days but does have episodes; Occasionally incontinent – less than daily; Frequently incontinent - daily but some control present; Incontinent - no control present).

4.5.2. Description

Refers the reader to a ACFI question on CHC for information on:

For the administration of stool softeners, aperients, suppositories or enemas for continence management see the Medication item 9a. in ACFI 8 CHC

For the care and management of an indwelling catheter or ostomy see ACFI 12.5 Complex Health Care

4.5.3. Recommendation:

- A medical diagnosis of incontinence or completion of the recommended assessment is needed if claiming incontinence.

4.5.4. Assessments

- A recommended comprehensive continence assessment tool (updated Continence Tools for Residential Aged Care) which delivers evidence-based best practice for continence management.
- It is designed for use by Residential Aged Care assessors
- The Continence Tools for Residential Aged Care is being modified to cover both the Home Care and Residential Care settings
- This Australian resource, developed for aged care, currently includes:
    - Continence management flow chart
    - Continence screening form
    - Three-day bladder chart
    - Seven-day bowel chart

- Monthly bowel chart
- Continence assessment form and care plan
- Continence care summary
- Clear process with simple tools, designed for Australian RACs.

The benefits of a comprehensive continence assessment approach, supported by the CFA, are that it is evidence-based, promotes best assessment and management practice, and is regularly reviewed.

Continence Records will continue to be mandated for provider assessments.

4.5.5. Assessment Summary

- No incontinence
- Continence Records completed
- Continence Assessment Form and Care Plan completed (a comprehensive assessment approach)
- Has a diagnosis of urinary/faecal incontinence.

4.5.6. Checklist Content

- The checklist will be based on the frequency of incontinence
- Reduced from an 8-point checklist to a 6-point checklist
- Simplified urine frequency groupings but with slightly higher frequency needed to reach the highest frequency group
- Simplified bowel frequency groupings.

4.5.7. Rating Scale

- A 6-point checklist is recommended
  - No incontinence or self-manages continence devices OR catheter/ostomy
  - Incontinent of urine up to 4 times per day OR >4 times per day
  - Incontinent of faeces up to 4 times per week OR >4 times per week.

4.5.8. Assessors

- This comprehensive assessment tool is suitable for external assessment (pre-entry or review) and internal assessment (new resident or re-appraisal).
- External Assessors could review the claim using evidence from:
  - Medical diagnoses of incontinence
  - Completion of Continence Assessment Form and Care Plan (if no diagnosis)
  - Continence Records and resident documentation
  - External Assessors could complete the Continence Assessment Form and Care Plan using informants e.g. resident, carer, continence nurse, Medical practitioner.

Chapter 4.6: R-ACFI ADL Assessment Pack

This pack contains:

- Introductory information about NATFRAME
- A review of the Physical Mobility Scale (PMS) and Falls Risk Assessment Tool (FRAT)
- A copy of the Mini Nutritional Assessment Short Form (MNA-SF) (Nestle, 2009). As the MNA has already been vetted as appropriate for use in the MY Aged Care website it was not reviewed
- Guidelines for use of the Physical Mobility Scale (developed by AACS)
- Physical Mobility Scale form with guided instructions (developed by AACS)
- A copy of the Falls Risk Assessment Tool (NATFRAME, p127)
- The Continence Tool Kit (Continence Foundation Australia) is currently in the final stages of review, to be included when the final version is available.

Table A4.1: Mandatory Assessments for Nutrition, Mobility & Continence under R-ACFI

R-ACFI Question	Question Description	Mandatory Assessment
R-ACFI 1	Nutrition	Mini Nutrition Assessment Short Form (MNA-SF)
R-ACFI 2	Mobility	Physical Mobility Scale (PMS) with guided instructions PMS Guidelines Falls Risk Assessment Tool (FRAT)
R-ACFI 5	Continence	Continence Tool Kit (Continence Foundation Australia)

NATFRAME: https://agedcare.health.gov.au/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi

The National Framework for Documenting Care in Residential Aged Care services (NATFRAME). The work has Commonwealth copyright. It is free of charge to download, display, print and reproduce the material in the manual provided it is unaltered internally. The assessment tools included in the NATFRAME are considered to reflect best practice, the majority of which have been validated by appropriately rigorous research. The assessment tools cover five specific domains: social, cultural and spiritual; physical; functional; communication; and cognitive and mental. It contains tools for the initial assessment of a resident and tools for the assessment of behaviour, cognition, continence, falls, physical mobility and ADL, self-administration of medicines (this is the APAC tool), nutrition and oral and dental health, pain, skin, wound and social, cultural and spiritual domains.

4.6.1. Assessment Tool: Physical Mobility Scale (PMS)

4.6.1.1. Description of purpose

- 9 items scored from 0-5 (dependent to independent scale) (Nitz & Hourigan, 2006)
  - positional changes (lying to side, lying to sit, sit to stand and reverse)
  - balance (sitting, standing)
  - transfers
  - ambulation
  - aids
- Can it be used for Identification? YES, it contributes.
- Can it be used for Evaluation? Potentially - as it gives quantitative data which could be used for evaluating resident outcomes after intervention.

4.6.1.2. Strengths

- Recommended for Mobility Assessment (addresses transfers and locomotion) PMS is a measurement-based assessment of Mobility that flow onto ADLs.
- Written by physiotherapists for gerontology.
- Objective outcomes inform on ADL ACFI items 2-4 and for evaluation of resident capability over time.
- Data would fit into care planning.

4.6.1.3. Limitations

- Lacks falls data aspects, gait timing, dexterity.
- Does not include resident participation data or Quality of Life aspects.

4.6.2. Assessment Tool: Falls Risk Assessment Tool (FRAT) (Source: NATFRAME)

4.6.2.1. Description of purpose

- Falls risk information and management plan (strategies) and evaluation included.
- Can it be used for Identification? YES, it contributes.
- Can it be used for Evaluation? YES, it contributes.

4.6.2.2. Strengths

- Recommended for Mobility Domain - comprehensive toolkit that has been specifically designed for nurses (both acute and RAC), trialled and validated.
- Guidelines included.
- Comprehensive approach to assessment across the care continuum.
- Based on CQI approach, produces objective data for potential Clinical Indicators and person/system evaluation.
- Nurse assessment.

4.6.2.3. Limitations

- Specifically designed for falls not for mobility generally.

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.

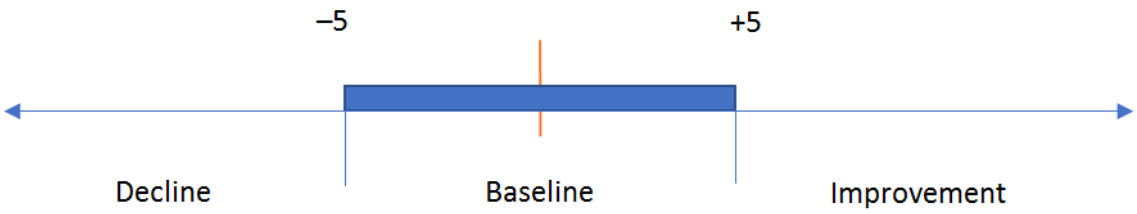
   Generally, a greater amount of assistance is indicated for lower scores. It is essential to review the assessor's comments for each task to ensure that appropriate staffing levels and equipment are being utilised when assisting the resident.

   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 modifications 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

Physical Mobility Scale		
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:**

place photo here

Name:

DOB: Room No:

PLACE ID LABEL HERE

FALLS RISK ASSESSMENT TOOL (FRAT)

Part 1—Fall Risk Status

Risk factor	Level	Risk score
Recent falls (To score this, complete history of falls, overleaf)	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
Medication Sedatives, Anti-Depressants Anti-Parkinson's, Diuretics Anti-Hypertensives	not taking any of these	1
	taking one	2
	taking two	3
	taking more than two	4
Phychological Anxiety, Depression Cooperation, Insight or Judgement esp, re mobility	does not appear to have any of these	1
	appears mildly affected by one or more	2
	appears moderately affected by one or more	3
	appears severely affected by one or more	4
Cognitive status MMSE Hodkinson Abbreviated Mental Score or MMSE	m-m score 9 or 10/10 **OR** intact	1
	m-m score 7–8 mildly impaired	2
	m-m score 5–6 mod impaired	3
	m-m score 4 or less severely impaired	4

(Low Risk: 5–11 Medium Risk: 12–15 High Risk: 16–20) **RISK SCORE:** /20

Automatic high risk status (if ticked then circle HIGH risk)

Current Problems:

- ☐ Recent change in functional status and/or medications affecting safe mobility (or anticipated)
- ☐ Dizziness/postural hypotension

FALL RISK STATUS: (circle) **LOW / MEDIUM / HIGH**

Important: If HIGH, commence fall alert

LIST FALL STATUS ON CARE PLAN/FLOW CHART

Part 2—Risk Factor Checklist

Vision	Reports/observed difficulty seeing—objects / finding way around/signs	☐
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid	☐
Transfers	Transfer status unknown or appears unsafe ie over-reaches, impulsive	☐
Behaviours	Observed or reported agitation, confusion, disorientation	☐
	Difficulty following instructions or non-compliant (observed or known)	☐
A.D.L's	Observed risk-taking behaviours, or reported from donor facility	☐
	Observed unsafe use of equipment	☐
	Unsafe footwear / inappropriate clothing	☐
Environment	Difficulties with orientation to environment i.e. areas b/w bed / bathroom / dining room	☐
Nutrition	Underweight / low appetite	☐
Continence	Reported or known urgency / nocturnia / accidents	☐
Other	Osteoporosis, history fractures	☐

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The Falls Risk Assessment Tool (FRAT)

Reproduced with permission from the Peninsula Health Falls Prevention Services, form revised 2003.

Appendix D: Chapter 5

Chapter 5.1: Rationale for new R-ACFI Cognition Question

The following provides the rationale for modifying the current ACFI Cognition question.

5.1.1. Relevant Assessment Tools Review

The NSAF comprehensive assessment supplementary cognitive tools include:

- Standardised Mini-Mental State Examination (SMMSE)
- Rowland Universal Dementia Assessment Scale (RUDAS)
- Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Kimberley Indigenous Cognitive Assessment (KICA-COG)
- Kimberley Indigenous Cognitive Assessment - Carer (KICA-Carer)

The NSAF approach collects individual aspects of cognition; short and long-term memory loss, impaired judgement, disorientation to time, place and person are also rated (never, occasionally, regularly, always). The NSAF can provide supporting evidence for the R-ACFI cognitive checklist which is based on assistance needs with IADL, personal care required with ADLs, memory loss, orientation and communication.

Adjustment to a new assessment tool

The use of the SMMSE will ensure all assessors can collect a universal cognitive assessment. The PAS-CIS and SMMSE tools have many similarities and the facility staff are likely to be familiar with both (they can receive SMMSE details from the NSAF, hospital letters, GPs etc.). The change should not result in disruption or require significant training. It will be easier for facilities to use information already received and in resident file notes.

5.1.2. R-ACFI Recommended Changes

- Mandated assessment tool SMMSE inserted to replace the PAS-CIS.
- The assessment must have been completed within the 3 months prior to assessment and continue to reflect the resident's cognitive needs at the time of appraisal. This would require the resident's mental status to be reviewed for any recent changes and the assessment to be signed off (for no changes to the mental status) during the appraisal period.
- Objective evidence is to be used and be verifiable to support a decision to use the checklist e.g. diagnosis or medical notes, clinical report.
- A provider must indicate why a resident cannot complete the cognitive assessment tool (recently mandated).

5.1.3. Assessments - Recommended Cognitive Assessment Tool

The SMMSE was selected because:

- It is used by the wider Australian aged care data assessment (NSAF includes the SMMSE as a supplementary cognition tool)
- It is used by the wider Australian health sector
- The SMMSE tool and guidelines are provided for use in Australia by the IHPA
- The set of questions provide an understanding of the individual aspects of cognition – problems with IADLs, ADLs, communication and memory
- These aspects fit into the ACFI checklist approach and descriptions (none, mild, moderate, severe)
- An updated Cognitive checklist continues to provide an alternative for residents who should not, or refuse to, be interviewed using the SMMSE
- The SMMSE and PAS-CIS are similar which will cause little disruption for the industry
- The SMMSE manual should result in minimal training support requirements
- The SMMSE is provided in Appendix 5.

5.1.4. Cognitive Skills Assessment Summary

- Recommended mandated assessment tool SMMSE inserted to replace the PAS-CIS.
- Evidence requirements for using the cognitive checklist when there is a speech or sensory impairment have been included.

5.1.5. Checklist Content

- Recommended mandated assessment tool SMMSE inserted to replace the PAS-CIS.
- Recommended mandated assessment tool SMMSE scores inserted.
- Information from the SMMSE guidelines (Molloy, 2014, p. 10) inserted into the checklist

5.1.6. Rating Scale

No changes to rating scale format, scores updated to reflect the SMMSE based on the SMMSE Guidelines (Molloy, 2014, p. 10):

- None or minimal impairment (SMMSE = 30-25) / Mild impairment (SMMSE = 24-21)
- Moderate impairment (SMMSE = 20-10) / Severe impairment (SMMSE = 9-0)

5.1.7. Assessors

- This tool is suitable for External Assessors (pre-entry or review) and provider assessors (new resident or re-appraisal) – it is widely used in the health sector.
- External Assessors could review the claim by documentation review or direct assessment:
    - Supporting evidence would include diagnoses that indicate cognitive impairment e.g. ACAT diagnosis items 520, 530, 570, 580
    - Supporting evidence would include clinical reports
    - Supporting evidence would include documentation from NSAF, Medical Practitioners or Memory Clinics regarding overall severity, or on individual aspects of cognition such as memory loss, IADL and ADL skill loss due to cognition, orientation and communication loss

- Completing the SMMSE directly with the resident.

Chapter 5.2: Rationale for new R-ACFI Behaviour Questions

The following provides the rationale for modifying the current ACFI questions for Wandering, Verbal and Physical behaviour.

5.2.1. Relevant Assessment Tools Review

The NSAF comprehensive assessment tool:

- Records frequency of behaviours (at risk behaviours, aggressive behaviours, resistive behaviours, agitation, hallucinations/delusions, wandering, disturbed sleep, anxiety) against a scale (never, occasionally, regularly, always).
- Does not involve supplementary behaviour assessment tools.

The interRAI assesses Behaviour by counting if behaviour symptoms were present (previously and in the last 3 days).

5.2.2. Recommended Assessment Approach

The recommended R-ACFI approach uses a behaviour disruptiveness scale for external and provider assessors and a frequency component which will also be required for provider assessment only. Severity or disruptiveness scales are commonly used in behaviour assessments (i.e. CMAI; NPI; BEHAVE-AD; PAS; DBRS). Assessments that use ratings without contextual information (i.e. mild, moderate) rely on the users having a shared understanding of the intent of those words. To improve the objectivity, the recommended disruptiveness scale has contextual descriptions.

The four-point disruptiveness rating scale is shown at Table A5.1.

Table A5.1: The Four-Point Disruptiveness Rating Scale

Rating	Description
Not at all or Mildly	Requires no intervention by staff OR Receives intervention, settles quickly. Mildly disruptive, co-operative response to intervention, not disruptive to other residents or visitors.
Moderately	Receives intervention, takes multiple attempts to settle. Moderately disruptive, not always co-operative, but can be resolved with intervention, sometimes disruptive to other residents or visitors.
Severely	Requires numerous interventions, often unable to settle. Very disruptive, sometimes requires immediate intervention, interferes with others, their belongings or visitors, asocial behaviour.
Extremely	Receives ongoing intervention, cannot effectively settle. 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.

An External Assessor will rely on informants for collecting disruptiveness over a recent time period (last 7 days). Recalling the most frequently disruptive behaviour in the past week that required an intervention should be easier and less subjective than recalling and estimating numerous frequency events. They should ask if the behaviour occurred less than daily, daily, 2/day or more often (refer to Table A5.2).

Disruptiveness is not a new concept, as all current behaviour recordings must receive staff interventions to meet the eligibility criteria. The level of disruptiveness is to be validated by informants and file notes. The Disruptiveness Rating produces an objective outcome of the type of staff intervention. If the disruptiveness was rated mild it is considered to be part of standard care. The behaviours (Wandering, Verbal or Physical) must occur at least daily to be allocated above Rating A (i.e. B, C or D rating).

Table A5.2: Frequency and Disruptiveness Matrix for determining the A, B, C, D Ratings for R-ACFI 7

Disruptiveness Ratings	Frequency Less than daily	Frequency Daily	Frequency Twice per day, everyday	Frequency More than twice per day, everyday
None or mild	A	A	A	A
Moderately	A	A	B	C
Severely	A	B	C	D
Extremely	A	C	D	D

Determining the A, B, C, D Rating for each of the three Behaviour Groups (Wandering, Verbal and Physical)

Steps for the RACF to determine the Behaviour ratings (e.g. A, B, C, D) for Wandering, Verbal Behaviour and Physical Behaviour:

1. **Complete the Behaviour Records over 7 days;**
    - Record every eligible event, total the daily frequency score.
    - Record a daily disruptiveness level.
2. **Complete the Behaviour Assessment Summary;**
    - Complete individualised behaviour descriptions for all claimed behaviour groups.
    - Record the frequency scores based on the Behaviour Records. Less than daily is scored 1; daily is scored 2; 2/day everyday is scored 3 and more than 2/day everyday is scored 4;
    - Record the disruptiveness scores based on the most frequently scored (over the 7 days) in the Behaviour Records. None or mildly is scored 1, moderately is scored 2, severely is scored 3, and extremely is scored 4.
3. **Complete the Behaviour Checklist;**
    - Use the Frequency-Disruptiveness matrix to determine the A, B, C, D rating for each Behaviour Group (Wandering, Verbal Behaviour and Physical Behaviour).

A behaviour description is also recommended as a mandatory requirement. This follows the IPA recommended ABC (Antecedents, Behaviour, Consequences) theoretical approach for managing disruptive behaviours (IPA, 2012). An individualised behaviour description will help an assessor to find supporting documentation.

Examples of Disruptiveness ratings to use in Behaviour Assessments:

- Cohen-Mansfield Agitation Inventory (CMAI)
- Neuropsychiatric Inventory (NPI)
- Behavioural Pathology in Alzheimer's Disease (BEHAVE-AD)
- Pittsburgh Agitation Scale (PAS)
- Disruptive Behavior Rating Scales (DBRS)

5.2.3. Changes to the Current Behaviour Questions – Wandering, Verbal & Physical

There are a number of changes to behaviour questions recommended as follows:

1. Verbal Refusal of Care behaviour sub-type has been dropped as it has not proven possible to accurately define and then measure this descriptor with any consistency. There has been a very significant increase in recording of this behaviour type from 52.2 per cent of residents in 2009 to 72.4 per cent of all aged care residents in June 2016. The significant increase is highly unlikely to be due to an actual rise in residents 'refusing care' but is more likely in the greater part due to confusion over what constitutes refusal of care behaviour that requires ongoing staff intervention.

   It has also become a term that is regularly used to describe behaviours that are reasonable and normal for a person who may be attempting to have some level of control, autonomy and choice over their day-to-day preferences with routines and activities. Dealing and negotiating with residents over needed activities such as dressing, washing and hygiene are considered usual business in an aged care context and successful strategies will reduce the impact of what may have been considered a problem behaviour.

   Residents or persons who refuse required health care in a persistent and consistent way that requires additional and excessive resources will almost certainly trigger another behaviour in the spectrum covered in the behaviour domain, or require a high level of support that will be captured in the ADL domain.

2. The Constantly Physically Agitated behaviour sub-type has been removed as all of the ACFI behaviour items cover various aspects of 'agitation' and there is widespread misidentification of this behaviour. There has also been a very significant increase in recording of this behaviour type, from 40 per cent of residents in 2009 to 63.7 per cent of all residents in June 2016. The increase is highly unlikely to be due to a significant rise in constantly agitated behaviour but more likely due to staff difficulty in understanding the provided definition.

3. The behavioural description of 'performing repetitious/ stereotypic mannerisms that are likely to cause physical harm to self or others e.g. patting, tapping, rocking self, fiddling with something, rubbing self or object, sucking fingers, taking off and on shoes, picking at self or clothing or objects, picking imaginary things out of the air/ floor, manipulation of nearby objects' has been simplified to 'Performing repetitious/ stereotypic mannerisms that cause physical harm to self or others'. Additionally, unable to sit still has been deleted.
4. A single ACFI Behaviour question replaces the three separate behaviour questions.
5. A behaviour must have occurred on a daily basis as recorded over a 7-day period to be claimed and a four-point scale of disruptiveness determines severity together with a frequency record which must be completed by aged care providers (Appendix 5).
6. Behaviour frequency has also been modified in the R-ACFI to simply the ratings:
    - Not at all or less than daily
    - Daily
    - Multiple times per day
7. A Detailed behaviour description is to be included in the Behaviour Assessment Summary to describe what was seen/heard. The behaviour description (i.e. the B in the ABC) will improve the identification of the behaviour from the resident's file notes, as it will be expected to be possibly included in ADL assessments (as this is a common trigger or antecedent for behaviours), recorded as an exceptional event in progress notes (disruptive behaviours should stand out as unusual), and should be included in the Care Plan. For simplicity, just the behaviour description has been requested, but it is intended to encourage the consideration of the context of the behaviour. Effective behaviour management begins by trying to clearly describe the behaviour.

5.2.4. Assessment - Recommended Behaviour Assessment approach

- Residential providers and External Assessors complete the Behaviour Assessment Summary which covers seven behaviour types and includes a Disruptiveness Scale and individualised Behaviour Descriptions.
- For External Assessors, the Disruptiveness rating is to be completed from discussions with carers, service provider and other clinical reports.
- For residential facility assessors, the Disruptiveness rating is to be completed via reference to progress notes and clinical reports.
- Residential providers will also complete a 7-day Behaviour record to provide evidence that the claimed behaviour occurred on a daily basis.
- The behaviour description fits into the ABC best practice approach to behaviour management (recommended by the IPA).

5.2.5. Assessors

- This tool has been modified to enable completion by interviewing an informant by focussing on the disruptiveness of the behaviours which can be collected at a single assessment point.
- The inclusion of the behaviour description will provide a reviewer with a stronger point of reference for identifying supporting documentation which can help to validate the behaviour.
- External Assessors could undertake a documentation review:
    - Supporting evidence could include diagnoses that indicate cognitive impairment e.g. ACAT diagnosis items 520, 530, 570, 580
    - Supporting evidence could include Clinical Reports
    - Supporting evidence could include documentation from the NSAF, Medical Practitioners or Behaviour Support Teams.
- External Assessor could interview informants (carers).

Steps for the External Assessor to determine the Behaviour ratings (e.g. A, B, C, D) for Wandering, Verbal Behaviour and Physical Behaviour

1. Complete the Behaviour Records by interviewing informants:
    - Record a daily disruptiveness level for each of the seven days.
    - Record the estimated frequency of the most disruptive behaviours.
2. Complete the Behaviour Assessment Summary:
    - Complete individualised behaviour descriptions for all claimed behaviour groups.
    - Record the disruptiveness scores based on the most frequently scored in the Behaviour Records:
        - None or mildly is scored 1
        - Moderately is scored 2,
        - Severely is scored 3
        - Extremely is scored 4.
    - Record the frequency scores based on the informants' estimations:
        - Less than daily is scored 1
        - Daily is scored 2
        - 2/day everyday is scored 3
        - More than 2/day everyday is scored 4.
3. Complete the Behaviour Checklist:
    - Use the Frequency-Disruptiveness matrix to determine the A, B, C, D rating for each Behaviour Group (Wandering, Verbal Behaviour and Physical Behaviour).

Chapter 5.3: R-ACFI Behaviour Domain Assessment Pack

Table A5.3.1: R-ACFI Assessment Pack

R-ACFI Question	Question Description	Mandatory Assessment
R-ACFI 6	Cognition	A1: Standardised Mini-Mental State Examination (SMMSE)
R-ACFI 7	Behaviours	A2: Generic Behaviour Descriptions A3: Behaviour Assessment Summary A4: 7-day Behaviour Record (A3)

Table A5.3.2: Standardised Mini-Mental State Examination (SMMSE)

Please see accompanying guidelines for administration and scoring instructions.

		Say: *I am going to ask you some questions and give you some problems to solve. Please try to answer as best you can.*	
1.		Allow ten seconds for each reply. **Say:**	*N/A*
	a	*What year is this?* (accept exact answer only)	/1
	b	*What season is this? (during the last week of the old season or first week of a new season, accept either)*	/1
	c	*What month is this? (on the first day of a new month or the last day of the previous month, accept either)*	/1
	d	*What is today's date? (accept previous or next date)*	/1
	e	*What day of the week is this? (accept exact answer only)*	/1
2.		Allow ten seconds for each reply. **Say:**	*N/A*
	a	*What country are we in?* (accept exact answer only)	/1
	b	*What state are we in? (accept exact answer only)*	/1
	c	*What city/town are we in? (accept exact answer only)*	/1
	d	*<At home> What is the street address of this house? (accept street name and house number or equivalent in rural areas)* *<In facility> What is the name of this building? (accept exact name of institution only)*	/1
	e	*<At home> What room are we in? (accept exact answer only)* *<In facility> What floor of the building are we on? (accept exact answer only)*	/1
3.		**Say:** I am going to name three objects. When I am finished, 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 (say slowly at approximately one-second intervals)	*N/A*
		Ball, Car, Man	*N/A*
		For repeated use: Bell, jar, fan; bill, tar, can; bull, bar, pan	*N/A*
		Say: *Please repeat the three items for me* (score one point for each correct reply on the first attempt)	/3
		Allow 20 seconds for reply; if the person did not repeat all three, repeat until they are learned or up to a maximum of five times (but only score first attempt)	*N/A*
4.		**Say:** *Spell the word WORLD* (you may help the person to spell the word correctly).	*N/A*
		Say: *Now spell it backwards please* (allow 30 seconds; if the person cannot spell world even with assistance, score zero). Refer to accompanying guide for scoring instructions (score on reverse of this sheet)	/5

5.	**Say:** *Now what were the three objects I asked you to remember?*	/3
	(score one point for each correct answer regardless of order; allow ten seconds)	*N/A*
6.	Show wristwatch. **Ask:** *What is this called?*	/1
	(score one point for correct response; accept 'wristwatch' or 'watch'; do not accept 'clock' or 'time', etc.; allow ten seconds)	*N/A*
7.	**Show pencil. Ask:** *What is this called?*	/1
	(score one point for correct response; accept 'pencil' only; score zero for pen; allow ten seconds for reply)	*N/A*
8.	**Say:** *I would like you to repeat a phrase after me: No ifs, ands, or buts*	/1
	(allow ten seconds for response. Score one point for a correct repetition. Must be exact, e.g. no ifs or buts, score zero)	*N/A*
9.	**Say:** *Read the words on this page and then do what it says*	/1
	Then, **hand** the person the sheet with CLOSE YOUR EYES (score on reverse of this sheet) on it. If the subject just reads and does not close eyes, you may repeat: *Read the words on this page and then do what it says*, a maximum of three times. See point number three in Directions for Administration section of accompanying guidelines. Allow ten seconds; score one point only if the person closes their eyes. The person does not have to read aloud.	*N/A*
10.	**Hand** the person a pencil and paper. **Say:** Write any complete sentence on that piece of paper	/1
	(allow 30 seconds. Score one point. The sentence must make sense. Ignore spelling errors).	*N/A*
11.	**Place** design (see page 3), pencil, eraser and paper in front of the person. **Say:** *Copy this design please.* Allow multiple tries.	/1
	[This cell is a break between number 11 and number 12.]	
12.	**Ask** the person if he is right or left handed. **Take** a piece of paper, hold it up in front of the person and **say** the following: *Take this paper in your right/left hand* (whichever is non-dominant), *fold the paper in half once with both hands and put the paper down on the floor*.	*N/A*
	Takes paper in correct hand____	/1
	Folds it in half _____	/1
	Puts it on the floor_____	/1
	TOTAL TEST SCORE:	/30
	ADJUSTED SCORE:	

The SMMSE tool and guidelines are provided for use in Australia by the Independent Hospital Pricing Authority under a licence agreement with the copyright owner, Dr D. William Molloy. The SMMSE Guidelines for administration and scoring instructions and the SMMSE tool must not be used outside Australia without the written consent of Dr D. William Molloy.

Molloy DW, Alemayehu E, Roberts R. Reliability of a standardized Mini-Mental State Examination compared with the traditional Mini-Mental state Examination. *American Journal of Psychiatry*, Vol. 14, 1991a, pp.102-105.

Table A5.3.3: Generic Behavioural Descriptions

All behavioural symptoms must disrupt others to the extent of requiring staff assistance.

Code	Behaviour Type	Guidelines
	Wandering	
☐ W1	Interfering while wandering	Interfering and disturbing other people or interfering with others' belongings while wandering
☐ W2	Trying to get to inappropriate places	Out of building, off the property, sneaking out of the room, leaving inappropriately, trying to get into locked areas, trespassing within the unit, into offices, other resident's room
	Verbal	
☐ V1	Verbal disruption to others	Verbal demanding that is not an unmet need. Making loud noises or screaming that is not an unmet need. Swearing, use of obscenity, profanity, verbal anger, verbal combativeness.
☐ V2	Paranoid ideation that disturbs others	Excessive suspiciousness or verbal accusations or delusional thoughts that are expressed and lead to significant and regular disturbance of others.
☐ V3	Verbally sexually inappropriate	Repeated sexual propositions, sexual innuendo or sexually abusive or threatening language
	Physical	
☐ P1	Physically threatens or does harm to self or others or property	▪ Biting self or others ▪ Grabbing onto people ▪ Striking others, pinching others, banging self or furniture ▪ Kicking, pushing, scratching ▪ Spitting - do not include salivating of which person has no control, or spitting into tissue or toilet ▪ Throwing things, destroying property ▪ Hurt self or others - burning, cutting, touching with harmful objects ▪ Making physical sexual advances - touching a person in an inappropriate sexual way, unwanted fondling or kissing or sexual intercourse ▪ Chronic substance abuse – current and persistent drug and/ or alcohol problem ▪ Performing repetitious/ stereotypic mannerisms that cause physical harm to self or others
☐ P2	Socially inappropriate behaviour that impacts on other care recipients	• Handling things inappropriately - picking up things that don't belong to them, rummaging through others' drawers • Hiding or hoarding things - excessive collection of other persons' objects • Eating/ drinking inappropriate substances • Inappropriate dress disrobing (outside of personal hygiene episodes), taking off clothes in public etc. • Inappropriate sexual behaviour - rubbing genital area or masturbation in a public area that disturbs others

Table A5.3.4: Disruptiveness Rating Scale

Rating	Descriptor
1.	**Not at all or Mildly** Requires no intervention by staff OR Receives intervention, settles quickly. Mildly disruptive, co-operative response to intervention, not disruptive to other residents or visitors.
2.	**Moderately** Receives intervention, takes multiple attempts to settle. Moderately disruptive, not always co-operative, but can be resolved with intervention, sometimes disruptive to other residents or visitors.
3.	**Severely** Requires numerous interventions, often unable to settle. Very disruptive, sometimes requires immediate intervention, interferes with others, their belongings or visitors, asocial behaviour.
4.	**Extremely** Receives ongoing intervention, cannot effectively settle. 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.

Table A5.3.5: Frequency Rating Scale

Rating	Descriptor
1.	Not at all or less than daily
2.	Daily
3.	Twice per day, everyday
4.	More than twice per day, everyday

7-Day Behaviour Records

Use separate pages for each behaviour type:

- Table A5.3.6: Behaviour Record Wandering
- Table A5.3.7: Behaviour Record Verbal
- Table A5.3.8: Behaviour Record Physical

Table A5.3.6: Behaviour Record Wandering

Note: This form has empty cells for appraisers to record the wandering behaviour and provide their initials. These cells are indicated with [Enter code] and [Enter initial] for accessibility purposes.

Resident name / ID			Facility ID				**ACFI 7 Behaviour Record – Wandering (Table A5.3.6)**							
ACFI Appraiser identification details							Record the behaviour code(s) of the behaviour(s) that occur every hour							
Appraiser name: Profession:							Behaviour Codes: W1= Interfering / W2 = Inappropriate places							
Signature: Date:							Further description:							
Date	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:		Day 5 Date:		Day 6 Date:		Day 7 Date:	
Disruptiveness	Day 1 rating:		Day 2 rating:		Day 3 rating:		Day 4 rating:		Day 5 rating:		Day 6 rating:		Day 7 rating:	
Hour starting	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
0000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
Total	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*

Table A5.3.7: Behaviour Record Verbal

Note: This form has empty cells for appraisers to record the verbal behaviour and provide their initials. These cells are indicated with [Enter code] and [Enter initial] for accessibility purposes.

Resident name / ID			Facility ID				**ACFI 7 Behaviour Record – Verbal (Table A5.3.7)**							
ACFI Appraiser identification details							Record the behaviour code(s) of the behaviour(s) that occur every hour							
Appraiser name: Profession:							Behaviour Codes: V1= Verbal disruption / V2 = Paranoid ideation / V3 = Sexually inappropriate							
Signature: Date:							Further description:							
Date	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:		Day 5 Date:		Day 6 Date:		Day 7 Date:	
Disruptiveness	Day 1 rating:		Day 2 rating:		Day 3 rating:		Day 4 rating:		Day 5 rating:		Day 6 rating:		Day 7 rating:	
Hour starting	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
0000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
Total	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*

Table A5.3.8: Behaviour Record Physical

Note: This form has empty cells for appraisers to record the physical behaviour and provide their initials. These cells are indicated with [Enter code] and [Enter initial] for accessibility purposes.

Resident name / ID			Facility ID				**ACFI 7 Behaviour Record – Physical (Table A5.3.8)**							
ACFI Appraiser identification details							Record the behaviour code(s) of the behaviour(s) that occur every hour							
Appraiser name: Profession:							Behaviour Codes: P1= Physically threatens / P2 = Socially inappropriate							
Signature: Date:							Further description:							
Date	Day 1 Date:		Day 2 Date:		Day 3 Date:		Day 4 Date:		Day 5 Date:		Day 6 Date:		Day 7 Date:	
Disruptiveness	Day 1 rating:		Day 2 rating:		Day 3 rating:		Day 4 rating:		Day 5 rating:		Day 6 rating:		Day 7 rating:	
Hour starting	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial	Code	Initial
0000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
0900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1400	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1500	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1600	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1700	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1800	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
1900	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2000	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2100	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2200	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
2300	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*	*[Enter code]*	*[Enter Initial]*
Total	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*	*[Enter total]*	*[Enter Initial]*

Behaviour Assessment Summary Table A5.3.9

Indicate the 1-week date period that behaviours are being recorded in. For each behaviour that is being claimed:

- Tick the correct code for each behaviour type
- Provide a detailed Individualised Behaviour Description
- Provide a Frequency Rating (aged care residential providers to use the Behaviour Record)
- Provide a Disruptiveness Rating using the Disruptiveness Scale.

Table A5.3.9: Behaviour Assessment Summary

Note: This form has blank cells, which are indicated with 'N/A'.

Behaviour Assessment Summary - Refer to the 7-day behaviour chart for frequency details											
Start date: __ __ / __ __/ __ __		**End date: __ __ / __ __/ __ __ (7 days)**									
Tick codes of behaviours		*N/A*	*N/A*				*N/A*				
Code	**Behaviour Type**	*N/A*	**Frequency**				**Disruptiveness**				
	Wandering	**Individualised Behaviour Description**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
☐ W1	Interfering wandering	*Enter description here.*	☐	☐	☐	☐	☐	☐	☐	☐
☐ W2	Inappropriate places									
	Verbal	**Individualised Behaviour Description**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
☐ V1	Verbal disruption	*Enter description here.*	☐	☐	☐	☐	☐	☐	☐	☐
☐ V2	Paranoid ideation									
☐ V3	Sexually inappropriate									
	Physical	**Individualised Behaviour Description**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
☐ P1	Physically threatens	*Enter description here.*	☐	☐	☐	☐	☐	☐	☐	☐
☐ P2	Socially inappropriate									

Note 1: The generic behaviour type descriptors are provided in Appendix 5 (these are not to be used as individualised behaviour descriptions)

Note 2: The behaviour record is provided in Appendix 5

Note 3: Frequency Rating 1 = Not at all or less than daily; 2 = Daily; 3= 2 times per day everyday; 4= more than 2 times per day everyday

Note 4: Disruptiveness Rating 1 = Not at all or Mildly; 2 = Moderately; 3 = Severely; 4 = Extremely

Appendix E: Chapter 6

Chapter 6.1: Analysis of Complex Health Care (CHC) Domain Questions

Table A6.1: ACFI Questions 11 (Medication) Item Frequencies from 2009 to 2016

Item	2010	2011	2012	2013	2014	2015	2016
No assistance	3.2%	2.9%	2.6%	2.5%	2.3%	2.0%	1.9%
Assistance	92.4%	92.4%	92.4%	92.3%	92.2%	92.2%	92.2%
Injections	4.4%	4.7%	5.0%	5.3%	5.5%	5.7%	5.9%

Table A6.2: ACFI Questions 12 (Complex Health Care) Item Frequencies from 2009 to 2016

Item	2009	2010	2011	2012	2013	2014	2015	2016
Q1. Blood Pressure	3.1%	3.6%	4.1%	4.5%	5.1%	5.6%	6.0%	6.2%
Q2. Blood Glucose	6.2%	6.8%	7.1%	7.5%	7.9%	8.2%	8.4%	8.6%
Q3. Pain	**18.8%**	**23.4%**	**28.1%**	**32.1%**	**36.1%**	**40.0%**	**45.1%**	**50.4%**
Q4a. Pain - RN	**5.8%**	**8.8%**	**13.1%**	**17.8%**	**22.2%**	**27.1%**	**30.5%**	**33.7%**
Q4b. Pain - AH	**1.7%**	**3.7%**	**6.5%**	**11.2%**	**14.8%**	**19.8%**	**27.6%**	**35.3%**
Q5. Skin Integrity	32.4%	31.8%	31.8%	32.5%	33.2%	34.3%	36.3%	38.7%
Q6. RN Feeding	1.0%	0.8%	0.7%	0.6%	0.5%	0.5%	0.4%	0.3%
Q7. Suppositories	2.9%	2.3%	1.8%	1.5%	1.3%	1.0%	0.9%	0.7%
Q8. Catheter Care	3.2%	3.3%	3.4%	3.4%	3.5%	3.5%	3.5%	3.4%
Q9. Infectious Conditions	1.1%	1.3%	1.6%	1.8%	1.8%	1.9%	1.8%	1.7%
Q10. Chronic Wounds	6.6%	7.3%	7.8%	8.1%	7.8%	7.5%	7.3%	6.8%
Q11. Intravenous Fluids & Dialysis	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Q12. Oedema	**11.6%**	**14.6%**	**18.3%**	**22.2%**	**25.4%**	**29.4%**	**35.3%**	**41.0%**
Q13. Oxygen Therapy	1.8%	2.0%	2.1%	2.2%	2.2%	2.2%	2.2%	2.1%
Q14. Palliative Care	0.9%	1.4%	1.7%	2.2%	2.3%	1.9%	1.3%	0.4%
Q15. Stoma Care	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
Q16. Tracheostomy	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Q17. Tube Feeding	0.9%	0.9%	0.8%	0.7%	0.7%	0.6%	0.6%	0.6%
Q18. Vital Signs Technical Equipment	0.2%	0.2%	0.3%	0.3%	0.4%	0.5%	0.5%	0.6%

Chapter 6.2: Rationale for new R-ACFI Complex Health Care Questions

This following describes how the recommended CHC domain changes:

- Relate to the NSAF and to the other identified international tool (interRAI)
- Will fit with an external assessment approach
- Impact on the changes required under the R-ACFI User Guide headings - descriptions, requirements, mandated assessment tools, checklists, rating scales.

The recommended format for the R-ACFI CHC questions then follows.

The following provides the rationale for modifying the current ACFI CHC question.

6.2.1. NSAF Assessment and the R-ACFI Recommendations

The NSAF comprehensive assessment covers depression and the supplementary tools are the GDS or the K-10. The use of these tools in the R-ACFI supports the use of shared assessments for persons who can self-complete assessment tools. The R-ACFI guidelines recommend the revised CSD in Dementia to remain as a recommended option for assessing the symptoms and severity of the depression in residential aged care.

6.2.2. Description

The CHC principles still apply.

The ACFI 11 and 12 questions are now included in the R-ACFI 8.

This question relates to the assessed need for ongoing CHC procedures and activities. It excludes temporary nursing interventions e.g. management of temporary post-surgical catheters or stomas, management of minor injuries or acute illnesses such as colds/ flu.

The ratings in this question relate to the technical complexity and frequency of the procedures. The minimum frequency of procedures is ‘at least weekly’ – if less than this it is not taken into account in calculating a rating.

6.2.3. Requirements

A resident must have a regular documented 3-monthly health assessment by a Registered Nurse (RN) if a claim is made in the CHC domain.

A procedure satisfies the requirements for R-ACFI 8 if:

- The stated requirements in the checklist are met for an item;
- A Health Professional acting in their scope of practice conducts an assessment of the resident’s usual care needs at the time of the appraisal;
- The Health Professional identifies the resident’s care needs in a Directive; and
- A record of treatment is provided in requested items.

6.2.4. Changes

- It will be a requirement for a claim in the CHC domain that the resident has a regular ongoing documented 3-monthly comprehensive health assessment undertaken and signed off by a Registered Nurse.
- It is recommended that for an assessment to be current it must have been completed within the past 3 months and continue to reflect the resident's complex health care needs at the time of appraisal. This would require the resident's complex health care needs to be reviewed for any recent changes and the assessment/directive to be signed off (indicating there are no changes) during the appraisal period.

6.2.5. Complex Health Care procedures

6.2.5.1. Items removed

- Blood Pressure (ACFI 12.1)
- Technical equipment for continuous monitoring (ACFI 12.18).

6.2.5.2. Items with reduced weighting

- Blood glucose monitoring (3 points to 1)
- Oxygen therapy (3 points to 1).

6.2.5.3. Items covered elsewhere in R-ACFI

- Pain Items (ACFI 12.3, 12.4a, 12.4b) – covered in new Therapy Program
- Suppositories and enemas (ACFI 12.7) – covered in new Medication Item 9a (Level 1)
- Management of arthritic joints and oedema by tubular elasticised support bandages (ACFI 12.12a) – covered in R-ACFI 3 Personal Hygiene (Dressing & Undressing).

6.2.5.4. Items added

- Medication - Assistance with daily medication; daily injections
- Depression.

6.2.5.5. Items modified

- Oedema item 12.12b has been modified to better fit with contemporary practice to ensure the correct clinical approach is supported.

6.2.6. Recommended Depression Assessments

Assessments are required for Depression. The assessments are not mandated, but recommendations have been made for Depression assessments, which are:

- Revised CSD in Dementia
- GDS
- K-10

The CSD is found in the ACFI Assessment Pack and is suitable for residents who cannot be interviewed including those with dementia.

The GDS and K-10 are supplementary tools used by the ACATs in the NSAF, the use of these tools supports the use of shared assessments across the Australian Aged Care sector. The GDS and the K-10 are designed for self-administration, they are not valid for use by a person with dementia.

6.2.7. Assessors

- The CHC domain is suitable for External and Provider assessors.
- External Assessors could appraise the claim by documentation review and direct assessment:
    - Supporting evidence could include assessments
    - Supporting evidence could include Medication Charts
    - Supporting evidence could include documentation from NSAF documents, Medical Practitioners, Clinical reports
    - Completing a Depression Assessment directly with the resident and/or informants
    - Interviewing informants

Chapter 6.3: Longer Term Changes to be Considered for the R-ACFI

6.3.1. Future Options

Some emerging complex health care issues are not feasible for implementation within this phase (i.e. within 12 months). With further data analysis, they could be considered in the future.

6.3.1.1. Bariatric Care – to be considered in a future R-ACFI Review

In line with the general population, there is an increasing number of residents who are obese or morbidly obese and reportedly, aged care facilities are reluctant to admit older hospital patients needing aged care if they are morbidly obese. The need for the provision of specialised care to people with bariatric care requirements was reported at all consultations to require:

(i) Increased resources, both in the form of staffing required to give assistance with personal care and mobility (requiring 3 or more staff)

(ii) Specialised equipment.

Research has also indicated that there is an increasing number of future aged care clients who are in the obese categories as there are around 7 out of 10 men and 6 out of 10 women aged between 45 and 64 years who are significantly overweight or obese (Stewart, Tikellis, Carrington, Walker, & O'Dea, 2008).

Morbidly obese clients (and many of those overweight or obese as they age) have specific requirements related to their need for bariatric specialised aged care. These requirements include (Australian Aged Care Quality Agency, 2015):

- They will be slower and hence take longer with their ADLs
- They are likely to have increased levels of pain due to the presence of moderate to severe physical disabilities
- They may experience stress incontinence
- They are likely to have reduced function and poor balance
- They may suffer from depression and anxiety.

Defining Bariatric care for R-ACFI Purposes

According to the WHO Classification (World Health Organization, 2017) and the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO, 2014):

- BMI 35-39.9 is Grade II obesity (very high risk)
- BMI below 40 is Grade III Morbid obesity (extremely high)
- BMI over 50 is Grade IV Super Obesity

As bariatric care impacts on both staffing and equipment resources, a further definition for which the level of obesity generally indicates a need for special equipment was sought. The Ashford and St. Peter's NHS Trust definition of BMI > 40 or exceeding the working load limit (WLL) for equipment was adopted as meeting this requirement for the R-ACFI Bariatric Care item (refer to box).

The Ashford and St. Peter's NHS Trust U.K. (2009) defines a bariatric patient as:

Anyone regardless of age, who has limitations in health and social care due to their weight, physical size, shape, width, health, mobility, tissue viability and environmental access with one or more of the following areas:

- Has a BMI > 40 kg/m2 and/or are 40kg above ideal weight for height (NICE 2004)
- Exceeds the Working load limit (WLL) and dimensions of the support surface such as a bed, chair, wheelchair, couch, trolley, toilet, mattress.

Recommendation

A Bariatric Care item be considered for future inclusion in the CHC Procedures list. The requirement for a claim in this item could include:

1. A Diagnosis of obesity (Medical Practitioner); and
2. Care Directive (registered nurse or medical practitioner]; and
3. A BMI > 40 kg/m2; and
4. The resident exceeds the Working load limit (WLL) and dimensions of the support surface such as a bed, chair, wheelchair, couch, trolley, toilet, mattress (Per the definition by Ashford and St. Peter's NHS Trust U.K., 2009); and
5. A possible item weighting of 3 in relativity to the other procedures.

6.3.1.2. Supplement Options

There were a number of other options considered for inclusion in the R-ACFI that would require more significant changes to the funding system and require a longer time frame than is available for this phase of the ACFI changes. Chronic Wounds (ACFI 12.10), Intravenous fluids and dialysis (ACFI 12.11), and Palliative Care (ACFI 12.14) may better fit in a limited lifespan supplement. It is suggested a pilot study be undertaken to determine if such a supplement is appropriate and a funding allocation would need to be determined.

Chronic wounds were claimed by 7 per cent or approximately 11,000 appraisals in 2016. Chronic wounds are possibly more prevalent than reflected in claims, as their occurrence alone does not always meet the criteria for an ACFI re-appraisal.

Intravenous fluids and dialysis claims were low (213 cases) as at June 30, 2016; however, they represent an area that can require a high resource demand when it occurs, and the pattern of their occurrence will better fit into supplements and the sub-acute type residents (that stakeholders informed were a growing area of demand on residential aged care).

Consultations informed that the low claim rate for Palliative Care (e.g. there were only 755 cases in 2016) does not reflect its actual occurrence. The low claim rate may be because a resident already has a D score in ACFI 12 when they are nearing the end of their life and so it

is not claimed, or the ACFI re-appraisal paperwork is perceived as too time consuming for a short-term gain. Further information on these items and how the criteria might be structured in some future ACFI iteration are provided in Appendix 6.

It is recommended that several items in R-ACFI be considered for being treated as supplements as they better fit in a limited lifespan supplement than their current location in the R-ACFI. The items are:

- Chronic Wounds (ACFI 12.10/ R-ACFI 8.11)
- Intravenous fluids and dialysis (ACFI 12.11/ R-ACFI 8.12)
- Palliative Care (ACFI 12.14/R-ACFI 8.15).

It is suggested a pilot project is conducted to determine if moving these items to the supplement category is the best action when considering the long-term approach to RACF.

The chronic wounds category was claimed in 7 per cent or approximately 11,000 appraisals in 2016. Chronic wounds are probably more prevalent than reflected in claims, as their occurrence alone does not always meet the criteria for an ACFI re-appraisal.

Intravenous fluids and dialysis claims were low (213 cases) in 2016; however, they represent an area of high resource demand, and the pattern of occurrence clinically, would better fit into supplements and the sub-acute type residents (that stakeholders informed were a growing area of demand in RACFs).

The low claim rate for Palliative Care (e.g. there were only 755 cases in 2016) does not reflect its actual occurrence. The low claim rate may be due to the fact that as they near the end of life, many residents already have a D score in ACFI 12 so the Palliative Care item is not claimed, or the ACFI re-appraisal paperwork is perceived as too time consuming for a short-term gain.

1. Chronic Wounds Supplement

It is suggested that 'Chronic Wounds' be removed from the CHC Domain and be included as a time-limited supplement. The recommended lifespan for the Chronic Wounds supplement is 3-months, after which the RACS can re-apply. The criteria for the Chronic Wounds supplement would be as per the current ACFI User Guide for ACFI 12.10 (Table A6.3).

Table A6.3: Criteria for the Chronic Wounds Supplement

Criteria	Description
Eligibility	Management of chronic wounds, including varicose and pressure ulcers, and diabetic foot ulcers.
Evidence Requirements	Medical certification (diagnosis) from a Medical Practitioner PLUS Directive by [registered nurse or allied health professional or medical practitioner] PLUS Application form.
How need is assessed	Assessment by [registered nurse or allied health professional or medical practitioner]

Criteria	Description
How approval is granted	AP sends requirements to DoH, DoH determine on behalf of the Secretary of the Department of Health. Notification of approval will appear on a service's Medicare payment statement. This is listed against the respective resident under the *Payment Type* column.
Period Applies	Payable from the date of the delegate's approval (on behalf of the Secretary of the Department of Health) for 3-months. Can re-apply.
Payments	*Standard chronic wounds supplement* TBD

2. Management of Ongoing Administration of Intravenous Fluids, Hypodermoclysis, Syringe Drivers & Peritoneal Dialysis Supplement

It is suggested that 'Intravenous Fluids, Hypodermoclysis, Syringe drivers & Dialysis' be removed from the CHC Domain and be included as a time-limited supplement. The recommended lifespan for the supplement is 3-months, after which the RACS can re-apply.

The criteria for the item supplement would be as per the current ACFI User Guide for ACFI 12.11, with the additional description of 'Peritoneal' before dialysis. There are two types of dialysis - haemodialysis and peritoneal (Kidney Health Australia, 2017). Haemodialysis is usually undertaken in hospital and does not require special follow up by the RAC staff except for general observation. Therefore, it is recommended that dialysis needing management by the RAC staff be defined as peritoneal dialysis.

Table A6.4: Criteria for the Intravenous Fluids, Hypodermoclysis, Syringe Drivers & Peritoneal Dialysis Supplement

Criteria	Description
Eligibility	Management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and peritoneal dialysis.
Evidence Requirements	Medical certification (prescription) from [nurse practitioner or medical practitioner] PLUS Directive by [nurse practitioner or medical practitioner] PLUS APPLICATION form.
How need is assessed	Directive by [nurse practitioner or medical practitioner]
How approval is granted	AP sends requirements to DoH, DoH determine on behalf of the Secretary of the Department of Health. Notification of approval will appear on a service's Medicare payment statement. This is listed against the respective resident under the *Payment Type* column.
Period Applies	Payable from the date of the delegate's approval (on behalf of the Secretary of the Department of Health) for 3-months. In most circumstances the delegate will backdate payment to the date of medical certification; or the date when the resident entered care, whichever is later. Can re-apply.
Payments	*Intravenous Fluids, Hypodermoclysis, Syringe Drivers & Peritoneal Dialysis standard supplement* TBD

3. Palliative Care Supplement

It is suggested that 'Palliative Care' be removed from the CHC Domain and be included as a time-limited supplement. The recommended lifespan for the Palliative Care supplement is 3-months, after which the provider can re-apply.

The criteria for the Palliative Care supplement would be based on the R-ACFI palliative care item. It is recommended that the resident is assessed using the Palliative Approach Toolkit for Residential Aged Care Facilities and it is signed off by a medical practitioner (Brisbane South Palliative Care Collaboration, 2013).

The definition of end-of-life is similar to and modified from the description referenced on page 6 of the 2016 ACFI User Guide: "*Palliative care is appropriate when the resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently." (Australian Palliative Residential Aged Care Project, 2006, p. 38).*

Table A6.5: Palliative Care – End of Life Supplement

Criteria	Description
Eligibility	Palliative care program involving End of Life care where ongoing care will involve very intensive clinical nursing and/ or complex pain management in the residential care setting
Evidence Requirements	Medical certification (diagnosis) from [medical practitioner] PLUS Directive by [Clinical Nurse Consultant/ Clinical Nurse Specialist in pain or palliative care or medical practitioner] PLUS Application form.
How need is assessed	Pain Assessment by [CNC/CNS in pain or palliative care or medical practitioner] It is recommended that the resident is to be assessed using the Palliative Approach Toolkit in Residential Aged Care Facilities and signed off by a Medical Practitioner. **End-of-life (terminal) care definition:** This description is similar to and modified from the end-of-life description found in page 6 of the 2017 ACFI User Guide**.** • *"… palliative care is appropriate when the resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently." (Australian Palliative Residential Aged Care Project, 2006, p. 38)*
How approval is granted	AP sends requirements to DoH, DoH determine on behalf of the Secretary of the Department of Health. Notification of approval will appear on a service's Medicare payment statement. This is listed against the respective resident under the *Payment Type* column.
Period Applies	Payable from the date of the delegate's approval (on behalf of the Secretary of the Department of Health) for 3-months. In most circumstances the delegate will backdate payment to the date of medical certification; or the date when the resident entered care, whichever is later. Can re-apply.
Payments	*Palliative care – end of life standard supplement* TBD

Appendix F: Chapter 7

Chapter 7.1: Assessment Pack – Therapy Program

7.1.1. Functional Assessments

Several suggested tools for the **assessment of functional ability** will be inserted into the R-ACFI Assessment Pack. The inclusion of these tools provides the industry with examples of assessment tools that have been selected for their objectivity, inter-rater reliability, accessibility and ease of use. Additionally, these tools support evidence-based processes and professional care practice.

- Physical Mobility Scale and guidelines (as provided in Chapter 4 and related Appendix)
- Manual Muscle Test
- Berg Balance Scale
- Short Physical Performance Battery

7.1.2. Pain Assessments

Several suggested tools for the **assessment of pain** will be inserted into the R-ACFI Assessment Pack. The inclusion of these tools provides the industry with examples of assessment tools that have been selected for their objectivity, inter-rater reliability, accessibility and ease of use. Additionally, these tools support evidence-based processes and professional care practice.

- Modified Resident's Verbal Brief Pain Inventory (M-RVBPI) is suitable for residents who can be interviewed.
- Pain Assessment in Advanced Dementia (PAINAD) or Abbey Pain Scale are suitable for observational assessment.
- Unidimensional tools (Numeric Pain Rating Scale (NRS) and Verbal Rating Scale (VRS)) are for the ongoing evaluation of pain intensity and response to treatment but are not suitable for residents with severe cognitive impairment.

Refer to Pain Management Guidelines (PMG kit for Aged Care) by Goucke, Kristjanson, and Toye (2007) sourced from https://www.apsoc.org.au/PDF/Publications/PMGKit_2007.pdf for copies of the recommended pain assessment tools.

A review of the recommended tools follows.

7.1.3. Review of the Recommended Functional Assessments

7.1.3.1. Physical Mobility Scale (PMS)

Description of purpose

- Assesses physical mobility and provides a scaled assessment of functional ability
- Comprised of 9 items, each scored from 0-5 (dependent to independent scale) (Nitz & Hourigan, 2006):
    - positional changes (lying to side, lying to sit, sit to stand and reverse)
    - balance (sitting, standing)
    - transfers
    - ambulation
    - aids.
- Can it be used for Identification of needs? YES, it contributes.
- Can it be used for Evaluation? Potentially - as it gives quantitative data which could be used for evaluating resident outcomes after intervention.

Strengths

- **Recommended** for Mobility Assessment (addresses transfers and locomotion).
- PMS is a measurement-based assessment of Mobility that flow onto ADLs.
- Written by physiotherapists for gerontology.
- Meets toolkit documentation framework.
- Objective outcomes inform on ADL ACFI items 2-4 and for evaluation of resident capability over time.
- Data would fit into care planning.

Limitations

- Lacks falls data aspects, gait timing, dexterity.
- Does not include resident participation data or Quality of Life aspects.

7.1.3.2. Manual Muscle Testing (MMT)

Description of purpose

- Standardised assessment of muscle strength.
    - Results in a grading (Medical Research Council method) (Florence et al., 1992):
    - 0: no palpable or observable contraction
    - 1: no visible movement; palpable or observable flicker contraction
    - 2: full ROM, gravity eliminated
    - 3: full ROM, against gravity, no resistance
    - 4: full ROM, against gravity, moderate resistance
    - 5: full ROM, against gravity, maximum resistance
- Can it be used for Identification of needs? YES it contributes (see below)
- Can it be used for Evaluation? YES it contributes

Strengths

- **Recommended** for Functional Assessments
- Identifies strength deficits in muscle groups that translate to function in ADLs.
- Able to prescribe targeted strength exercises.
- Universally used and understood by physiotherapists.
- Quick assessment, no equipment needed.
- Effective to screen for strength in lower limbs to transfer/mobilise.
- Suitable for use by registered nurses with appropriate training.

MMT can provide an objective measure of strength (Grade 1-5) and can be used as a predictor of all ADL performance. Although there can be some variation between therapists in the amount of resistance applied for higher grade scores, there is evidence in the literature supporting its reliability (Fan et al., 2010; Florence et al., 1992). It is a relatively easy assessment to undertake, and is widely used by physiotherapists with the potential for training of registered nurses to undertake the assessment.

- Deficits in muscle strength can be easily documented by facility staff to support any assistance requirements for ADLs.
- Easily translated to the development of individualised therapy plans.

Limitations

- Requires trained professionals to conduct test
- Requires intact cognition to appropriately test
- Increased subjectivity of assessment with higher grades (Hayes & Falconer, 1992)
- Reliability testing researched for neurological conditions (Fan et al., 2010; Florence et al., 1992)
- Limited reliability evidence available for geriatric population

More objective, quantifiable methods of strength testing exist with good evidence, such as hand-held dynamometers (Mahony, Hunt, Daley, Sims, & Adams, 2009). Cost of equipment must be considered if favoured over MMT.

7.1.3.3. Berg Balance Scale (BBS)

Description of purpose

- BBS is an objective assessment of balance
- Contains 14 items scored from 0-4 on an ordinal scale which are then summed (total 0-56) to interpret as:
    - 45-56: independent
    - <45: greater risk of falling / need for assistive device or supervision

Other interpretation of scores exist for population-specific groups e.g. stroke (41-56: Independent; 21-40: Walking with assistance; 0-20: Wheelchair bound) (Stroke Centre, n.d.)

- Assessment for:
    - Static sitting balance

  - Static standing balance (eyes open/closed; feet together; tandem stance, single leg)
  - Dynamic standing balance (reaching forward; pick up object from floor; turning; step onto stool)
  - Transfers (sit-stand; pivot transfer chair-bed)
- Can it be used for Identification of needs? Yes – it contributes
- Can it be used for Evaluation? Provides quantitative data with high internal consistency to evaluate outcomes before and after interventions.

Strengths

- Recommended for Functional Assessment
- The BBS translates to functional positions needed to complete ADLs.
- High inter- (0.97) and intra-rater (0.98) reliability (Downs, Marquez, & Chiarelli, 2013) and used in care facilities (Conradsson et al., 2007).
- Formal training not needed; assessment form and equipment easily accessible.
- Suitable for Nurse assessment - YES
- Objective outcomes inform ACFI Items 2-4

Substantial literature exists to support the BBS as a reliable and objective balance outcome measure that is applicable to the geriatric population. The BBS has high reliability and ease of use. Resources to conduct this test are easily accessible.

A comprehensive balance assessment will be adequate evidence to support assistance claims for any ADLs that involve sitting or standing balance. Depending on the resident, testing may be time consuming; however, the amount of information obtained from the BBS can also be used to formulate specific balance therapy plans that are functionally relevant to the resident and helpful to care planners.

Limitations

- Ceiling effect when close to maximum score (Downs, Marquez, & Chiarelli, 2013)
- Normative scores decline after 70 years of age in healthy community dwellers (Downs, Marquez, & Chiarelli, 2014)
- Unable to use as a guide for gait-aid prescription (Stevenson, Connelly, Murray, Huggett, & Overend, 2010)

7.1.3.4. Short Physical Performance Battery (SPPB)

Description of purpose

The SPPB balance tests assess aspects of balance and their impact on gait and chair stands

Three Balance items are scored from 1-7 (tried but unable, could not hold position unassisted, not attempted, unable to understand instructions, other, refusal); and an overall balance score:

  - Standing feet together side by side
  - Semi tandem stand
  - Tandem stand

Gait Speed Test

Two timed walking tests (same test repeated)

- Length of walk (3 or 4 metres)
- Time (seconds)
- Scored from 1-7 (tried but unable, could not hold position unassisted, not attempted, unable to understand instructions, other, refusal); and an overall walking score:
- Aids
- Score the shorter time, a table is provided to determine points for time taken

Chair Stand Test

- Repeated chair stands
- Safe to stand without help
- Stood with/without using arms, test not completed
- Single chair test scored 1-7 (tried but unable, could not stand unassisted, not attempted, unable to understand instructions, other, refusal)
- Repeated up to five times and time to complete five attempts (directives provided for when not to continue)
- Overall score (1-7)
- Overall score (0-4) based on time taken

Battery scores

- Total Balance score
- Gait speed score
- Chair stand score
- Total score

- Can it be used for Identification of needs? Yes
- Can it be used for Evaluation? Provides quantitative data (at item levels, and for the three types of tests) which could be used for evaluating resident outcomes after intervention.

Strengths

- Freely available, widely used in the literature.
- Objective performance based outcomes.
- Data informs on therapy program development and evaluation.

Physiotherapy Rehabilitation of Osteoporotic Vertebral Fracture (2013) note that:

> "The short physical performance battery (SPPB) is a group of measures that combines the results of the gait speed, chair stand and balance tests. It has been used as a predictive tool for possible disability and can aid in the monitoring of function in older people." (p. 1)

Brandeis University (n.d.) further states that: This battery assesses lower extremity function in adults.

Reliability: Internal consistency of the SPPB is 0.76

Validity: Has predictive validity, showing a gradient of risk for mortality, nursing home admission, and disability.

Limitations

- Does not include consumer participation data.

7.1.4. Review of the Recommended Pain Assessments

7.1.4.1. Modified Resident's Verbal Brief Pain Inventory (M-RVBPI)

Description of purpose

The Modified Resident's Verbal Brief Pain Inventory (M-RBVPI) is the pain assessment tool recommended by the APS for residents who are able to communicate. The M-RVBPI is a modified version of the Brief Pain Inventory that was developed specifically for use in RACFs. The M-RVBPI asks the resident about several aspects of their pain including pain intensity and the impact of the pain on quality of life and various activities.

Strengths

The M-RVBPI takes into consideration evidence that most residents with moderate degrees of dementia prefer verbal descriptors of pain intensity, rather than numeric rating scales. A study of a nursing home group with mild to moderate dementia found 65 per cent could complete a verbal descriptor scale while only 47 per cent could complete a numeric intensity scale. Accordingly, the M-RVBPI uses verbal descriptors to assess intensity of all variables (Australian Pain Society, 2005).

The M-RVBPI assesses the physical and psychosocial factors relevant to pain in detail. On average, it takes about seven minutes to administer. The first question determines the need for further assessment. If the answer to the first question is no, then no further questions are indicated. Further questions evaluate pain intensity and the effectiveness of current treatments. A body map defines the site of pain. This is helpful in evaluating the cause of pain. The remainder of the M-RVBPI looks at the impact of pain on activity, mood, mobility, socialisation and sleep (Australian Pain Society, 2005).

Strengths: resident self-report.

Limitations

- Limited number of residents in residential aged care would be sufficiently verbally able to complete the inventory; additional pre-screening of resident cognitive capabilities may be needed.

7.1.4.2. Abbey Pain Scale

Description of purpose

The Abbey Pain Scale was created for the measurement of pain in people with dementia who cannot verbalise. Based on observation and knowledge of a resident's usual function and medical history, the resident is rated on a four-point word descriptor scale (absent, mild, moderate, severe) across six domains of pain-related behaviour:

- vocalisation
- facial expressions
- change in body language
- change in behaviour
- physiological change
- physical changes.

Scores are combined to give an overall assessment of pain intensity ranging from no pain to severe pain. Pain is also rated as being acute, acute on chronic or chronic. The Abbey Pain Scale takes between two and six minutes to administer (Australian Pain Society, 2005).

Strengths

- Observation-based assessment tool, can be used among residents with dementia, severe cognitive impairment or language barriers. Measurement-based (scales).
- Currently widely used by staff in RACFs.

Limitations

- Lack of item descriptions, therefore reliability may be challenged. No indication of staff skills to complete, or links to interventions or ongoing evaluation (in PMG Kit).

7.1.4.3. Pain Assessment in Advanced Dementia PAINAD

Description of purpose

The PAINAD Scale is derived from the Discomfort Scale for Dementia of the Alzheimer's Type (DS-DAT) but is easier to administer (taking 4 to 8 minutes) and to score. It is specifically targeted at pain and incorporates behaviours from a paediatric observational pain scale. Low scores are associated with low pain and higher scores show greater pain. PAINAD Scale scores should be regarded as a statement about the probability of pain: the higher the score, the greater the probability (Australian Pain Society, 2005).

Strengths

Observation-based assessment tool, can be used among residents with dementia, severe cognitive impairment or language barriers. Tool gives scoring and good description of PAINAD item definitions. Assessment can be conducted under varying conditions.

The tool covers only 3 of 6 categories of non-verbal pain behaviours in the AGS Persistent Pain Guidelines: facial expression, verbalizations/ vocalizations and body language.

Limitations

More subtle pain indicators such as changes in activity patterns or routines, mental status changes and changes in interpersonal interactions may be missed, so the tool's ability to detect pain in residents with dementia with more subtle changes in behaviour may be less effective.

7.1.4.4. Numeric Pain Rating Scale (NPRS) and Verbal Rating Scale (VRS)

Description of purpose

Unidimensional scale for the ongoing assessment of pain.

1. NRS – pain is rated on a scale of zero to 10, with zero indicating no pain and 10 meaning the worst possible pain.
2. VRS - pain is described using categories such as no pain, mild pain, moderate pain, severe pain, very severe pain, worst possible pain.

Strengths

Unidimensional assessments can be performed daily, or more often, if the information gained will help to guide treatment.

VRS - Some older adults, whether or not cognitively impaired, may have difficulty responding to an NRS. If they have relatively good retention of verbal communication, a VRS may be more useful than an NRS. Several types of VRS have been validated. They ask people to respond to brief descriptions of levels of pain intensity. Residents, with whom communication is adversely affected by linguistic or cultural backgrounds or limited education, may be able to respond to a VRS (Australian Pain Society, 2005).

Limitations

Only assesses one dimension of pain, may not be suitable for cognitively impaired residents, those with language barriers or dementia. Quick check but needs more detailed information for thorough assessment.

Appendix G: Chapter 8

Chapter 8.1: R-ACFI IRT Analysis

A discussion of the benefits of IRT method are described in Chapter 2 Methods.

8.1.1. IRT Analysis of ACFI ADL Data

There were two modifications made to the ADL domain before application of the IRT analysis was applied. These were:

(i) Nutrition item

Based on the feedback from the consultations and data analysis the nutrition question was modified into a single checklist. As has been detailed in Chapter 4 the new R-ACFI Nutrition item now has four levels (Table A8.1). The IRT analysis used the recode Nutrition data in the analysis.

Table A8.1: R-ACFI Nutrition Checklist

1. R-ACFI Nutrition Checklist *Usual daily care needs for Eating and drinking activities*	**Assistance level** (Tick one)
Standard Care: Independent during the activity, staff standing by for occasional or episodic assistance, provision of modified textured food and drinks and setting up activities e.g. taking lids off, cut up food, specialised plates and cutlery, special diets, placing food in front of resident etc.	☐ 0
Monitoring: Needs general monitoring for an assessed nutritional need using the mandated assessment. **Includes residents with either ACFI checklist rating of 'Physical Assistance' for Readiness to Eat OR 'Supervision' for 'Eating'.**	☐ 1
Moderate Assistance: Always providing verbal or physical assistance, on a one-to-one basis, for part of the activity, whenever the activity is needed due to a swallowing issue or other impairment. **Includes residents with the ACFI checklist ratings of 'Physical Assistance' for 'Readiness to Eat' AND the 'Supervision' for 'Eating'.**	☐ 2
Full assistance: Always providing physical assistance, on a one-to-one basis, throughout the entire activity, whenever the activity is needed. **Includes residents with the ACFI checklist rating of 'Physical Assistance' for 'Eating'.**	☐ 3

(ii) The Personal Hygiene Checklist Item 'Grooming'

The personal hygiene checklist item 'grooming' was removed from the analysis as it was not statistically discriminating and the effort is captured in other checklist items. This served to also simplify the provider claiming requirements.

8.1.2. IRT Analysis Steps and Results

While the R-ACFI ADL items are good measures of ADL performance, as with any other measures used to capture dependency or need, ability or performance can never be fully

captured in a measurement model. Conceptually ADL performance can be considered a latent trait, and the assessment items can be considered as indicators, as each item reflects part of the latent trait. The better the assessment items or indicators, the more accurately the latent trait is represented.

The IRT analysis sought to create a latent dimension for ADL based on the modified ACFI checklist data. The A, B, C, D ratings were not used as the distributions were highly skewed and they were effectively composites of the checklists which are a more 'pure' measure of functioning. The checklists therefore provided the 'raw' data for the analysis as they are the best indicators of care needs and resource requirements.

Since IRT is not an additive (regression) model, the analysis can proceed even if there are cases with missing data on some items. All that is required is a sufficient spread of items and persons across the range of the scale being developed. Classical test theory (CTT) methods cannot cope with missing data since procedures like factor analysis depend on a correlation matrix (or covariance matrix) that excludes any case with data missing on any item. IRT handles skewed data, unlike factor analysis which assumes normally distributed items.

The statistics for IRT are based on a series of 'encounters' between persons of a given ability on the ADL items against checklist items at that level of difficulty.

- A person's score is largely independent of the number and difficulty of the items scored on, although the score can be estimated more precisely if the person is scored on more ADL checklist items of difficulty similar to their overall functioning level.
- The checklist item's difficulty is largely independent of the number and overall functioning of the persons rated on the scale, although the difficulty can be estimated more precisely if the item difficulty estimate is based on more person responses with an overall ability close to the difficulty level of the item.

The data set used in the analysis comprised records from all residents that had had an ACFI appraisal in the 2015 – 2016 period (233,996 records). This data was selected to represent the most recent information available to the consultants.

8.1.2.1. Looking at IRT results

The Graded Response Method (GRM) version of IRT was used in the analysis since as there were items with several categories for which the differences between categories varied across items. The ADL IRT model converged and confirmed that the R-ACFI ADL scale strongly is a unidimensional set of items.

8.1.2.2. IRT Discrimination Coefficients

The discrimination coefficients (Tables A8.2) show how well the categories of an item (variable) are differentiated. The difficulty coefficients shown in Tables A8.3 (the terminology comes from achievement testing) show the location of each response (in theta units) on the underlying latent trait scale. The location is the point at which a person of given functional ability (across the ADL items) has a 50 per cent probability of being rated at a particular level of a checklist item (e.g. needs physical assistance with locomotion). The set

of difficulty coefficients therefore indicate the relative difficulty of the checklist item categories. For example, how much more dependent is a resident when going from a moderate to a severe checklist rating and what are the difficulty 'step' differences across the checklist items for a resident with a particular overall functional level. IRT produces scores of a residents overall functional ability and a measure of the difficulty of the checklist item categories mapped on to the same scale.

8.1.2.3. Means for categories

In order to provide a more descriptive meaning for the difficulty coefficients, the mean ADL latent score (0/100 normalised scale; Table A8.4) is shown for the group of residents rated at each category of each checklist item (Table A8.5to Table A8.13). A high mean value for a given item category indicates that residents rated at that category are high on the overall latent trait, ADL score. For a given checklist item, the means across the categories show the relative importance (ADL) of the checklist categories.

8.1.2.4. Dummy regression

To determine a weighted score for use in the R-ACFI a dummy variable regression was used (Table A8.14). After running the IRT analysis a score is estimated for each resident on the ADL scale, together with the standard associated error (Tables A8.15). The independent variable for the regression is the ADL latent score. While this approach has some redundancy, it serves to provide an accurate set of coefficients to be used in emulating/recreating the latent score. The coefficients together with the ADL checklist item responses are then used to produce an 'ADL score' for the resident, based on their care need weightings on the checklist items (Tables A8.15).

8.1.2.5. Calculating the ADL Score in the R-ACFI

The scoring algorithm is the sum the relevant regression coefficients across all variables to compute a total score for each person. For example, the relevant regression coefficients for the Nutrition item to the total score is:

- For response 0, add 0.00
- For response 1, add 1.20
- For response 2, add 3.43
- For response 3, add 10.23

The score for a resident can only be one of these values for each ADL item. A resident with a response of 0 to all ADL items would get a total score of 0. A resident with the maximum response to all items would get a total score of 100.

Figure A8.1 shows the distribution of the ADL latent scores. The distribution is significantly improved from the current ACFI ADL domain. The new weightings provide improved discrimination and better target care needs areas that are more highly resource dependent.

Table A8.2: IRT Discrimination Coefficients – Nutrition

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Nutrition	1.85	0.01	235	0	1.84	1.87
Discrimination	-2.48	0.01	-273	0	-2.50	-2.47
Difference	-1.27	0.00	-255	0	-1.28	-1.26
Greater than 1	1.05	0.00	229	0	1.04	1.06
Greater than 2	4.13	0.02	196	0	4.09	4.17
Equal to 3	-1.87	0.01	-359	0	-1.88	-1.86

Table A8.2a: IRT Discrimination Coefficients – Mobility

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Mobility - Transfers	-0.50	0.00	-169	0	-0.51	-0.50
Discrimination	0.97	0.00	283	0	0.97	0.98
Difference	3.82	0.02	189	0	3.78	3.86
Greater than 1	-2.14	0.01	-335	0	-2.15	-2.13
Greater than 2	-0.37	0.00	-127	0	-0.38	-0.37
Equal to 3	4.88	0.04	118	0	4.80	4.96
Mobility - Locomotion	-2.43	0.01	-288	0	-2.45	-2.42
Discrimination	-1.46	0.00	-355	0	-1.47	-1.45
Difference	4.23	0.04	119	0	4.16	4.30
Greater than 1	-2.70	0.01	-238	0	-2.72	-2.68
Equal to 2	-1.62	0.00	-344	0	-1.63	-1.61

Table A8.2b: IRT Discrimination Coefficients – Hygiene

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Hygiene - Dressing	5.65	0.04	148	0	5.58	5.73
Discrimination	-1.76	0.00	-376	0	-1.77	-1.75
Difference	-0.76	0.00	-250	0	-0.76	-0.75
Greater than 1	4.77	0.03	145	0	4.71	4.84
Greater than 2	-1.88	0.01	-355	0	-1.89	-1.86
Hygiene - Washing	-1.13	0.00	-324	0	-1.14	-1.12
Discrimination	1.27	0.01	180	0	1.26	1.29
Difference	-1.58	0.01	-204	0	-1.60	-1.57
Greater than 1	-1.08	0.01	-183	0	-1.09	-1.07
Greater than 2	1.03	0.01	180	0	1.02	1.04

Table A8.2c: IRT Discrimination Coefficients – Toileting

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Toileting - Use	-0.28	0.01	-54	0	-0.29	-0.27
Discrimination	0.64	0.01	114	0	0.63	0.66
Difference	1.85	0.01	235	0	1.84	1.87
Greater than 1	-2.48	0.01	-273	0	-2.50	-2.47
Greater than 2	-1.27	0.00	-255	0	-1.28	-1.26
Toileting - Completion	1.05	0.00	229	0	1.04	1.06
Discrimination	4.13	0.02	196	0	4.09	4.17
Difference	-1.87	0.01	-359	0	-1.88	-1.86
Greater than 1	-0.50	0.00	-169	0	-0.51	-0.50
Greater than 2	0.97	0.00	283	0	0.97	0.98

Table A8.2d: IRT Discrimination Coefficients – Continence

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf.	Interval]
Continence - Urine	3.82	0.02	189	0	3.78	3.86
Discrimination	-2.14	0.01	-335	0	-2.15	-2.13
Difference	-0.37	0.00	-127	0	-0.38	-0.37
Greater than 1	4.88	0.04	118	0	4.80	4.96
Greater than 2	-2.43	0.01	-288	0	-2.45	-2.42
Continence - Faecal	-1.46	0.00	-355	0	-1.47	-1.45
Discrimination	4.23	0.04	119	0	4.16	4.30
Difference	-2.70	0.01	-238	0	-2.72	-2.68
G 1	-1.62	0.00	-344	0	-1.63	-1.61
Greater than 2	5.65	0.04	148	0	5.58	5.73

Graded Response Model IRT Analysis

(N equals 233,996; Log likelihood equals minus 1150430.4)

Table A8.3: IRT Difficulty Coefficients for Discrimination

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf. Interval]	
Nutrition	1.85	0.01	234.7	0	1.84	1.87
Mobility - Transfers	4.13	0.02	195.7	0	4.09	4.17
Mobility - Locomotion	3.82	0.02	188.6	0	3.78	3.86
Hygiene - Dressing	4.88	0.04	118.5	0	4.80	4.96
Hygiene – Washing	4.23	0.04	118.9	0	4.16	4.30
Toileting – Use	5.65	0.04	147.9	0	5.58	5.73
Toileting - Completion	4.77	0.03	144.6	0	4.71	4.84
Urinary - continence	1.27	0.01	180.0	0	1.26	1.29
Faecal - continence	1.03	0.01	180.0	0	1.02	1.04

Table A8.3a: IRT Difficulty Coefficients for Discrimination at Different Levels

Question	Coef.	Std. Err.	z	P>|z|	[95% Conf. Interval]	
Nutrition – [Monitoring]	-2.48	0.01	-273.4	0	-2.50	-2.47
Nutrition – [Moderate Assistance]	-1.27	0.00	-254.9	0	-1.28	-1.26
Nutrition – [Full Assistance]	1.05	0.00	229.0	0	1.04	1.06
Mobility – Transfers [Moderate Assistance]	-1.87	0.01	-358.6	0	-1.88	-1.86
Mobility – Transfers [Full Assistance]	-0.50	0.00	-169.3	0	-0.51	-0.50
Mobility – Transfers [Lifting Machine]	0.97	0.00	283.2	0	0.97	0.98
Mobility – Locomotion [Moderate Assistance]	-2.14	0.01	-334.7	0	-2.15	-2.13
Mobility – Locomotion [Full Assistance]	-0.37	0.00	-127.3	0	-0.38	-0.37
Hygiene – Dressing [Moderate Assistance]	-2.43	0.01	-287.8	0	-2.45	-2.42
Hygiene – Dressing [Full Assistance]	-1.46	0.00	-355.4	0	-1.47	-1.45
Hygiene – Washing [Moderate Assistance]	-2.70	0.01	-238.5	0	-2.72	-2.68
Hygiene – Washing [Full Assistance]	-1.62	0.00	-344.4	0	-1.63	-1.61
Toileting – Use [Moderate Assistance]	-1.76	0.00	-375.7	0	-1.77	-1.75
Toileting – Use [Full Assistance]	-0.76	0.00	-250.4	0	-0.76	-0.75
Toileting – Completion [Moderate Assistance]	-1.88	0.01	-355.5	0	-1.89	-1.86
Toileting – Completion [Full Assistance]	-1.13	0.00	-324.1	0	-1.14	-1.12
Urinary – continence [some of the time]	-1.58	0.01	-204.3	0	-1.60	-1.57
Urinary – continence [all the time]	-1.08	0.01	-182.8	0	-1.09	-1.07
Urinary – continence [some of the time]	-0.28	0.01	-54.3	0	-0.29	-0.27
Urinary – continence [all the time]	0.64	0.01	113.8	0	0.63	0.66

Table A8.4: Distribution of the ADL Latent Score

Variable: ADL Latent	Number	Mean	Std. Dev.	Min	Max
Raw score	233,996	0	0.93	-3.02	1.62
Raw score se	233,996	0.35	0.1	0.18	0.57
Standardised score	233,996	0	1	-3.26	1.75
Scale 0/100	233,996	65.07	19.98	0	100

Figure A8.1: Distribution of the ADL Latent Score

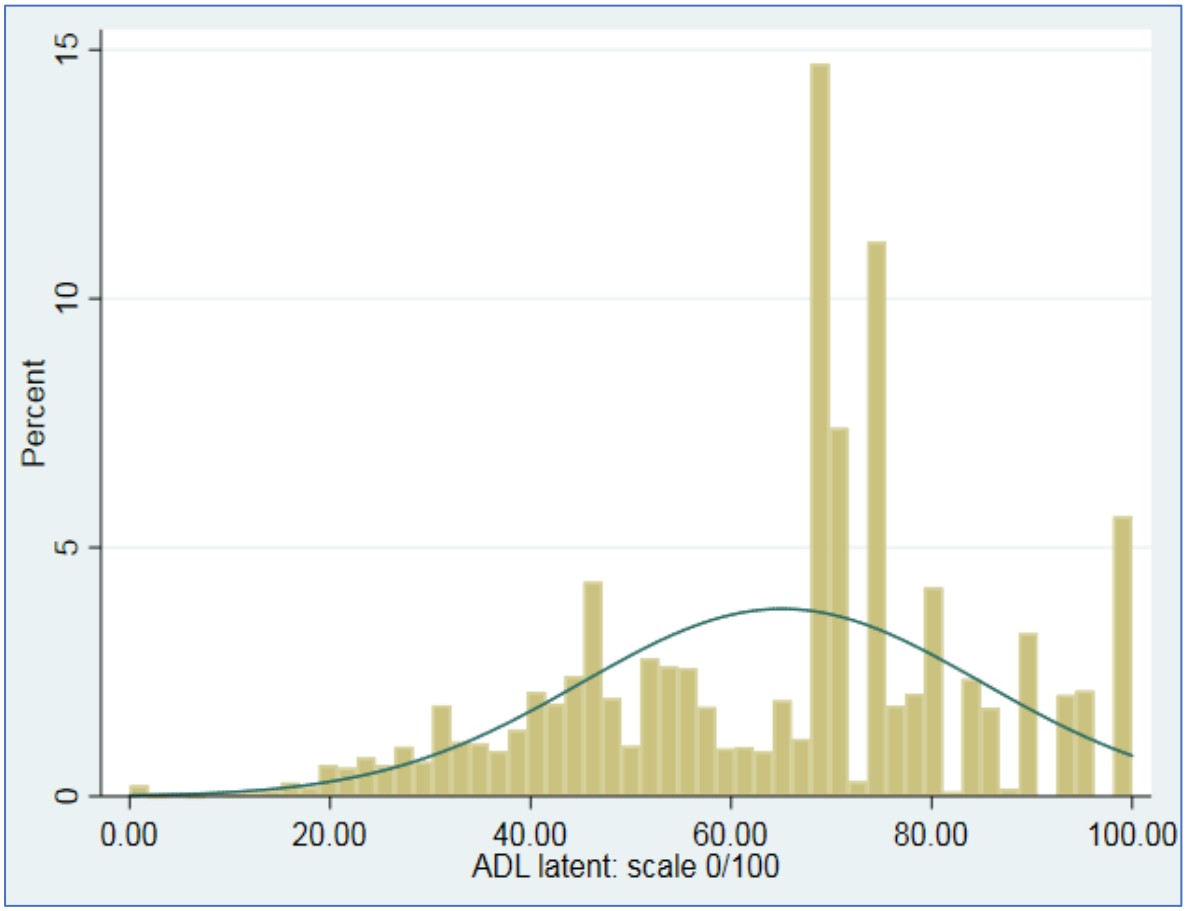


Table A8.5: Mean ADL Latent Score by Nutrition Checklist Item Levels

Q01 Nutrition	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	34.74	19.33	9,414
Monitoring	41.10	13.64	32,446
Moderate Assistance	65.73	14.08	140,086
Full Assistance	83.72	14.3	52,050
Total	65.07	19.98	233,996

Table A8.6: Mean ADL Latent Score by Mobility Checklist Item Levels

Q2.1 Mobility - Transfers	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	26.26	11.6	10,771
Moderate Assistance	44.00	9.18	63,684
Full Assistance	70.31	6.93	116,324
Mechanical Lifting	91.68	7.89	43,217
Total	65.07	19.98	233,996
Q2.2 Mobility - Locomotion	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	28.70	18.32	6,395
Moderate Assistance	45.01	11.23	78,419
Full Assistance	77.17	11.44	149,182
Total	65.07	19.98	233,996

Table A8.7: Mean ADL Latent Score by Hygiene Checklist Item Levels

Q3.1 Hygiene - Dressing	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	13.34	9.4	2,396
Moderate Assistance	30.36	7.07	19,293
Full Assistance	68.81	16.76	212,307
Total	65.07	19.98	233,996
Q3.2 Hygiene – Washing	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	9.44	9.59	1,353
Moderate Assistance	29.12	7.63	15,937
Full Assistance	68.06	17.4	216,706
Total	65.07	19.98	233,996

Table A8.8: Mean ADL Latent Score by Toilet Use Checklist Item Levels

Q4.1 Toileting – Use	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Standard Care	24.35	10.64	11,999
Moderate Assistance	41.03	6.76	44,858
Full Assistance	73.92	13.08	177,139
Total	65.07	19.98	233,996
Q4.2 Toileting - Completion	**Summary of ADL Mean Latent Score**	**ADL latent: scale Std. Dev.**	**Frequency Scale 0/100**
Standard Care	22.58	8.89	10,051
Moderate Assistance	37.36	7.73	26,004
Full Assistance	70.87	15.29	197,941
Total	65.07	19.98	233,996

Table A8.9: Mean ADL Latent Score by Continence Checklist Item Levels

Q5.1 Continence - Urinary	Summary of ADL Mean Latent Score	ADL latent: scale Std. Dev.	Frequency Scale 0/100
Self manages	46.64	21.9	41,031
Incontinent at times	52.99	17.57	19,521
Incontinent at all times	70.79	16.15	173,444
Total	65.07	19.98	233,996
Q5.2 continence – Faecal	**Summary of ADL Mean Latent Score**	**ADL latent: scale Std. Dev.**	**Frequency Scale 0/100**
Self manages	54.07	18.77	102,099
Incontinent at times	69.37	15.99	44,760
Incontinent at all times	75.75	16.2	87,137
Total	65.07	19.98	233,996

Table A8.10: Dummy Regression Model for ADL latent with no constant

Source	SS	df	MS	Number of obs.	=	233,996
N/A	*N/A*	*N/A*	*N/A*	F(20, 233976)	>	99999
Model	1.0831	20	54154761.2	Prob. > F	=	0.000
Residual	1100486.79	233,976	4.7034174	R-squared	=	0.999
N/A	*N/A*	*N/A*	*N/A*	Adj. R-squared	=	0.999
Total	1.0842	233,996	4633.39421	Root MSE	=	2.1687

Table A8.11: Dummy Regression Coefficients for ADL latent with no constant – Nutrition

R-ACFI ADL Scale	Coef. Weights	Std. Err.	t	P>|t|	95% Conf. Interval	
Monitoring	1.48	0.03	54.79	0	1.38	1.48
Moderate Assistance	3.73	0.03	137.8	0	3.56	3.67
Full Assistance	10.75	0.03	369.23	0	10.36	10.47

Table A8.11a: Dummy Regression Coefficients for ADL latent with no constant – Mobility

Mobility – Transfers	Coef. Weights	Std. Err.	t	P>|t|	95% Conf. Interval	
Moderate Assistance	2.43	0.03	83.4	0	2.29	2.4
Full Assistance	8.89	0.03	257.13	0	8.55	8.68
Mechanical Lifting	26.48	0.04	725.31	0	25.57	25.71
Mobility – Locomotion	**Coef. Weights**	**Std. Err.**	**t**	**P>|t|**	**95% Conf. Interval**	
Moderate Assistance	4.62	0.03	137.34	0	4.4	4.53
Full Assistance	15.57	0.04	420.07	0	15	15.14

Table A8.11b: Dummy Regression Coefficients for ADL latent with no constant – Hygiene

Hygiene – Dressing	Coef. Weights	Std. Err.	t	P>|t|	95% Conf. Interval	
Moderate Assistance	5.34	0.06	92.1	0	5.06	5.28
Full Assistance	8.77	0.06	141.12	0	8.37	8.6
Hygiene – Washing	**Coef. Weights**	**Std. Err.**	**t**	**P>|t|**	**95% Conf. Interval**	
Moderate Assistance	9.51	0.06	161.6	0	9.1	9.32
Full Assistance	12.47	0.06	199.89	0	11.95	12.19

Table A8.11c: Dummy Regression Coefficients for ADL latent with no constant –Toileting

Toileting – Use	Coef. Weights	Std. Err.	t	P>|t|	95% Conf. Interval	
Moderate Assistance	4.91	0.03	145.45	0	4.69	4.81
Full Assistance	11.67	0.04	313.57	0	11.23	11.37
Toileting – Completion	**Coef. Weights**	**Std. Err.**	**t**	**P>|t|**	**95% Conf. Interval**	
Moderate Assistance	2.26	0.03	63.13	0	2.13	2.26
Full Assistance	7.38	0.04	187.45	0	7.06	7.21

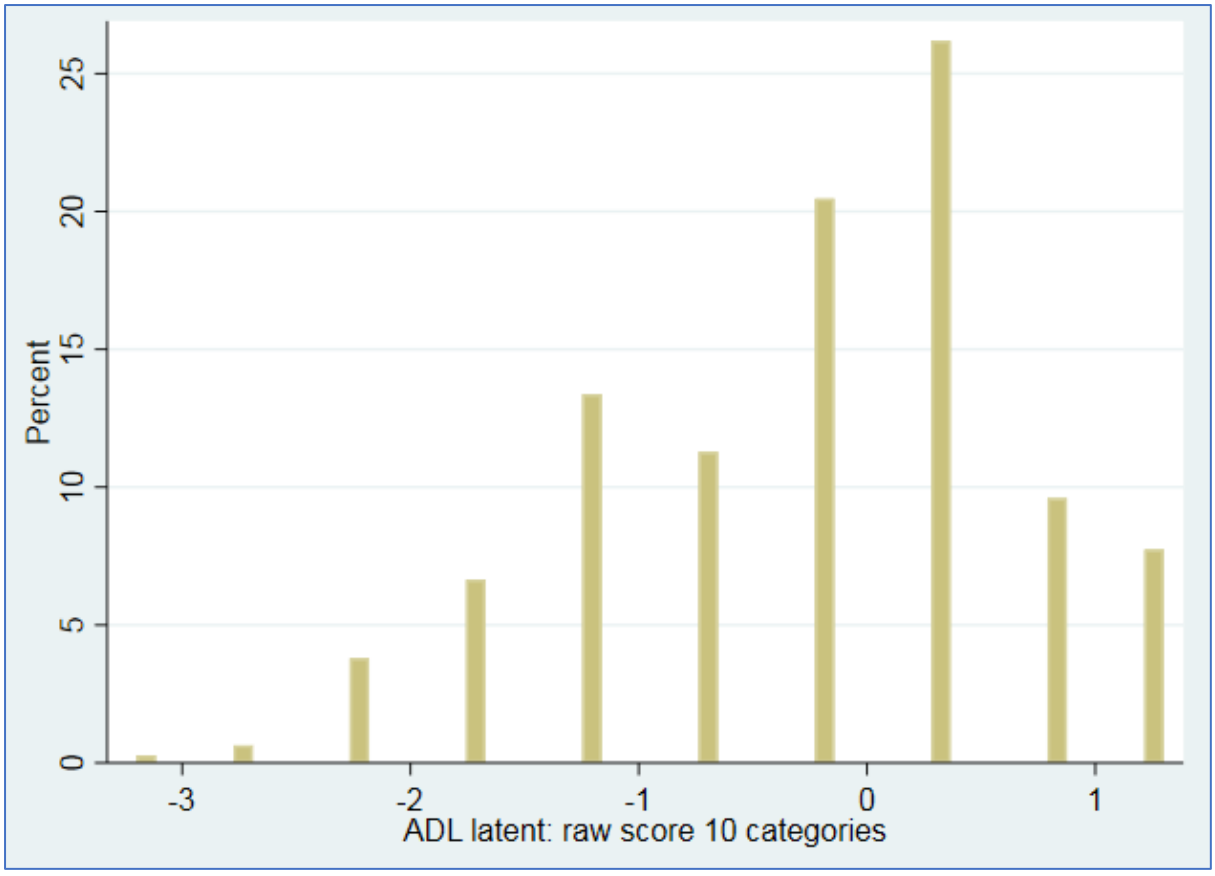
Table A8.11d: Dummy Regression Coefficients for ADL latent with no constant –Continence

Continence – Urinary	Coef. Weights	Std. Err.	t	P>|t|	95% Conf. Interval	
Incontinent at times	0.57	0.02	28.14	0	0.51	0.59
Incontinent at all times	3.34	0.01	227.27	0	3.2	3.25
Continence – Faecal continence	**Coef. Weights**	**Std. Err.**	**t**	**P>|t|**	**95% Conf. Interval**	
Incontinent at times	1.14	0.01	84.41	0	1.07	1.12
Incontinent at all times	3.57	0.01	308.21	0	3.43	3.48

Table A8.12: Example 10 Category Version of ADL

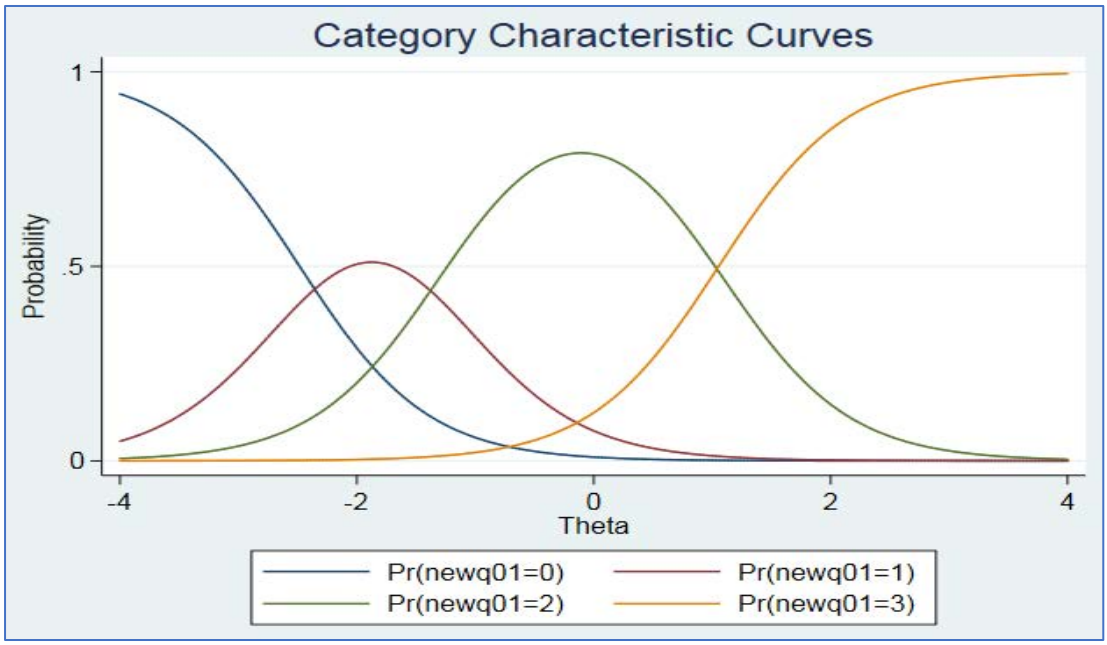
ADL 10	Freq.	Percent	Cumulative
-3.2	632	0.27	0.27
-2.7	1,479	0.63	0.9
-2.2	8,889	3.8	4.7
-1.7	15,553	6.65	11.35
-1.2	31,289	13.37	24.72
-0.7	26,391	11.28	36
-0.2	47,888	20.47	56.46
0.3	61,289	26.19	82.66
0.8	22,471	9.6	92.26
1.3	18,115	7.74	100
Total	233,996	100	

Figure A8.2: Example 10 Category Version of ADL



Category Characteristic Curves Figure A8.3 shows the distribution of category probabilities for persons (ability theta) selecting each response in the Nutrition question (Nil; Monitoring; Moderate Assistance; Full Assistance). The Category Characteristic Curves are highly discriminating showing the new R-ACFI item recoding is highly effective at distributing the relative care needs in Nutrition.

Figure A8.3: IRT Category Characteristic Curves



Pr(newq01=0) is the probability of a response of NIL in the new nutrition question

Pr(newq01=1) is the probability of a response of MONITORING in the new nutrition question

Pr(newq01=2) is the probability of a response of MODERATE ASSISTANCE in the new nutrition question

Pr(newq01=3) is the probability of a response of FULL ASSISTANCE in the new nutrition question

Figure A8.3a shows the cumulative probability boundary characteristic curves for the R-ACFI Nutrition ADL item. The difficulty (theta) is set at a probability equal to 0.5.

Figure A8.3a: Cumulative Probability Boundary Characteristic Curves for Nutrition