Aged Care Funding Instrument (ACFI)

User Guide

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# Introduction

The Aged Care Funding Instrument (ACFI) is a resource allocation instrument. It focuses on the main areas that discriminate core care needs among care recipients. The ACFI assesses core care needs as a basis for allocating funding.

The ACFI focuses on care needs related to day to day, high frequency need for care. These aspects are appropriate for measuring the average cost of care in longer stay environments.

While based on the differential resource requirements of individual persons, the ACFI is primarily intended to deliver funding to the financial entity providing the care environment. This entity for most practical purposes is the residential aged care service. When completed on all care recipients in the service the ACFI provides sufficient precision to determine the overall relative care needs profile and the subsequent funding.

The ACFI consists of 12 questions about assessed care needs, and two diagnostic sections.

While the ACFI questions provide basic information that is related to fundamental care need areas, it is not a comprehensive assessment package. Comprehensive assessment considers a broader range of care needs than is required in the ACFI.

Comprehensive assessment is used for the purposes of ensuring care recipients receive quality and safe care that appropriately meets their care needs. Approved providers responsibilities in this regard are set out in the *Aged Care Act 1997*. In particular the *User Rights Principles 1997* and the *Quality of Care Principles 2014*.

**This ACFI User Guide applies to ACFI appraisals or reappraisals with a date of effect on or after 1 January 2017.**

**Earlier appraisals relate to previous versions of the ACFI User Guide, see table below.**

| Publication Date | Applicable to ACFI Appraisal dates |
| --- | --- |
| 29 February 2008 | 20 March 2008 to 31 December 2009 |
| 15 December 2009 | 1 January 2010 to 31 January 2013 |
| 7 January 2013 | 1 February 2013 to 30 June 2013 |
| 1 May 2013 | 1 July 2013 to 31 December 2016 |

# The ACFI as a calculator of the residential aged care subsidy

Three domains of residential care are subsidised by the ACFI:

* **Activities of Daily Living Domain** (ACFI Questions 1-5; Nutrition, Mobility, Personal Hygiene, Toileting and Continence) Ratings calculated from completing checklists in this domain determines the level of the subsidy.
* **Behaviour Domain** (ACFI Questions 6-10; Cognitive Skills, Wandering, Verbal Behaviour, Physical Behaviour and Depression). Ratings calculated from completing checklists in this domain determines the level of the subsidy.
* **Complex Health Care Domain** (ACFI Questions 11-12; Medication and Complex Health Care Procedures) Ratings calculated from completing checklists in this domain determines the level of the subsidy.

The amount payable in respect of a particular care recipient depends on the ratings (A, B, C or D where relevant) determined for each of the ACFI questions (1–12) as well as the supporting documentation provided in the Answer Appraisal Pack against each of the ratings. Diagnoses are also required to be contained in the ACFI Answer Appraisal Pack and are used to support the claim for subsidy.

Appendix 3 sets out the relationship between the ACFI questions and the three domains, and provides the question scores and category thresholds.

# Definitions and acronyms

## ACAP

The **ACAP** (Aged Care Assessment Program) is an important part of Australia’s aged care system. The Commonwealth engages each state and territory government to manage the day-to-day operations of the ACAP and Aged Care Assessment Teams (ACATs or in Victoria referred to as the Aged Care Assessment Services). The focus of the ACAT’s is to comprehensively assess the care needs of frail older people to determine eligibility for care types under the Aged Care Act 1997.

## ACCR

The **ACCR** (Aged Care Client Record) prior to the introduction of the NSAF was completed by an Aged Care Assessment Team or Service. A copy of the ACCR content can be filed in the ACFI Answer Appraisal Pack if relevant and provides evidence to substantiate an ACFI claim made in the pack.

## Activities

Activities are the actions required to meet a care recipients care needs. Activities must be informed by an assessment and only the specified activities in a nominated ACFI question can be taken into account in the ACFI appraisal. Also refer page 19, Activities of Daily Living Domain, for further information.

## Answer Appraisal Pack

This refers to an **ACFI Answer Appraisal Pack** and is the completed record of the care recipient’s ACFI appraisal or reappraisal. The pack must include all relevant documentation required to substantiate the claim for ACFI subsidy.

The documentation must be in the form specified in this guide and relates to the time of the appraisal/reappraisal. Refer page 13 ‘Table1: ACFI at a glance’ for evidence requirements.

Under section 7 of the *Records Principles 2014*, it is the responsibility of approved providers to ensure their Answer Appraisal Pack is up to date, complete, and available when ACFI reviews are undertaken by the Department of Health to validate the ACFI classification.

## Assessment

**Assessments** are required to evidence the completed checklists for ACFI. The Assessment Pack prescribes some tools to be used in completing an ACFI. For questions that do not have a prescribed assessment tool the appraiser can use a validated evidence based tool of their choice. A list of suggested tools have been provided at <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>

An Assessment provided as evidence for an ACFI checklist would be completed by a person who is appropriately qualified to undertake the assessment. It must be evidence based and identify the Usual Care Needs and dependencies of the care recipient at the time of the appraisal.

To be included as evidence in the Answer Appraisal Pack an assessment must be completed no greater than six months prior to the appraisal submission date and must be consistent with the dependencies of the care recipient at the time of the ACFI appraisal.

Details from the ACFI assessments must be completed in the relevant ACFI assessment summary.

## Assessment Summary

**Assessment Summaries** are required to be completed for some ACFI questions. They indicate which assessment or evidence source was used to support a claim. The Assessment Summaries will then be included in the Answer Appraisal Pack.

## Checklists

**Checklists** form the minimum data set (MDS) underpinning the ACFI appraisal. They are single-focussed items about the care needs within each question. Checklists are required to be completed for each ACFI question in the ACFI Answer Appraisal Pack.

## Clinical Reports

A **Clinical Report** is not mandatory for any ACFI question. For ACFI 6 (Cognition) and ACFI 10 (Depression), existing clinical reports, **if available**, may be included in the ACFI Answer Appraisal Pack to support the rating.

The Clinical Report must be completed by **a registered health professional** in the following disciplines: medical practitioner, medical specialist (Pain medicine), medical specialist (Palliative medicine), medical specialist (Physician - Geriatric medicine), psychologist, suitably qualified registered nurse or nurse practitioner. The details about the clinical report must be completed in the relevant ACFI assessment summary.

## Clinical Nurse Consultant (CNC) / Clinical Nurse Specialist (CNS)

For ACFI 12 item 14 a CNC (Clinical Nurse Consultant) / CNS (Clinical Nurse Specialist) is a registered nurse who has at least five years full time equivalent post registration experience and approved post-registration nursing qualifications in the specialty fields of pain and/ or palliative care.

## Contemporaneous

The term **Contemporaneous** in the context of this guide refers to information completed no greater than six months prior to the appraisal submission date, and is consistent with the dependencies of the care recipient at the time of the ACFI appraisal.

## End of Life

ACFI 12 item 14 enables a claim for a Palliative care program involving end of life care. For this claim the reference for the definition of End of Life is in the Palliative Approach Toolkit for Residential Aged Care Facilities March 2016, Fact Sheet 10 <https://www.caresearch.com.au/caresearch/Portals/0/PA-Tookit/Resources_2016_Update/Fact_Sheet_10_End_of_Life_Terminal_Care_Pathways.pdf>

## Medication(s)

**Medication(s)** refers to any substance(s) listed in Schedule 2, 3, 4, 4D, 8 or 9 of the Standard for the Uniform Scheduling of Drugs and Poisons (and its amendments) and/or Medication(s) ordered by an authorised health professional or authorised for nurse initiated Medication by a Medication Advisory Committee or its equivalent. For ACFI 11 this excludes food supplements, with or without vitamins, and emollients (e.g. sorbolene cream, aqueous cream, etc).

## NSAF (National Screening and Assessment Form)

The **National Screening and Assessment Form** (NSAF) has been progressively replacing the ACCR since 1 February 2016. The NSAF is used to screen and assess the aged care needs of care recipients.

Throughout this document the term NSAF refers to the Comprehensive Assessment component of the National Screening and Assessment Form. For ACFI the NSAF can be accessed through the My Aged Care service provider portal and stored either electronically or in print form.

The Answer Appraisal Pack may include copies of the parts of the NSAF that are relevant as supporting evidence for the appraisal. On the day of an ACFI review, approved providers can provide this evidence:

* In hard copy, as part of the completed Answer Appraisal Pack
* Via email to the department’s relevant email address
* Via the My Aged Care service provider portal.

## Nurse Practitioner

A **Nurse Practitioner** is a registered nurse working at a clinically advanced level of practice who meets the legislative requirements to prescribe (within limits), order certain diagnostics and to refer patients. Regulation of nurse practitioners is the responsibility of the Nursing and Midwifery Board of Australia.

## Source Materials

In the diagnosis sections (refer page 15 to 18 of this Guide) and for ACFI questions 11 and 12, the appraiser will need to complete the **Source Materials** to indicate which evidence source(s) support the rating. Only source documents which continue to reflect the status of the care recipient at the time of appraisal can be used.

Under section 7 of the *Records Principles 2014*, approved providers must retain an ACFI Answer Appraisal Pack to support each ACFI claim. Copies of the source materials must therefore be stored as part of the Answer Appraisal Pack. For source materials evidencing ‘ongoing’ needs in ACFI 12 i.e ‘record of treatment’, the Answer Appraisal Pack must include copies of these records for a reasonable period post the appraisal date.

In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must be dated within the twelve month period, prior to the ACFI submission date.

## Technical Equipment (Pain Management)

**Technical Equipment** designed specifically for pain management' refers to electro-therapeutic equipment such as TENS, interferential therapy, ultrasonic therapy, laser therapy, acupuncture, dry needling and wax baths. The Department of Health does not maintain an exhaustive list of equipment that can be included as this is subject to change over time.

## Therapeutic Massage

**Therapeutic massage** involves skin to skin contact (or through / over clothes or towel) between the therapist and the care recipient.

## Usual Care Needs

The ACFI questions refer to **Usual Care Needs**. These are what has been assessed as the ongoing care needs of the care recipient at the time of the appraisal. This does not include any expected occasional needs or any occasional or unusual needs that are present at the time of the appraisal. **These needs are evidenced in relevant assessment documentation**.

# The ACFI process

For each question:

## Step 1: Assessment

Assess the care recipient for the usual care required. Assessments must be provided for each question as detailed in Table 1, page 13, of this guide. The assessment supports the checklist.

## Step 2: Checklist

Use the information provided in this guide to determine how to correctly complete the checklists in the Answer Appraisal Pack against each ACFI question. The direct relationship between the assessments and checklist requirements is detailed in Table 1.

## Step 3: Rating A to D

Use the completed checklists to determine the rating to use in claiming subsidy for that question, and subsequently for that domain.

## Step 4: Submissions

Submit claims for subsidy to the Department of Human Services (DHS), based on the ratings and supporting documentation you have determined in your ACFI Answer Appraisal Pack.

Queries related to the process of submitting ACFI claims to DHS can be emailed to:

* Aged.Care.Liaison@humanservices.gov.au

## Step 5: Record keeping

Approved providers must keep records relating to ACFI appraisals for the service for three years after 30 June in the year when permanent care ends for the care recipient. Answer Appraisal Packs must include all relevant information needed by the department to verify a provider’s ACFI claim. The types of records that must be kept are specified in paragraphs 7(a) – (c) of the ***Records Principles 2014***. They include:

* care recipient assessments;
* appraisal and reappraisal records in the form of Answer Appraisal Packs e.g. assessment tools from the Assessment Pack and sources of evidence kept in accordance with this guide; and
* copies of classification for care recipient applications that were not sent to DHS in electronic form.

The care recipient’s pack is to be available on request when a review is undertaken by the department.

The person/s authorised by the approved provider to complete the Answer Appraisal Pack and submit the ACFI Application for Classification must certify as part of the application that it is true and correct. This includes ensuring the ACFI Appraiser Identification Details Boxes are completed.

ACFI Appraiser Identification Details Box

| Name of appraiser |  |
| --- | --- |
| Profession |  |
| Signature |  |
| Date |  |

The ACFI Appraiser Identification Boxes are found on the assessments in the Assessment Pack. When these Assessments are completed and used as evidence for ACFI questions 5 to 10 the ACFI Appraiser Identification Details Boxes are to be completed by the person taking responsibility for the appraisal of that question.

Where the ACFI appraiser has chosen to use a previously completed assessment, in completing the **ACFI Appraiser Identification Box**, the ACFI appraiser is signifying that:

* he/she is responsible for the accurate transcription of the information into the records for all ACFI questions;
* he/she is responsible for including the previously completed Psychogeriatric Assessment Scales – Cognitive Impairment Scale (PAS – CIS) and/ or Cornell Scale for Depression (CSD) in the ACFI Answer Appraisal Pack; and
* that the information in the records and assessments continues to provide an accurate reflection of the status of the care recipient.

# Documentation Requirements

The documentation specified in this section comprises the requirements for a completed Answer Appraisal Pack to substantiate a claim.

The completed ACFI Answer Appraisal Pack must be presented upon request and must include:

* completed ACFI assessments;
* Assessment Summaries;
* completed Checklists;
* any clinical reports which provide supporting evidence for ACFI 6 and 10;
* diagnoses, assessments, directives and records of treatment, as required for ACFI 12;
* ACFI appraisal evidence and Source Materials used for the completion of all questions and the diagnosis sections; and
* a copy of the Application for Classification.

# Diagnosis questions

## Mental and Behavioural Diagnosis

* a completed Mental and Behavioural Disorders Checklist;
* a completed Source Materials Checklist; and
* copies of the source materials; e.g. NSAF, ACCR, GP comprehensive medical assessment, or other medical practitioner assessments or notes.

The filed Source Materials must identify the name and profession of the health professional who has made the diagnosis and the date on which it was made.

## Medical Diagnosis

* a completed Medical Diagnosis Checklist;
* a completed Source Materials Checklist; and
* copies of the source materials; e.g. NSAF, ACCR, GP comprehensive medical assessment, or other medical practitioner assessments or notes.

The filed Source Materials must identify the name and profession of the health professional who has made the diagnosis and the date on which it was made.

## Activities of Daily Living (ADL) domain

### ACFI 1 to 4 Nutrition, Mobility, Personal Hygiene and Toileting

* a completed contemporaneous assessment for each of Nutrition, Mobility, Personal Hygiene and Toileting (A list of suggested tools can be found at <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>)

For a rating of B, C or D:

* a completed checklist for each question, based upon the contemporaneous assessment for each question.

#### **ACFI 5 Continence**

* a completed Continence Assessment Summary; and
* a completed Continence Checklist.

For a rating of B, C or D:

* a completed Continence Record.

If claiming for scheduled toileting, you must provide documentary evidence that the care recipient was incontinent prior to the implementation of scheduled toileting e.g. NSAF or a continence flowchart completed prior to scheduled toileting being implemented.

Continence logs or diaries which have been completed in the past six months and are consistent with the current dependency of the care recipient may be used to complete the Continence Record if they contain all the required information.

## Behaviour domain

### ACFI 6 Cognitive Skills

* a completed Cognitive Skills Assessment Summary (If a PAS-CIS score is not included, the assessment must provide the reason why it could not be completed and any relevant supporting document, such as a clinical report); and
* a completed Cognitive Skills Checklist.

For a rating of B, C or D:

* a completed PAS-CIS, or
* a clinical report if identified in the Cognitive Skills Assessment Summary as the supporting document for the claim

### ACFI 7 to 9 Cognitive, Wandering, Verbal and Physical Behaviour

* a completed Behaviour Assessment Summary (refer to Appendix 2 for behaviour descriptors relevant to ACFI); and
* a completed Behaviour Checklist

For a rating of B, C or D:

* a completed Behaviour Record

### ACFI 10 Depression

* a completed Depression Assessment Summary (the Assessment must provide the name of the supporting document, such as a clinical report); and
* a completed Depression Checklist

For a rating of B, C or D:

* a completed Cornell Scale for Depression; and
* a copy of the clinical report or other supporting document as detailed in the Depression Assessment Summary.

For a rating of C or D:

* a copy of a Contemporaneous or provisional diagnosis of depression

**The diagnosis, or provisional diagnosis, reconfirmation of the diagnosis, should have been completed in the past twelve months**. Diagnosis sources may include medical practitioner assessments or notes, comprehensive medical assessments and/or the NSAF. If a diagnosis or provisional diagnosis is being sought at the time of the appraisal (indicated in the symptoms of Depression Checklist), then when it is obtained, a copy of it must be included in the Answer Appraisal Pack.

Behaviour Domain Funding

To qualify for the highest level of the Behaviour Domain funding, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis must be provided. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the 12 months prior to the ACFI submission date.

## Complex Health Care domain

### ACFI 11 Medication

* a completed checklist.

For a rating of B or C:

* a completed Source Materials Checklist; and
* a copy of the medication chart that was applicable on the date of submitting the appraisal.

### ACFI 12 Complex Health Care

For a rating of B, C or D, i.e. where one or more complex health care procedures are provided as required on at least the specified frequency:

* the completed checklist; and
* copies of all required diagnoses, assessments and directives as specified below.

Where it is specified that a record of treatment is required, copies of these records must be included with the ACFI Answer Appraisal Pack. The records of treatments must cover the period where treatment was provided in the appraisal period and for a reasonable period post the appraisal date.

The following tables provide an overview of the ACFI questions, the required level of appraisal evidence and the assistance required.

Table 1: ACFI at a glance

|  | Question | Appraisal Evidence Requirements |
| --- | --- | --- |
|  | Mental and Behavioural Diagnosis | * Disorders/ diagnosis checklists * Source materials checklists * Copies of source materials e.g. NSAF, ACCR, GP comprehensive medical assessment, other medical practitioner assessments or notes |
|  | Medical Diagnosis |
| Activities of Daily Living Domain | | |
|  | **Nutrition**  Care need: readiness to eat / eating  Assistance level = independent OR supervision OR physical assistance | * Assessment * Nutrition Checklist |
|  | **Mobility**  Care need: transfers / locomotion  Assistance level = independent OR supervision OR physical assistance OR mechanical lifting equipment | * Assessment * Mobility Checklist |
|  | **Personal Hygiene**  Care need: dressing / washing / grooming  Assistance level = independent OR supervision OR physical assistance | * Assessment * Personal Hygiene Checklist |
|  | **Toileting**  Care need: use of toilet / toilet completion  Assistance level = independent OR supervision OR physical assistance | * Assessment * Toileting Checklist |
|  | **Continence**  Urinary continence and faecal continence  Measurement = frequency | * Continence Assessment Summary * Continence Record * Continence Checklist * Documentary evidence of incontinence prior to the implementation of a scheduled toileting program   (Note: Other types of logs or diaries may be used to complete the continence record providing they contain all the required information.) |
| Behaviour Domain | | |
|  | **Cognitive Skills**  Care need: needs arising from cognitive impairment  Measurement = none, mild, moderate, severe | * Cognitive Skills Assessment Summary * PAS - CIS if appropriate * Cognitive Checklist (refer page 26)   (Note: A clinical report may be attached to provide supporting evidence) |
|  | **Wandering**  Care need: absconding or interfering whilst wandering  Measurement = frequency | * Wandering/ verbal/ physical behaviour assessment summary * Wandering/ verbal/ physical behaviour records * Wandering/ verbal/ physical Behaviour checklists   (Note: Other types of logs or diaries may be used to complete the behaviour records. Copies of these records can also be included in the ACFI Answer Appraisal Pack to provide further supporting evidence). |
|  | **Verbal**  Care need: verbal behaviour  Measurement = frequency |
|  | **Physical**  Care need: physical behaviour  Measurement = frequency |
|  | **Depression**  Care need: depressive symptoms  Measurement = none, mild, moderate, severe | * Depression Assessment Summary * Cornell Scale for Depression * Depression Checklist * Diagnosis   (Note: A clinical report may be attached to provide supporting evidence) |
| Complex Health Care Domain | | |
|  | **Medication**  Care need : assistance with medications  Measurement = complexity & frequency. | * Source materials table * Medication Checklist * Medication chart |
|  | **Complex Health Care**  Care need: complex health care procedures  Measurement = complexity and frequency | * Complex Health Care Checklist * Diagnoses, assessments and directives as specified * records of treatments completed in appraisal period and for a period after |

**REQUIREMENT**: As per page 8 ‘Record keeping’, all relevant evidence listed above **must be stored** in the ACFI Answer Appraisal Pack (AAAP) to substantiate a claim, additional evidence may be requested by the department.

Table 2: Summary of assistance required provisions for ACFI 1 to 4:

| Independent  Requires no supervision with the stated activities or is not applicable | Supervision    Requires supervision with the stated activities | | Physical assistance    Requires one-to-one physical assistance with the stated activities |
| --- | --- | --- | --- |
| Setting-up | Standby in the stated activities2 | Physical |
| **ACFI 1 Nutrition** | | | |
| **Readiness to eat** | Place utensils in the care recipient’s hand | Not applicable | Cutting up food or vitamising food |
| **Eating** | Not applicable | Stand by to provide assistance (verbal and/ or physical)  OR  daily oral intake when ordered by a dietitian for person with a PEG tube | Placing or guiding food into mouth for most of the meal |
| **ACFI 2 Mobility** | | | |
| **Transfers** | Locking wheels to enable transfers  AND  adjusting/ removing foot plates or side arms | Stand by to provide assistance (verbal and/ or physical) | Physically assist, one to one, moving to or from chairs, or wheelchairs, or beds  OR  use of mechanical lifting equipment |
| **Locomotion** | Hand care recipient the mobility aid  OR  fitting of callipers, leg braces or lower limb prostheses | Stand by to provide assistance (verbal and/ or physical) | Need for staff to push wheelchair  OR  staff to assist with walking with a minimum one to one staffing effort throughout the activity |
| **ACFI 3 Personal Hygiene** | | | |
| **Dress/Undress** | Choosing and laying out appropriate clothing  OR  undoing and doing up zips, buttons or other fasteners including velcro | Stand by to provide assistance (verbal and/ or physical) | One-to-one physical assistance for dressing  AND  undressing i.e. putting on or taking off clothing  AND  footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings)  OR  fitting and removing of hip protectors, slings, cuffs, splints, medical braces and prostheses other than for the lower limb |
| **Wash/dry** | Set up toiletries within reach, adjusting taps | Stand by to provide assistance (verbal and/ or physical) | Washing and drying body |
| **Groom** | Set up articles for grooming | Stand by to provide assistance (verbal and/ or physical) | Dental care  OR  hair care  OR  shaving |
| **ACFI 4** |  | |  |
| **Use of a toilet** | Setting-up toilet aids, hand person the bedpan/ urinal, place ostomy articles in reach | Stand by to provide assistance (verbal and/ or physical) | Positioning care recipient for use of toilet or commode or bedpan or urinal |
| **Toilet completion** | Emptying of drainage or stoma bags or bedpans | Stand by to provide assistance (verbal and/ or physical) | Adjusting clothes  AND  wiping and cleaning of peri-anal area |

2Refer to Activities of Daily Living (ADL) Domain page 19

# Mental and Behavioural Diagnosis

## Description

If the care recipient has a mental and behavioural disorder(s) that has an impact on their current care needs for support and assistance, a documented diagnosis is required.

## Requirements

The diagnosis is to be recorded in the Checklist and a copy placed in the Answer Appraisal Pack. You may tick more than one diagnosis if required to support your claim.

The diagnosis provided in the Answer Appraisal Pack must be dated and identify the name and profession of the health professional who has confirmed the diagnosis.

## Checklist must be completed

There are two checklists for this component of the ACFI, the first is completed by indicating the Source Materials filed in the Answer Appraisal Pack.

More than one source may be ticked. The second checklist is where the diagnoses are recorded.

Mental and Behavioural Diagnosis

| Indicate which sources of evidence have been filed in the ACFI Appraisal Pack | Tick if yes |
| --- | --- |
| Aged Care Client Record (ACCR) / National Screening and Assessment Form (NSAF) |  D1.1 |
| GP comprehensive medical assessment |  D1.2 |
| General medical practitioner notes or letters |  D1.3 |
| Geriatrician notes or letters |  D1.4 |
| Psychogeriatrician notes or letters |  D1.5 |
| Psychiatrist notes or letters |  D1.6 |
| Other medical specialist notes or letters |  D1.7 |
| Other–please describe |  D1.8 |

Gfh

If the care recipient has no relevant disorder, place a tick in the first option on the checklist (no diagnosis) and proceed to Medical Diagnosis.

Important information:

To qualify for the highest level of funding in the Behaviour Domain, a dementia diagnosis, provisional dementia diagnosis, psychiatric diagnosis or behavioural diagnosis must be provided. In the case of diagnoses covering depression, psychotic and neurotic disorders (refer mental and behavioural diagnosis codes 540, 550A, 550B, 560) the diagnosis, provisional diagnosis or re-confirmation of the diagnosis must have been completed within the **twelve months prior** to the ACFI submission date.

Mental and Behavioural Diagnosis Checklist

|  | Mental and Behavioural Disorders | Tick if YES |
| --- | --- | --- |
| 0 | No diagnosed disorder currently impacting on functioning |  |
| 500 | Dementia, Alzheimer’s disease including early onset, late onset, atypical or mixed type or unspecified |  |
| 510 | Vascular dementia e.g. multi-infarct, subcortical, mixed |  |
| 520 | Dementia in other diseases, e.g. Pick’s Disease, Creutzfeldt-Jakob, Huntington’s, Parkinson’s, HIV |  |
| 530 | Other dementias, e.g. Lewy Body, alcoholic dementia, unspecified |  |
| 540 | Delirium |  |
| 550A | Depression, mood and affective disorders, Bi-Polar |  |
| 550B | Psychoses e.g. schizophrenia, paranoid states |  |
| 560 | Neurotic, stress related, anxiety, somatoform disorders e.g. post traumatic stress disorder, phobic and anxiety disorders, nervous tension/stress, obsessive-compulsive disorder |  |
| 570 | Intellectual and developmental disorders e.g. intellectual disability or disorder, autism, Rhett’s syndrome, Asperger’s syndrome etc |  |
| 580 | Other mental and behavioural disorders e.g. due to alcohol or psychoactive substances (includes alcoholism, Korsakov’s psychosis), adult personality and behavioural disorders. |  |

For categories 540, 550A, 550B, and 560 the diagnosis / provisional diagnosis or reconfirmation of the diagnosis must have been completed in the **twelve months prior to the ACFI submission date**.

# Medical Diagnosis

## Description

This item relates to a diagnosed and documented disease or disorder excluding the mental and behavioural disorders recorded in the Mental and Behavioural Diagnosis. The health condition **must** be relevant to the care needs of the person at the time of the appraisal.

The health condition codes used here are the diagnostic codes used by Aged Care Assessment Teams/ Services. A complete listing titled **‘ACAP code list for health condition’** is included in Appendix 1.

## Requirements

To complete this section in the ACFI Answer Appraisal Pack, the appraiser must identify each medical diagnosis that has a discernible impact on the care recipients care needs at the time of the appraisal. Diagnoses are to be recorded in the checklist and a copy placed in the Answer Appraisal Pack. More than one diagnosis can be ticked if required to support your claim. The Application for Classification collects a maximum of three diagnoses. For care recipients who have more than three diagnoses, please identify the **three most significant** in terms of impact on care needs when you complete the Application for Classification.

The diagnosis provided in the Answer Appraisal Pack must be dated and identify the name and profession of the health professional who has confirmed the diagnosis.

## Checklist must be completed

There are two Checklists for this component of the ACFI and both must be completed. The first Checklist is completed by indicating the Source Materials filed in the Answer Appraisal Pack. More than one source may be ticked.

The second checklist is where the diagnoses are recorded.

Medical Diagnosis

| Indicate which sources of evidence have been filed in the ACFI Appraisal Pack | Tick if YES |
| --- | --- |
| Aged Care Client Record (ACCR) / National Screening and Assessment Form (NSAF) |  D2.1 |
| GP comprehensive medical assessment |  D2.2 |
| General medical practitioner notes or letters |  D2.3 |
| Geriatrician notes or letters |  D2.4 |
| Psychogeriatrician notes or letters |  D2.5 |
| Psychiatrist notes or letters |  D2.6 |
| Other medical specialist notes or letters |  D2.7 |
| Other–please describe |  D2.8 |

Medical Diagnosis Checklist

| CODE | If no diagnosis tick one of the following, otherwise provide full details below |
| --- | --- |
| 0 |  No diagnosed disorder currently impacting |
| 9998 |  No formal diagnosis available |
| 9999 |  Not stated or inadequately described |
| CODE | Description of condition(s) / disease(s) |
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# Activities of Daily Living (ADL) Domain

This domain consists of the following questions:

ACFI 1 Nutrition;

ACFI 2 Mobility;

ACFI 3 Personal Hygiene;

ACFI 4 Toileting; and

ACFI 5 Continence.

## Assessments

Contemporaneous assessments are to be used as evidence to complete the checklists for these questions. **Only the specified Activities in each question must be considered, and rated in the appraisal process.**

The Assessments would have been completed no more than six months prior to the ACFI submission date and are consistent with the **usual care needs** of the care recipient at the time of the appraisal.

## Requirements

In ACFI questions 1 to 4 each care need is rated using the following scales.

**Independent**: the care recipient requires no assistance or minimal assistance, or the care need is not applicable to the care recipient.

**Supervision**: comprises setting-up and standby

* **Setting-up** activities are defined as assisting the person to initiate a specified activity or complete part of that activity. The setting-up activities that are taken into account are defined for each question.
* **Standby** is defined as standing by during the stated specified activities to provide assistance (verbal or physical) for:
* ACFI 1 Nutrition, there must be sufficient proximity to assist one-to-one as needed at the table/ eating place;
* ACFI 2 Mobility, this is a commitment of staff on a one-to-one basis;
* ACFI 3 Personal Hygiene, this is a commitment of staff on a one-to-one basis; and
* ACFI 4 Toileting, this is a commitment of staff on a one-to-one basis.

**Physical assistance:** is the requirement for individual physical assistance from another person or persons, with a minimum one to one staffing effort, throughout the specified activity.

The activities that are taken into account are defined for each question.

**Use of mechanical lifting equipment:** this rating is only considered in the care need of ‘transfers’ in ACFI 2 Mobility.

# ACFI 1 Nutrition

## Description

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

For tube feeding refer to ACFI 12 Complex Health Care. For assisting a care recipient to the dining room or assisting care recipients who are unable to position their chair appropriately see ACFI 2 Mobility.

## Requirements

Care needs: Nutrition Checklist must be completed

1. Readiness to eat
2. Eating

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

| Nutrition Checklist | Assistance level  (Tick one per care need) |
| --- | --- |
| 1. Readiness to eat   Supervision is 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. |  0 (Independent/NA)   1 (Supervision)   2 (Physical assistance) |
| 1. 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:   * place or guide food into the care recipient’s mouth for most of the meal. |  0 (Independent/NA)   1 (Supervision)   2 (Physical assistance) |

**ACFI 1 Rating key**

RATING A = 0 in both care needs (readiness to eat and eating)

RATING B = 0 in readiness to eat AND 1 in eating

RATING B = 1 in readiness to eat AND 0 in eating

RATING B = 1 in readiness to eat AND 1 in eating

RATING B = 2 in readiness to eat AND 0 in eating

RATING C = 2 in readiness to eat AND 1 in eating

RATING C = 0 in readiness to eat AND 2 in eating

RATING C = 1 in readiness to eat AND 2 in eating

RATING D = 2 in readiness to eat AND 2 in eating

# ACFI 2 Mobility

## Description

This question relates to the person’s usual day to day assessed care needs with regard to mobility.

For manual handling for maintenance of skin integrity such as frequent changing of the position of a care recipient with severely impaired mobility refer to ACFI 12 Complex Health Care, item 5.

Generally, a claim of D in ACFI 7 Wandering would not be accompanied by a D in ACFI 2 Mobility.

## Requirements

Care needs: Mobility Checklist must be completed

1. Transfers
2. Locomotion

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

Please note that the care need ‘transfers’ has an extra assistance level of ‘mechanical lifting equipment.’

| Mobility Checklist | Assistance level  (Tick one per care need) |
| --- | --- |
| 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. |  0 (Independent/NA)   1 ( Supervision)   2 (Physical assistance)   3 (Mechanical Lifting Equipment) |
| 1. 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 |  0 (Independent/NA)   1 (Supervision)   2 (Physical assistance) |

**ACFI 2 Rating key**

RATING A = 0 in both care needs (transfers and locomotion)

RATING B = 1 or 2 in transfers AND 0 in locomotion

RATING B = 0 in transfers AND 1 or 2 in locomotion

RATING C = 1 or 2 in transfers AND 1 in locomotion

RATING C = 1 in transfers AND 2 in locomotion

RATING D = 2 in transfers AND 2 in locomotion

RATING D = 3 in transfers

# ACFI 3 Personal Hygiene

## Description

This question relates to the person’s usual day to day assessed care needs with regard to personal hygiene.

## Requirements

Care needs: Personal Hygiene Checklist must be completed

1. Dressing and undressing
2. Washing and drying
3. Grooming

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

| Personal Hygiene Checklist | Assistance level  (tick one per care need) |
| --- | --- |
| 1. Dressing and undressing   Supervision is:   * choosing and laying out appropriate garments; OR * undoing and doing up zips, buttons or other fasteners Including velcro; OR * commitment of one staff member **standing by** to provide   assistance (verbal and/or physical).  One-to-one physical assistance is required throughout the specified activity of:   * dressing AND undressing i.e. putting on and taking off clothing AND footwear (i.e. underwear, shirts, skirts, pants, cardigan, socks, stockings); OR * fitting and removing of hip protectors, slings, cuffs, splints, medical braces or prostheses other than for the lower limb (refer ACFI 2). |  0 (Independent/ NA)   1 (Supervision)   2 (Physical assistance) |
| 1. Washing and drying   Supervision is:   * setting up toiletries, or turning on and adjusting taps; OR * commitment of staff on a one to one basis by **standing by** to provide assistance (verbal and/or physical).   One-to-one physical assistance is required throughout the process of:   * washing and/or drying the body. |  0 (Independent/ NA)   1 (Supervision)   2 (Physical assistance) |
| 1. Grooming   Supervision is:   * setting up articles for grooming; OR * commitment of one staff member **standing by** to provide assistance (verbal and/or physical).   One-to-one physical assistance is required throughout the activity for:   * dental care OR hair care OR shaving. |  0 (Independent/ NA)   1 (Supervision)   2 (Physical assistance) |

**ACFI 3 Rating key**

RATING A = 0 in all care needs (dressing and washing and grooming)

RATING B = 1 in any of the three care needs (dressing, washing, grooming)

RATING C = 2 in any of the three care needs (dressing, washing, grooming)

RATING D = 2 in all three care needs (dressing and washing and grooming)

# ACFI 4 Toileting

## Description

This question relates to the person’s usual day to day assessed care needs with regard to toileting. It relates to the assessed needs with regard to use of a toilet, commode, urinal or bedpan. It also includes emptying drainage bags of care recipients who have stomas and catheters.

For location change related to toileting refer to ACFI 2 Mobility. For the clinical care of catheters and the administration of suppositories and enemas in continence management see ACFI 12 Complex Health Care.

## Requirements

Care needs: Toileting Checklist must be completed

1. Use of a toilet (setting up to use the toilet)
2. Toilet completion (the ability to appropriately manage the toileting activity)

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

| Toileting Checklist | Assistance level  (tick one per care need) |
| --- | --- |
| 1. Use of toilet   Supervision is:   * setting up toilet aids, or handing the care recipient the bedpan or   urinal, or placing ostomy articles in reach; OR   * commitment of one staff member **standing by** to provide assistance with setting up activities (verbal and/ or physical).   One-to-one physical assistance is required for:   * positioning care recipient for use of toilet or commode   or bedpan or urinal |  0 (Independent/ NA)   1 (Supervision)   2 (Physical assistance) |
| 1. Toilet completion   Supervision is:   * commitment of one staff member **standing by** while the care recipient toilets to provide assistance (verbal and/ or physical) with adjusting clothing or peri-anal hygiene; OR * emptying drainage bags, urinals, bed pans or commode bowls.   One-to-one physical assistance is required for:   * adjusting clothing; AND * wiping the peri-anal area. |  0 (Independent/ NA)   1 (Supervision)   2 (Physical assistance) |

**ACFI 4 Rating key**

RATING A = 0 in both care needs (use of toilet and toilet completion)

RATING B = 1 in one or two care needs (use of toilet, and/ or toilet completion)

RATING C = 2 in one care need (use of toilet or toilet completion)

RATING D = 2 in both care needs (use of toilet and toilet completion)

# ACFI 5 Continence

## Description

This question relates to the person’s usual assessed needs with regard to continence of urine and faeces.

For the administration of stool softeners, aperients, suppositories or enemas for continence management see ACFI 11 Medication and ACFI 12 Complex Health Care. For the care and management of an indwelling catheter or ostomy see ACFI 12 Complex Health Care.

In counting **frequency of incontinence** the following are included:

* episodes of incontinence;
* changing of wet or soiled pads;
* increase in pad wetness;
* passing urine/ bowels open during scheduled toileting (as this is an avoided incontinence episode).

For the purposes of this ACFI question **scheduled toileting** is:

* staff accompanying a care recipient to the toilet (or commode); or
* providing a urinal or bedpan or other materials for planned voiding or evacuation according to a documented or assessed daily schedule designed to reduce incontinence.

## Requirements

Documentary evidence of incontinence prior to the implementation of scheduled toileting must be provided as evidence in the ACFI Answer Appraisal Pack if claiming for scheduled toileting e.g. NSAF, ACCR or a flowchart completed prior to scheduled toileting being implemented.

Care needs: Continence Checklist must be completed

1. Urinary continence
2. Faecal continence

## Assessment

The required Assessment for the completion of the checklist is the Continence Record from the Assessment Pack. The Continence Record includes a three-day Urinary Record and a seven-day Bowel Record. Alternatively, continence logs or diaries that were completed within the six months prior to the appraisal may be used to complete the Continence Record if the log or diary accurately informs on the Continence Record and it continues to reflect the care recipient’s continence status at the time of the appraisal.

A urine assessment (i.e. urine continence section of the Continence Record) is not required if the care recipient is continent of urine (including persons with a urinary catheter) or self-manages continence devices. A bowel assessment (i.e. faecal continence section of the Continence Record) is not required if the care recipient is continent of faeces (including persons with an ostomy) or self-manages continence devices.

Complete the urinary record for three consecutive days and bowel record for seven consecutive days. In exceptional circumstances where the care recipient is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record. Use the codes provided and complete the record. Codes 1 to 4 relate to episodes of urinary incontinence. Codes 5 to 7 relate to episodes of faecal incontinence.

Code 1: incontinent of urine

Code 2: pad change for incontinence of urine

Code 3: increase in pad wetness

Code 4: passed urine during scheduled toileting

Code 5: incontinent of faeces

Code 6: pad change for incontinence of faeces

Code 7: bowel open during scheduled toileting

## Assessment summary table must be completed

Indicate which assessments were completed

ACFI 5 Continence

| Continence Assessment Summary | Tick if YES |
| --- | --- |
| No incontinence recorded |  5.1 |
| 3-day Urine Continence Record |  5.2 |
| 7-day Bowel Continence Record |  5.3 |

**Checklist must be completed**

You must tick one selection from items 1–4 and one selection from items 5–8.

| Continence Checklist | Tick if YES |
| --- | --- |
| **Urinary continence** | |
| No episodes of urinary incontinence or self-manages continence devices |  1 |
| Incontinent of urine less than or equal to once per day |  2 |
| 2 to 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting |  3 |
| More than 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting |  4 |
| **Faecal continence** | |
| No episodes of faecal incontinence or self-manages continence devices |  5 |
| Incontinent of faeces once or twice per week |  6 |
| 3 to 4 episodes weekly of faecal incontinence or passing faeces during scheduled toileting |  7 |
| More than 4 episodes per week of faecal incontinence or passing faeces during scheduled toileting |  8 |

**ACFI 5 Rating key**

RATING A = yes to (item 1) and (item 5)

RATING B = yes to (item 2) or (item 6)

RATING C = yes to (item 3) or (item 7)

RATING D = yes to (item 4) or (item 8)

# Behaviour Domain

This domain consists of the following questions;:

ACFI 6 Cognitive skills,

ACFI 7 Wandering,

ACFI 8 Verbal Behaviour,

ACFI 9 Physical Behaviour, and

ACFI 10 Depression.

## Assessments

The Assessment Pack contains the mandatory assessments to be completed for this Domain.

ACFI 6 - the Psychogeriatric Assessment Scales - Cognitive Impairment Scale (PAS-CIS)

ACFI 7, 8 and 9 – the relevant behaviour record

ACFI 10 Depression - Cornell Scale for Depression (CSD).

These Assessments would have been completed no more than six months prior to the ACFI submission date and are consistent with the **usual care needs** of the care recipient at the time of the appraisal.

## Requirements

In ACFI questions 6 to 10, the appraiser must complete the Assessment Summary to indicate which evidence source(s) are included in the Answer Appraisal Pack, to support the rating.

# ACFI 6 Cognitive Skills

## Description

This question relates to the person’s assessed usual cognitive skills.

## Requirements

To support a B, C or D rating in ACFI 6, the Psychogeriatric Assessment Scales– Cognitive Impairment Scale (PAS - CIS) must be completed and the score entered into the checklist. If a score is not included the assessment must provide the reason why it could not be completed and alternative supporting evidence such as a clinical report must be provided in the ACFI Answer Appraisal Pack.

Refer to Definitions and Acronyms for further information on Clinical Report.

If the PAS - CIS has been completed for the care recipient in the last six months, it may be used if it continues to reflect the cognitive status of the care recipient at the time of appraisal. Indicate if an assessment was used or the reason why an assessment was not suitable. The PAS - CIS may not be suitable for some people of non-English speaking background. It may not be suitable for some Aboriginal or Torres Strait Islander care recipients, depending on their background. In some circumstances, care recipient impairments may prevent the use of the PAS - CIS.

If a clinical report is provided in the Answer Appraisal Pack this must be recorded in the assessment summary.

## Assessment summary table must be completed

ACFI 6 Cognitive Skills

| Cognitive Skills Assessment Summary | Tick if yes |  |
| --- | --- | --- |
| No PAS - CIS undertaken–and nil or minimal cognitive impairment |  6.1 |  |
| Cannot use PAS - CIS due to severe cognitive impairment or unconsciousness or have a diagnosis of 520, 530, 570 or 580 |  6.2 |  |
| Cannot use PAS - CIS due to speech impairment |  6.3 |  |
| Cannot use PAS - CIS due to cultural or linguistic background |  6.4 |  |
| Cannot use PAS - CIS due to sensory impairment |  6.5 |  |
| Cannot use PAS - CIS due to resident’s refusal to participate |  6.6 |  |
| Clinical report provides supporting information for the ACFI 6 appraisal |  6.7 |  |
| PAS – CIS:  enter score |  6.8 | SCORE |

## Checklist must be completed

| Cognitive Skills Checklist  Checklist must be completed | Tick if yes |
| --- | --- |
| 1. No or minimal impairment   PAS - CIS = 0–3 (including a decimal fraction below 4)  If no PAS - CIS assessment:  No significant problems in everyday activities. Demonstrates no difficulties or only minor difficulties in the following–memory loss (e.g. may forget names, misplace objects), handling money, solving problems (e.g. judgement and reasoning skills are intact), cognitively capable of self-care |  1 |
| 1. Mild impairment   PAS - CIS = 4–9 (including a decimal fraction below 10)  If PAS - CIS assessment is inappropriate: May appear normal but on investigation has some problems in everyday activities.  Memory and  personal care: memory loss of recent events that impacts on ADLs (i.e. needs prompting not physical assistance)  Interests: not independent in chores/ interests requiring reasoning judgement, planning etc. (i.e. cooking, use of telephone, shopping).  Orientation: disorientation in unfamiliar places |  2 |
| 1. Moderate impairment   PAS - CIS = 10–15 (including a decimal fraction below 16)  If PAS - CIS assessment is inappropriate:  Has significant problems in the performance of everyday activities, requires supervision and some assistance.  Memory: new material rapidly lost, only highly learned material retained  Personal care: requires physical assistance with some ADLs (e.g. personal hygiene, dressing)  Orientation: disorientation to time and place is likely  Communication: possibly fragments of sentences, more vague |  3 |
| 1. Severe impairment   PAS - CIS= 16–21  If PAS - CIS assessment is inappropriate: Has severe problems in everyday activities and requires full assistance as unable to respond to prompts and directions.  Memory: only fragments of past events remain  Personal care: requires full assistance with most or all  ADLs related to cognitive impairment orientation: orientation to person only  Communication: speech disturbances are common |  4 |

**ACFI 6 Rating key**

RATING A = yes to (item 1)

RATING B = yes to (item 2)

RATING C = yes to (item 3)

RATING D = yes to (item 4)

# ACFI 7 Wandering

## Description

This question relates to repeated attempts to leave the service to enter any areas within or outside the service where his/ her presence is unwelcome or inappropriate. For example kitchens or other persons’ rooms, or interfering while wandering in these places (refer Appendix 2, Description of Behavioural Symptoms).

## Requirements

To support a B, C or D rating in ACFI 7, a behaviour record must be completed by the service. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the care recipient is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record.

If the behaviour record has been completed for the care recipient in the last six months, you may use that assessment if it continues to reflect the behavioural needs of the care recipient at the time of appraisal. The behaviour must impact on current care needs and require attention from a staff member.

Generally, a claim of D in ACFI 7 Wandering would not be accompanied by a D in ACFI 2 Mobility.

The ACFI appraiser will be responsible for:

1. ensuring that the behaviour record has been initialled by the staff member who observed the behaviour occurrence
2. the availability of a signature log for the period the behaviour record was completed.

## Assessment summary table must be completed

Indicate the identified behaviour(s).

ACFI 7 Wandering

| Wandering Behaviour Assessment Summary | Tick if yes |
| --- | --- |
| No behaviours recorded |  7.1 |
| Interfering while wandering |  7.2 |
| Trying to get to inappropriate places |  7.3 |

Checklist must be completed

| Wandering Checklist | Tick if yes |
| --- | --- |
| Problem wandering does not occur or occurs less than two days per week |  1 |
| Problem wandering occurs at least two days per week |  2 |
| Problem wandering occurs at least six days in a week |  3 |
| Problem wandering occurs twice a day or more, at least six days in a week |  4 |

**ACFI 7 Rating key**

RATING A = yes to (item 1)

RATING B = yes to (item 2)

RATING C = yes to (item 3)

RATING D = yes to (item 4)

# ACFI 8 Verbal Behaviour

## Description

This question relates to the following verbal behaviours,:

1. verbal refusal of care
2. verbal disruption (not related to an unmet need)
3. paranoid ideation that disturbs others

OR

1. verbal sexually inappropriate advances directed at another person, visitor or member of staff.

Refer Appendix 2, Description of Behavioural Symptoms for further detail.

## Requirements

To support a B, C or D rating in ACFI 8, a behaviour record must be completed by the service. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the care recipient is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record. If the behaviour record has been completed for the care recipient in the last six months, you may use that assessment if it continues to reflect the behavioural needs of the care recipient at the time of appraisal. The behaviour must impact on current care needs and require attention from a staff member. The ACFI appraiser will be responsible for:

1. ensuring that the behaviour record has been initialled by the staff member who has observed the behaviour
2. the availability of a signature log for the period the behaviour record was completed.

## Assessment summary table must be completed

Indicate the identified behaviour(s).

ACFI 8 Verbal Behaviour

| Verbal Behaviour Assessment Summary | Tick if yes |
| --- | --- |
| No behaviours recorded |  8.1 |
| Verbal refusal of care |  8.2 |
| Verbal disruption to others |  8.3 |
| Paranoid ideation that disturbs others |  8.4 |
| Verbal sexually inappropriate advances |  8.5 |

## Checklist must be completed

| Verbal Behaviour Checklist | Tick if yes |
| --- | --- |
| Verbal behaviour does not occur or occurs less than two days per week |  1 |
| Verbal behaviour occurs at least two days per week |  2 |
| Verbal behaviour occurs at least six days in a week |  3 |
| Verbal behaviour occurs twice a day or more, at least six days in a week |  4 |

**ACFI 8 Rating key**

RATING A = yes to (item 1)

RATING B = yes to (item 2)

RATING C = yes to (item 3)

RATING D = yes to (item 4)

# ACFI 9 Physical Behaviour

## Description

This question relates to:

1. physical conduct by a care recipient that is threatening and has the potential to physically harm another person, visitor or member of staff or property (biting, grabbing, striking, kicking, pushing, scratching, spitting, throwing things, sexual advances, chronic substance abuse behaviours);
2. socially inappropriate behaviour that impacts on other care recipients (inappropriately handling things, inappropriately dressing/ disrobing, inappropriate sexual behaviour, hiding or hoarding, consuming inappropriate substances); OR
3. being constantly physically agitated, (always moving around in seat, getting up and down, inability to sit still, performing repetitious mannerisms).

Refer Appendix 2, page 47, Description of Behavioural Symptoms for further detail.

This question excludes where a person has a medical condition that might lead to injury, for example, through seizure or loss of consciousness, or where a person has a risk of falls related to poor mobility or balance, or frailty or a disease. It excludes a range of behaviours which might in the longer term be considered as damaging or health reducing such as smoking or non-compliance with a specialised diet.

## Requirements

To support a B, C or D rating in ACFI 9, a behaviour record must be completed by the service. The codes in the behaviour record must be completed according to the description of behaviour symptoms in Appendix 2. In exceptional circumstances where the care recipient is unavailable in a 24 hour period, then an extra 24 hours can be taken, and the reason noted on the record.

If the behaviour record has been completed for the care recipient in the last six months, you may use that assessment if it continues to reflect the behavioural needs of the care recipient at the time of appraisal. The behaviour must impact on current care needs and require attention from a staff member.

The ACFI appraiser will be responsible for:

1. ensuring that the behaviour record has been initialled by the staff member who has observed the behaviour; and
2. the availability of a signature log for the period the behaviour record was completed.

## Assessment summary table must be completed

Indicate which assessment was used and the identified behaviour(s).

ACFI 9 Physical Behaviour

| Physical Behaviour  Assessment Summary | Tick if yes |
| --- | --- |
| No behaviours recorded |  9.1 |
| Physically threatening or doing harm to self, others or property |  9.2 |
| Socially inappropriate behaviour impacts on other residents |  9.3 |
| Constantly physically agitated |  9.4 |

## Checklist must be completed

| Physical Behaviour Checklist | Tick if yes |
| --- | --- |
| Physical behaviour does not occur or occurs less than two days per week |  1 |
| Physical behaviour must occurs at least two days per week |  2 |
| Physical behaviour occurs at least six days in a week |  3 |
| Physical behaviour occurs twice a day or more, at least six days in a week |  4 |

**ACFI 9 Rating key**

RATING A = yes to (item 1)

RATING B = yes to (item 2)

RATING C = yes to (item 3)

RATING D = yes to (item 4)

# ACFI 10 Depression

## Description

This question relates to symptoms associated with depression and dysthymia (chronic mood disturbance).

It excludes behaviour covered in ACFI 8 Verbal Behaviour or ACFI 9 Physical Behaviour. It excludes physical illness or disability recorded in the Medical Diagnosis.

## Requirements

For a rating of C or D, there must be a diagnosis or provisional diagnosis of depression. Where an existing diagnosis or provisional diagnosis is not available, and the service has indicated that a diagnosis is being sought, then a conditional C or D rating, as appropriate, will be used to determine the care recipient’s classification. A period of three months has been allowed for a service to obtain the diagnosis.

If the service is unable to provide a diagnosis or provisional diagnosis on request, then the care recipient’s classification will be reviewed and recalculated using a rating of B for this question.

## Assessment

The Cornell Scale for Depression (CSD) must be completed to appraise care needs at the B, C or D level. If this instrument has been completed for the care recipient in the last six months, you may use that assessment if it continues to reflect the care needs of the care recipient at the time of appraisal. The symptoms must impact on current care needs and require attention from a staff member. [If using the CSD with non-English speaking persons, the assessor should confer with an interpreter (this could include a family member or staff) where required to confirm any verbal signs or symptoms.]

The notes section on the CSD instrument should also be completed to evidence that the symptom recorded is occurring on a regular, persistent basis (reflecting usual care needs). It should be observable and noted by a majority of informants on a day-to-day basis. The symptoms will be chronic, persistent and not directly related to day-to-day events in the care environment.

If there is a clinical report available that supports your rating please indicate this in the assessment summary. The CSD must still be completed. Refer to ‘Definitions and acronyms’ for details about a clinical report.

If a diagnosis or provisional diagnosis of depression is available please indicate this in the assessment summary. The diagnosis / provisional diagnosis, or reconfirmation of the diagnosis / provisional diagnosis, must have been completed in the past twelve months. Diagnosis sources are the NSAF, ACCR, GP comprehensive medical assessment, or other medical practitioner assessments or notes. Evidence of a diagnosis or provisional diagnosis of depression is to be documented in Mental and Behavioural Diagnosis and included in the Appraisal Pack.

## Assessment summary table must be completed

Symptoms of Depression Assessment Summary table with CSD score and Symptoms of Depression Checklist must be completed, and a diagnosis must be provided.

Indicate whether a CSD was undertaken and, if so, enter the score. Indicate whether a clinical report is provided.

ACFI 10 Depression

| Symptoms of Depression Assessment Summary | Tick if yes | Score |
| --- | --- | --- |
| No CSD undertaken |  10.1 |  |
| CSD – enter score |  10.2 |  |
| Clinical report provided supporting information for the ACFI 10 appraisal  Note: CSD must be completed |  10.3 |  |

## Checklist must be completed

| Symptoms of Depression Checklist | Tick if yes |
| --- | --- |
| CSD = 0–8 or no CSD completed  Minimal symptoms or symptoms did not occur |  1 |
| CSD = 9–13  Symptoms caused mild interference with the person’s ability to participate in their regular activities |  2 |
| CSD = 14–18  Symptoms caused moderate interference with the person’s ability to function and participate in regular activities |  3 |
| CSD = 19–38  Symptoms of depression caused major interference with the person’s ability to function and participate in regular activities |  4 |
| There is a diagnosis or provisional diagnosis of depression completed or reconfirmed in the past twelve months (diagnosis evidence required as per Mental and Behavioural Diagnosis) |  5 |
| Diagnosis or provisional diagnosis of depression being sought and will be made available on request within three months of the appraisal date |  6 |

**ACFI 10 Rating key**

RATING A = yes to (item 1)

RATING B = yes to (item 2)

RATING B = yes to (item 3) AND NOT (item 5 or item 6)

RATING B = yes to (item 4) AND NOT (item 5 or item 6)

RATING C = yes to (item 3) AND (item 5 or item 6)

RATING D = yes to (item 4) AND (item 5 or item 6)

# Complex Health Care Domain

This domain consists of the following questions:

* ACFI 11 Medication, and
* ACFI 12 Complex Health Care.

## Assessments

Assessments provided as evidence for this domain would have been completed no more than six months prior to the ACFI submission date and be consistent with the **usual care needs** of the care recipient at the time of the appraisal.

# ACFI 11 Medication

## Description

This question relates to the needs of the person for assistance in taking medications. It relates to medication administered on a regular basis. Infrequent or irregular administration of medication(s) is not covered in this question.

For intravenous infusions and the administration of suppositories and enemas as part of bowel management see ACFI 12 Complex Health Care. Where a person is responsible for their own medication administration from a dose administration aid or self injecting their medication, this does not comprise assistance with medication for this question.

**Medication(s)** refers to:

* any substance(s) listed in Schedule 2, 3, 4, 4D, 8 or 9 of the Standard for the Uniform Scheduling of Drugs and Poisons (and its amendments); and/or
* medication(s) ordered by an authorised health professional or authorised for nurse initiated Medication by a Medication Advisory Committee or its equivalent. This excludes food supplements, with or without vitamins, and emollients (e.g. sorbolene cream, aqueous cream, etc).

**Assistance** means either standby (to provide physical or verbal assistance) or to provide individual physical assistance or extensive prompting so that the person completes the ingestion or takes medication by the route ordered.

**Authorised health professional** means medical practitioner, dentist, nurse practitioner or other health professional authorised to prescribe medication by relevant state/ territory legislation.

**Administration**  
Does not include supervision of a resident injecting their medication.

## Requirements

The evidence source in the source materials box must be completed. The evidence is a copy of the most recent medication chart that was applicable on the date the ACFI appraisal was submitted. This source document would identify the name and profession of the health professional who has signed and dated that they have completed the document.

## Source materials

| Medication chart to be filed with ACFI Appraisal Pack |
| --- |
| Name of person(s) authorising medication(s) |
| Profession |
| Date completed |

## Checklist must be completed

| Medication Checklist | Tick if yes |
| --- | --- |
| No medication |  1 |
| Self-manages medication |  2 |
| Application of patches at least weekly, but less frequently than daily |  3 |
| Needs assistance with daily medications |  4 |
| Needs daily administration of a subcutaneous drug |  5 |
| Needs daily administration of an intramuscular drug |  6 |
| Needs daily administration of an intravenous drug |  7 |

**ACFI 11 Rating key**

RATING A = yes to (item 1) or (item 2)

RATING B = yes to (item 3) or (item 4)

RATING C = yes to (item 5) or (Item 6) or (Item 7)

# ACFI 12 Complex Health Care

## Description

This question relates to the assessed need for ongoing complex health care 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.

## Requirements

A procedure satisfies the requirements for ACFI 12 if:

* A Health Professional acting in their scope of practice conducts an Assessment of the care recipient’s Usual Care Needs at the time of the appraisal; and
* The Health Professional identifies the care recipient’s care needs in a Directive.

## Directives

A **Directive** must:

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

## Record of Treatment

The Record of Treatment must be kept in accordance with the directive as long as the treatment is being provided.

The ACFI Answer Appraisal Pack must include copies of treatment records post the submission date, for a reasonable period, to support the claim. Refer page 8, Record Keeping, the *‘ACFI appraisal pack must include all information needed by the department to verify a provider’s ACFI claim’*.

An Australian Government Authorised Officer may request to see a record of treatment.

## Health Professionals

‘**Health Professional’** means a practitioner listed in (a) or (b) below:

(a)

* **Nurse practitioner;**
* **Registered nurse;**
* **Medical practitioner**;
* **an allied health professional who is an**:
  + Occupational therapist;
  + Physiotherapist;
  + Podiatrist;
  + Chiropractor;
  + Osteopath;

and has a current certificate of registration issued by the National Board for that person’s profession (see the *Health Practitioner National Regulation Law 2009* (the National Law); and

## an ****allied health professional**** who is a Dietitian or Speech pathologist and has current accreditation with the relevant self-regulated professional body.

## Pain Management Assessments

To support claims under ACFI 12.3, 12.4a and 12.4b a claimant is required to use an evidence-based pain assessment tool relevant to the care recipient’s needs. (A list of suggested tools can be found at <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> and www.apsoc.org.au/publications)

## Complex Pain Management

Under Item 4a Complex Health Care, a directive that describes the complex pain management to be performed must be given by a registered nurse or a medical practitioner or an allied health professional included on the list of allied health professionals. Under item 4a, a registered nurse or an allied health professional must undertake the complex pain management and practice.

Under Item 4b pain management services must be undertaken by a listed allied health professional and the directive given by a medical practitioner or listed allied health professional.

Under Items 4a and 4b, it is permissible for the service to be undertaken by a different health professional than the one who gave the directive, provided they are included in the list of relevant health professionals who can undertake the service and are operating within their scope of practice. The service provided would equate to one on one staff time delivering treatment.

To meet the requirements for Item 4b, consistent ongoing treatment must be provided as required by the care recipient.

**Technical Equipment** designed specifically for pain management' refers to electro-therapeutic equipment such as TENS, interferential therapy, ultrasonic therapy, laser therapy, acupuncture, dry needling and wax baths, The Department of Health does not maintain an exhaustive list of equipment that can be included as this is subject to change over time.

**Therapeutic massage** involves skin to skin contact (or through / over clothes or towel) between the therapist and the care recipient.

Complete all complex health care procedures relevant to the resident

| Score | Complex health care procedures | Evidence Requirements | Tick if yes |
| --- | --- | --- | --- |
| 1 | Blood pressure measurement for diagnosed hyper/ hypotension is a usual care need  AND  frequency at least daily | 1. Medical practitioner directive  AND  on request: record |  1 |
| 3 | Blood glucose measurement for the monitoring of a diagnosed medical condition e.g. diabetes, is a usual care need  AND  frequency at least daily | 1. Medical practitioner directive  AND  on request: record |  2 |
| 1 | Pain management involving therapeutic massage or application of heat packs  AND  Frequency at least weekly  AND  Involving at least 20 minutes of one on one staff time in total | 1. Directive [registered nurse or medical practitioner or allied health professional]  AND  2. Evidence based pain assessment  AND  on request: record |  3 |
| 3 | Complex pain management and practice undertaken by an allied health professional or registered nurse. This will involve therapeutic massage and/ or pain management involving technical equipment specifically designed for pain management  AND  Frequency at least weekly  AND  Involving at least 20 minutes of one on one staff time in total.  *You can only claim one item 4–either 4a or 4b* | 1. Directive [registered nurse or medical practitioner or allied health professional]  AND  2. Evidence based pain assessment  AND  on request: record |  4a |
| 6 | Complex pain management and practice undertaken by an allied health professional. This will involve therapeutic massage and/ or pain management involving technical equipment specifically designed for pain management  AND  Ongoing treatment as required by the resident, at least 4 days per week,  AND  Involving at least 80 minutes of one on one staff time in total.  *You can only claim one item 4–either 4a or 4b.* | 1. Directive [medical practitioner or allied health professional]  AND  2. Evidence based pain assessment  AND  on request: record |  4b |
| 3 | Complex skin integrity management for residents with compromised skin integrity who are usually confined to bed and/ or chair and cannot self-ambulate. The management plan must include repositioning at least  4 times per day. | 1. Directive [registered nurse or medical practitioner or allied health professional]  AND  2. Skin integrity assessment |  5 |
| 3 | Management of special feeding undertaken by an RN, on a one-to-one basis, for people with severe dysphagia, excluding tube feeding.  Frequency at least daily. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner or allied health professional]  AND  3. Swallowing assessment |  6 |
| 1 | Administration of suppositories or enemas for bowel management is a usual care need. The minimum required frequency is ‘at least weekly.’ | 1. Directive [registered nurse or medical practitioner]  AND  on request: record |  7 |
| 3 | Catheter care program (ongoing); excludes temporary catheters e.g. short term post-surgery catheters. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner] |  8 |
| 6 | Management of chronic infectious conditions   * Antibiotic resistant bacterial infections * Tuberculosis * AIDS and other immune-deficiency conditions * Infectious hepatitis | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner] |  9 |
| 6 | Management of chronic wounds, including varicose and pressure ulcers, and diabetic foot ulcers. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner or allied health professional]  AND  3. Wound assessment  AND  on request: record |  10 |
| 6 | Management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis. | 1. Directive/ prescription [authorised nurse practitioner or medical practitioner] |  11 |
| 1 | Management of arthritic joints and oedema related to arthritis by the application of tubular and/or other elasticised support bandages.  **Note:** The maximum score for claiming both items 12.12a and 12.12b is 3 points. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner or allied health professional] |  12a |
| 3 | Management of;   * non-arthritic oedema OR deep vein thrombosis by the fitting and removal of compression garments and/or compression bandages,   OR   * chronic skin conditions by the application and removal of dry dressings and/or protective bandaging.   **Note:** The maximum score for claiming both items 12.12a and 12.12b is 3 points. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner or allied health professional] |  12b |
| 3 | Oxygen therapy not self-managed. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner] |  13 |
| 10 | 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. | 1. Directive by CNC/ CNS in pain or palliative care or medical practitioner  AND  2. Pain assessment |  14 |
| 1 | Management of ongoing stoma care.  Excludes temporary stomas e.g. post-surgery. Excludes supra pubic catheters (SPCs) | 1. Diagnosis   AND  2. Directive [registered nurse or medical practitioner] |  15 |
| 6 | Suctioning airways, tracheostomy care. | 1. Diagnosis  AND  2. Directive [registered nurse or medical practitioner] |  16 |
| 6 | Management of ongoing tube feeding. | 1. Diagnosis   AND  2. Directive [registered nurse or medical practitioner or allied health professional] |  17 |
| 3 | Technical equipment for continuous monitoring of vital signs including Continuous Positive Airway Pressure (CPAP) machine. | 1. Directive [registered nurse or medical practitioner]  AND  on request: record |  18 |

**ACFI 12 rating key**

RATING A = score of 0 (no procedures)

RATING B = score of 1–4

RATING C = score of 5–9

RATING D = score of 10 or more

# Appendix 1: ACAP code list for health condition–long

[From the AIHW web site: <http://www.aihw.gov.au/publications/index.cfm/title/8127> ]

**Certain infectious and parasitic diseases**

0101 Tuberculosis

0102 Poliomyelitis

0103 HIV/ AIDS

0104 Diarrhoea and gastroenteritis of presumed infectious origin

0199 n.o.s. or n.e.c. (includes leprosy, listeriosis, scarlet fever, meningococcal infection, septicaemia, viral meningitis)

**Neoplasms (tumours/ cancers)**

0201 Head and neck cancer

0202 Stomach cancer

0203 Colorectal (bowel) cancer

0204 Lung cancer

0205 Skin cancer

0206 Breast cancer

0207 Prostate cancer

0208 Brain cancer

0209 Non-Hodgkin’s lymphoma

0210 Leukaemia

0211 Other malignant tumours n.o.s. or n.e.c.

0299 Other neoplasms (includes benign tumours and tumours of uncertain or unknown behaviour)

**Diseases of the blood and blood forming organs and immune mechanism**

0301 Anaemia

0302 Haemophilia

0303 Immunodeficiency disorder (excluding AIDS)

0399 Other diseases of blood and blood forming organs and immune mechanism n.o.s. or n.e.c.

**Endocrine, nutritional and metabolic disorders**

Other infectious and parasitic diseases

0401 Disorders of the thyroid gland (includes iodine-deficiency syndrome, hypothyroidism, hyperthyroidism, thyroiditis)

0402 Diabetes mellitus–type 1 (IDDM)

0403 Diabetes mellitus–type 2 (NIDDM)

0404 Diabetes mellitus–other specified/ unspecified/unable to be specified

0405 Malnutrition

0406 Nutritional deficiencies

0407 Obesity

0408 High cholesterol

0499 Other endocrine, nutritional and metabolic disorders n.o.s. or n.e.c. (includes hypoparathyroidism, Cushing’s syndrome)

**Mental and behavioural disorders**

See Mental and Behavioural Diagnosis Checklist

**Diseases of the nervous system**

0601 Meningitis and encephalitis (excluding ‘viral’)

0602 Huntington’s disease

0603 Motor neurone disease

0604 Parkinson’s disease (includes Parkinson’s disease, secondary Parkinsomism)

0605 Transient cerebral ischaemic attacks (T.I.A.s)2

0606 Brain disease/ disorders (includes senile degeneration of brain n.e.c., degeneration of nervous system due to alcohol, Schilder’s disease)

0607 Multiple sclerosis

0608 Epilepsy

0609 Muscular dystrophy

0610 Cerebral palsy

0611 Paralysis-non-traumatic (includes hemiplegia, paraplegia, quadriplegia, tetraplegia and other paralytic syndromes, e.g. diplegia and monoplegia; excludes spinal cord injury code 1699)

0612 Chronic/ postviral fatigue syndrome

0699 Other diseases of the nervous system n.o.s. or n.e.c. (includes dystonia, migraines, headache syndromes, sleep disorders e.g. sleep apnoea and insomnia, Bell’s palsy, myopathies, peripheral neuropathy, dysautonomia)

**Diseases of the eye and adnexa**

0701 Cataracts

0702 Glaucoma

0703 Blindness (both eyes, one eye, one eye and low vision in other eye)

0704 Poor vision (low vision both eyes, one eye, unspecified visual loss)

0799 Other diseases of the eye and adnexa n.o.s or n.e.c (includes conjunctivitis)

**Disease of the ear and mastoid process**

0801 Ménière’s disease (includes Ménière’s syndrome, vertigo)

0802 Deafness/ hearing loss

0899 Other diseases of the ear and mastoid process n.o.s. or n.e.c. (includes disease of external ear, otitis media, mastoiditis and related conditions, myringitis, otosclerosis, tinnitus)

**Diseases of the circulatory system**

0900 Heart disease

0901 Rheumatic fever

0902 Rheumatic heart disease

0903 Angina

0904 Myocardial infarction (heart attack)

0905 Acute and chronic ischaemic heart disease

0906 Congestive heart failure (congestive heart disease)

0907 Other heart diseases (pulmonary embolism, acute pericarditis, acute and subacute endocarditis, cardiomyopathy, cardiac arrest, heart failure–unspecifed)

0910 Cerebrovascular disease2,3

0911 Subarachnoid haemorrhage2,3

0912 Intracerebral haemorrhage2,3

0913 Other intracranial haemorrhage2,3

0914 Cerebral infarction2,3

0915 Stroke (CVA)–cerebrovascular accident unspecified2,3

0916 Other cerebrovascular diseases2 (includes embolism, narrowing, obstruction and thrombosis of basilar, carotid, vertebral arteries and middle, anterior, cerebral arteries, cerebellar arteries not resulting in cerebral infarction)

0920 Other diseases of the circulatory system

0921 Hypertension (high blood pressure)

0922 Hypotension (low blood pressure)

0923 Abdominal aortic aneurysm

0924 Other arterial or aortic aneurysms (includes thoracic, unspecified, aneurysm of carotid artery, renal artery, unspecified)

0925 Atherosclerosis

0999 Other diseases of the circulatory system n.o.s. or n.e.c. (includes other peripheral vascular disease, arterialembolism and thrombosis, other disorders of arteries and arterioles, diseases of capillaries, varicose veins, haemorrhoids)

**Diseases of the respiratory system**

1001 Acute upper respiratory infections (includes common cold, acute sinusitis, acute pharyngitis, acute tonsillitis, acute laryngitis, upper respiratory infections of multiple and unspecified sites)

1002 Influenza and pneumonia

1003 Acute lower respiratory infections (includes acute bronchitis, bronchiolitis and unspecified acute lower respiratory infections)

1004 Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis and sinusitis, chronic diseases of tonsils and adenoids)

1005 Chronic lower respiratory diseases (includes emphysema, chronic obstructive airways disease (COAD), asthma)

1099 Other diseases of the respiratory system n.o.s. or n.e.c.

**Diseases of the digestive system**

1101 Diseases of the intestine (includes stomach/ duodenal ulcer, abdominal hernia (except congenital), enteritis, colitis, vascular disorders of intestine, diverticulitis, irritable bowel syndrome, diarrhoea, constipation)

1102 Diseases of the peritoneum (includes peritonitis)

1103 Diseases of the liver (includes alcoholic liver disease, toxic liver disease, fibrosis and cirrhosis of liver)

1199 Other diseases of the digestive system n.o.s. or n.e.c. (includes diseases of oral cavity, salivary glands and jaws, oesophagitis, gastritis and duodenitis, cholecystitis, other diseases of gallbladder, pancreatitis, coeliac disease)

**Diseases of the skin and subcutaneous tissue**

1201 Skin and subcutaneous tissue infections (includes impetigo, boil, cellulitis)

1202 Skin allergies (dermatitis and eczema)

1299 Other diseases of the skin and subcutaneous tissue n.o.s. or n.e.c. (includes bedsore, urticaria, erythema, radiation-related disorders, disorders of skin appendages)

**Diseases of the musculoskeletal system and connective tissue**

1301 Rheumatoid arthritis

1302 Other arthritis and related disorders (includes gout, arthrosis, osteoarthritis)

1303 Deformities of joints/ limbs–acquired

1304 Back problems–dorsopathies (includes scoliosis)

1305 Other soft tissue/ muscle disorders (includes rheumatism)

1306 Osteoporosis

1399 Other disorders of the musculoskeletal system and connective tissue n.o.s. or n.e.c. (includes osteomyelitis)

**Diseases of the genitourinary system**

1401 Kidney and urinary system (bladder) disorders (includes nephritis renal failure, cystitis; excludes urinary tract infection and incontinence)

1402 Urinary tract infection

1403 Stress/ urinary incontinence (includes stress, overflow, reflex and urge incontinence)

1499 Other diseases of the genitourinary system n.o.s. or n.e.c. (includes prostate, breast and menopause disorders, urinary incontinence (stress, overflow, reflex, urge)

**Congenital malformations, deformations and chromosomal abnormalities**

1501 Spina bifida

1502 Deformities of joints/ limbs–congenital

1503 Down’s syndrome

1504 Other chromosomal abnormalities

1505 Congenital brain damage/ malformation

1599 Other congenital malformations and deformations n.o.s. or n.e.c.

**Injury, poisoning and certain other consequences of external causes**

1601 Injuries to the head (includes injuries to ear, eye, face, jaw, acquired brain damage)

1602 Injuries to arm/ hand/ shoulder (includes, dislocations, sprains and strains)

1603 Injuries to leg/ knee/ foot/ ankle/ hip (includes dislocations, sprains and strains)

1604 Amputation of the finger/ thumb/ hand/ arm/ shoulder–traumatic

1605 Amputation of toe/ ankle/ foot/ leg–traumatic

1606 Fracture of neck (includes cervical spine and vertebra)

1607 Fracture of rib(s), sternum and thoracic spine (includes thoracic spine and vertebra)

1608 Fracture of lumbar spine and pelvis (includes lumbar vertebra, sacrum, coccyx, sacrum)

1609 Fracture of shoulder, upper arm and forearm (includes clavicle, scapula, humerus, radius, ulna)

1610 Fracture at wrist and hand level

1611 Fracture of femur (includes hip (neck of femur)

1612 Fracture of lower leg and foot

1613 Poisoning by drugs, medicaments and biological substances (includes systemic antibiotics, hormones, narcotics, hallucinogens, analgesics, antipyretics, antirheumatics, antiepileptic, antiparkinsonism drugs, includes overdose of the above substances)

1699 Other injury, poisoning and consequences of external causes n.o.s. or n.e.c. (including all other injuries to the body, spinal cord injury, multiple fractures, unspecified dislocations, sprains, strains, fractures, burns, frostbite, toxic effects of substances of nonmedical source, complications of surgical and medical care)

**Symptoms and signs n.o.s or n.e.c4**

1701 Abnormal blood-pressure reading, without diagnosis

1702 Cough

1703 Breathing difficulties/ shortness of breath

1704 Pain

1705 Nausea and vomiting

1706 Dysphagia (difficulty in swallowing)

1707 Bowel/ faecal incontinence

1708 Unspecified urinary incontinence

1709 Retention of urine

1710 Jaundice (unspecified)

1711 Disturbances of skin sensation (includes pins and needles, tingling skin)

1712 Rash and other nonspecific skin eruption

1713 Abnormal involuntary movements (includes abnormal head movements, tremor unspecified, cramp and spasm, twitching n.o.s)

1714 Abnormalities of gait and mobility (includes ataxic and spastic gait, difficulty in walking n.e.c)

1715 Falls (frequent with unknown aetiology)

1716 Disorientation (confusion)

1717 Amnesia (memory disturbance, lack or loss)

1718 Dizziness and giddiness (light- headedness, vertigo n.o.s.)

1719 Restlessness and agitation

1720 Unhappiness (worries n.o.s.)

1721 Irritability and anger

1722 Hostility

1723 Physical violence

1724 Slowness and poor responsiveness

1725 Speech and voice disturbances

1726 Headache

1727 Malaise and fatigue (includes general physical deterioration, lethargy and tiredness)

1728 Blackouts, fainting, convulsions

1729 Oedema n.e.c. (includes fluid retention n.o.s.)

1730 Symptoms and signs concerning food and fluid intake (includes loss of appetite, excessive eating and thirst, abnormal weight loss and gain)

1799 Other symptoms and signs n.o.s. or n.e.c. (includes gangrene, haemorrhage from respiratory passages, heartburn, disturbances of smell and taste, enlarged lymph nodes, illness n.o.s.)

1899 Has other health condition not elsewhere specified

n.e.c. not elsewhere classified

n.o.s. not otherwise specified

1 In any analysis of ‘diseases of the nervous system’ code 0500 ‘dementia in Alzheimer’s disease’ should be grouped with 0600

2 In any analysis of ‘cerebrovascular disease’ code 0605 transient cerebral ischaemic attacks (TIAs) should be grouped with 0910

3 Transient cerebral ischaemic attacks (TIAs) should be coded to 0605

4 These codes should only be used to record certain symptoms that represent important problems in their own right, regardless of whether a related diagnosed disease or disorder is also reported

# Appendix 2–Description of behavioural symptoms

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

| **Code** | **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 care recipient’s room |
| **Code** | **Verbal behaviour** |  |
| V1 | Verbal refusal of care | Refusal (verbally uncooperative) to participate in required activities of daily living such as dressing, washing and hygiene |
| V2 | 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. |
| V3 | 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. |
| V4 | Verbally sexually inappropriate | Repeated sexual propositions, sexual innuendo or sexually abusive or threatening language |
| **Code** | **Physical behaviour** |  |
| 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 |
| 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, faecal smearing * 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 |
| P3 | Constantly physically agitated | * Always moving around in seat, getting up and sitting down, inability to sit still * Performing repetitious mannerisms - stereotypic movement 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 |

# Appendix 3–Interaction of the Aged Care Funding Instrument and the funding model

