



Australian Government
Department of Health

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-Toolkit/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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Assessment Nutrition Checklist
	Mobility Care need: transfers / locomotion Assistance level = independent OR supervision OR physical assistance OR mechanical lifting equipment	<ul style="list-style-type: none"> Assessment Mobility Checklist
	Personal Hygiene Care need: dressing / washing / grooming Assistance level = independent OR supervision OR physical assistance	<ul style="list-style-type: none"> Assessment Personal Hygiene Checklist
	Toileting Care need: use of toilet / toilet completion Assistance level = independent OR supervision OR physical assistance	<ul style="list-style-type: none"> Assessment Toileting Checklist
	Continence Urinary continence and faecal continence Measurement = frequency	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Source materials table Medication Checklist Medication chart
	Complex Health Care Care need: complex health care procedures Measurement = complexity and frequency	<ul style="list-style-type: none"> 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 (AAP) 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 activities ²	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)	<input type="checkbox"/> D1.1
GP comprehensive medical assessment	<input type="checkbox"/> D1.2
General medical practitioner notes or letters	<input type="checkbox"/> D1.3
Geriatrician notes or letters	<input type="checkbox"/> D1.4
Psychogeriatrician notes or letters	<input type="checkbox"/> D1.5
Psychiatrist notes or letters	<input type="checkbox"/> D1.6
Other medical specialist notes or letters	<input type="checkbox"/> D1.7
Other—please describe	<input type="checkbox"/> D1.8

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	<input type="checkbox"/>
500	Dementia, Alzheimer's disease including early onset, late onset, atypical or mixed type or unspecified	<input type="checkbox"/>
510	Vascular dementia e.g. multi-infarct, subcortical, mixed	<input type="checkbox"/>
520	Dementia in other diseases, e.g. Pick's Disease, Creutzfeldt-Jakob, Huntington's, Parkinson's, HIV	<input type="checkbox"/>
530	Other dementias, e.g. Lewy Body, alcoholic dementia, unspecified	<input type="checkbox"/>
540	Delirium	<input type="checkbox"/>
550A	Depression, mood and affective disorders, Bi-Polar	<input type="checkbox"/>
550B	Psychoses e.g. schizophrenia, paranoid states	<input type="checkbox"/>
560	Neurotic, stress related, anxiety, somatoform disorders e.g. post traumatic stress disorder, phobic and anxiety disorders, nervous tension/stress, obsessive-compulsive disorder	<input type="checkbox"/>
570	Intellectual and developmental disorders e.g. intellectual disability or disorder, autism, Rhett's syndrome, Asperger's syndrome etc	<input type="checkbox"/>
580	Other mental and behavioural disorders e.g. due to alcohol or psychoactive substances (includes alcoholism, Korsakov's psychosis), adult personality and behavioural disorders.	<input type="checkbox"/>

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)	<input type="checkbox"/> D2.1
GP comprehensive medical assessment	<input type="checkbox"/> D2.2
General medical practitioner notes or letters	<input type="checkbox"/> D2.3
Geriatrician notes or letters	<input type="checkbox"/> D2.4
Psychogeriatrician notes or letters	<input type="checkbox"/> D2.5
Psychiatrist notes or letters	<input type="checkbox"/> D2.6
Other medical specialist notes or letters	<input type="checkbox"/> D2.7
Other—please describe	<input type="checkbox"/> D2.8

Medical Diagnosis Checklist

CODE	If no diagnosis tick one of the following, otherwise provide full details below
0	<input type="checkbox"/> No diagnosed disorder currently impacting
9998	<input type="checkbox"/> No formal diagnosis available
9999	<input type="checkbox"/> Not stated or inadequately described
CODE	Description of condition(s) / disease(s)

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)
<p>1. Readiness to eat</p> <p>Supervision is required for an assessed care need for:</p> <ul style="list-style-type: none"> • placing utensils in the care recipient’s hand. <p>One-to-one physical assistance is required for an assessed care need:</p> <ul style="list-style-type: none"> • cut up food OR vitamised food. 	<input type="checkbox"/> 0 (Independent/NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 2 (Physical assistance)
<p>2. Eating</p> <p>Supervision is required for an assessed care need for:</p> <ul style="list-style-type: none"> • 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. <p>One-to-one physical assistance is required for an assessed care need to:</p> <ul style="list-style-type: none"> • place or guide food into the care recipient’s mouth for most of the meal. 	<input type="checkbox"/> 0 (Independent/NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 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)
<p>1. Transfers</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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). <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> • moving to and from chairs or wheelchairs or beds. <p>Mechanical lifting equipment:</p> <ul style="list-style-type: none"> • requiring physical assistance with the use of mechanical lifting equipment for transfers. 	<input type="checkbox"/> 0 (Independent/NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 2 (Physical assistance) <input type="checkbox"/> 3 (Mechanical Lifting Equipment)
<p>2. Locomotion</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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). <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> • staff to push wheelchair; OR • assistance with walking 	<input type="checkbox"/> 0 (Independent/NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 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)
<p>1. Dressing and undressing</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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). <p>One-to-one physical assistance is required throughout the specified activity of:</p> <ul style="list-style-type: none"> • 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). 	<input type="checkbox"/> 0 (Independent/ NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 2 (Physical assistance)
<p>2. Washing and drying</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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). <p>One-to-one physical assistance is required throughout the process of:</p> <ul style="list-style-type: none"> • washing and/or drying the body. 	<input type="checkbox"/> 0 (Independent/ NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 2 (Physical assistance)
<p>3. Grooming</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • setting up articles for grooming; OR • commitment of one staff member standing by to provide assistance (verbal and/or physical). <p>One-to-one physical assistance is required throughout the activity for:</p> <ul style="list-style-type: none"> • dental care OR hair care OR shaving. 	<input type="checkbox"/> 0 (Independent/ NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 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)
<p>1. Use of toilet</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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). <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> • positioning care recipient for use of toilet or commode or bedpan or urinal 	<input type="checkbox"/> 0 (Independent/ NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 2 (Physical assistance)
<p>2. Toilet completion</p> <p>Supervision is:</p> <ul style="list-style-type: none"> • 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. <p>One-to-one physical assistance is required for:</p> <ul style="list-style-type: none"> • adjusting clothing; AND • wiping the peri-anal area. 	<input type="checkbox"/> 0 (Independent/ NA) <input type="checkbox"/> 1 (Supervision) <input type="checkbox"/> 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	<input type="checkbox"/> 5.1
3-day Urine Continence Record	<input type="checkbox"/> 5.2
7-day Bowel Continence Record	<input type="checkbox"/> 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	<input type="checkbox"/> 1
Incontinent of urine less than or equal to once per day	<input type="checkbox"/> 2
2 to 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	<input type="checkbox"/> 3
More than 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	<input type="checkbox"/> 4
Faecal continence	
No episodes of faecal incontinence or self-manages continence devices	<input type="checkbox"/> 5
Incontinent of faeces once or twice per week	<input type="checkbox"/> 6
3 to 4 episodes weekly of faecal incontinence or passing faeces during scheduled toileting	<input type="checkbox"/> 7
More than 4 episodes per week of faecal incontinence or passing faeces during scheduled toileting	<input type="checkbox"/> 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	<input type="checkbox"/> 6.1	
Cannot use PAS - CIS due to severe cognitive impairment or unconsciousness or have a diagnosis of 520, 530, 570 or 580	<input type="checkbox"/> 6.2	
Cannot use PAS - CIS due to speech impairment	<input type="checkbox"/> 6.3	
Cannot use PAS - CIS due to cultural or linguistic background	<input type="checkbox"/> 6.4	
Cannot use PAS - CIS due to sensory impairment	<input type="checkbox"/> 6.5	
Cannot use PAS - CIS due to resident's refusal to participate	<input type="checkbox"/> 6.6	
Clinical report provides supporting information for the ACFI 6 appraisal	<input type="checkbox"/> 6.7	
PAS – CIS: enter score	<input type="checkbox"/> 6.8	SCORE

Checklist must be completed

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

- a. ensuring that the behaviour record has been initialled by the staff member who observed the behaviour occurrence
- b. 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	<input type="checkbox"/> 7.1
Interfering while wandering	<input type="checkbox"/> 7.2
Trying to get to inappropriate places	<input type="checkbox"/> 7.3

Wandering Checklist	Tick if yes
Problem wandering does not occur or occurs less than two days per week	<input type="checkbox"/> 1
Problem wandering occurs at least two days per week	<input type="checkbox"/> 2
Problem wandering occurs at least six days in a week	<input type="checkbox"/> 3
Problem wandering occurs twice a day or more, at least six days in a week	<input type="checkbox"/> 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,:

- a. verbal refusal of care
 - b. verbal disruption (not related to an unmet need)
 - c. paranoid ideation that disturbs others
- OR
- d. 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:

- a. ensuring that the behaviour record has been initialled by the staff member who has observed the behaviour
- b. 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	<input type="checkbox"/> 8.1
Verbal refusal of care	<input type="checkbox"/> 8.2
Verbal disruption to others	<input type="checkbox"/> 8.3
Paranoid ideation that disturbs others	<input type="checkbox"/> 8.4
Verbal sexually inappropriate advances	<input type="checkbox"/> 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	<input type="checkbox"/> 1
Verbal behaviour occurs at least two days per week	<input type="checkbox"/> 2
Verbal behaviour occurs at least six days in a week	<input type="checkbox"/> 3
Verbal behaviour occurs twice a day or more, at least six days in a week	<input type="checkbox"/> 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:

- a. 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);
- b. 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
- c. 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:

- a. ensuring that the behaviour record has been initialled by the staff member who has observed the behaviour; and
- b. 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	<input type="checkbox"/> 9.1
Physically threatening or doing harm to self, others or property	<input type="checkbox"/> 9.2
Socially inappropriate behaviour impacts on other residents	<input type="checkbox"/> 9.3
Constantly physically agitated	<input type="checkbox"/> 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	<input type="checkbox"/> 1
Physical behaviour must occurs at least two days per week	<input type="checkbox"/> 2
Physical behaviour occurs at least six days in a week	<input type="checkbox"/> 3
Physical behaviour occurs twice a day or more, at least six days in a week	<input type="checkbox"/> 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	<input type="checkbox"/> 10.1	
CSD – enter score	<input type="checkbox"/> 10.2	
Clinical report provided supporting information for the ACFI 10 appraisal Note: CSD must be completed	<input type="checkbox"/> 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	<input type="checkbox"/> 1
CSD = 9–13 Symptoms caused mild interference with the person's ability to participate in their regular activities	<input type="checkbox"/> 2
CSD = 14–18 Symptoms caused moderate interference with the person's ability to function and participate in regular activities	<input type="checkbox"/> 3
CSD = 19–38 Symptoms of depression caused major interference with the person's ability to function and participate in regular activities	<input type="checkbox"/> 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)	<input type="checkbox"/> 5
Diagnosis or provisional diagnosis of depression being sought and will be made available on request within three months of the appraisal date	<input type="checkbox"/> 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	<input type="checkbox"/> 1
Self-manages medication	<input type="checkbox"/> 2
Application of patches at least weekly, but less frequently than daily	<input type="checkbox"/> 3
Needs assistance with daily medications	<input type="checkbox"/> 4
Needs daily administration of a subcutaneous drug	<input type="checkbox"/> 5
Needs daily administration of an intramuscular drug	<input type="checkbox"/> 6
Needs daily administration of an intravenous drug	<input type="checkbox"/> 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

- (b) 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	<input type="checkbox"/> 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	<input type="checkbox"/> 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	<input type="checkbox"/> 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. <i>You can only claim one item 4—either 4a or 4b</i>	1. Directive [registered nurse or medical practitioner or allied health professional] AND 2. Evidence based pain assessment AND on request: record	<input type="checkbox"/> 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. <i>You can only claim one item 4—either 4a or 4b.</i>	1. Directive [medical practitioner or allied health professional] AND 2. Evidence based pain assessment AND on request: record	<input type="checkbox"/> 4b

Score	Complex health care procedures	Evidence Requirements	Tick if yes
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	<input type="checkbox"/> 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	<input type="checkbox"/> 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	<input type="checkbox"/> 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]	<input type="checkbox"/> 8
6	Management of chronic infectious conditions <ul style="list-style-type: none"> • Antibiotic resistant bacterial infections • Tuberculosis • AIDS and other immune-deficiency conditions • Infectious hepatitis 	1. Diagnosis AND 2. Directive [registered nurse or medical practitioner]	<input type="checkbox"/> 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	<input type="checkbox"/> 10
6	Management of ongoing administration of intravenous fluids, hypodermoclysis, syringe drivers and dialysis.	1. Directive/ prescription [authorised nurse practitioner or medical practitioner]	<input type="checkbox"/> 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]	<input type="checkbox"/> 12a

Score	Complex health care procedures	Evidence Requirements	Tick if yes
3	Management of; <ul style="list-style-type: none"> non-arthritic oedema OR deep vein thrombosis by the fitting and removal of compression garments and/or compression bandages, OR <ul style="list-style-type: none"> 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]	<input type="checkbox"/> 12b
3	Oxygen therapy not self-managed.	1. Diagnosis AND 2. Directive [registered nurse or medical practitioner]	<input type="checkbox"/> 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	<input type="checkbox"/> 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]	<input type="checkbox"/> 15
6	Suctioning airways, tracheostomy care.	1. Diagnosis AND 2. Directive [registered nurse or medical practitioner]	<input type="checkbox"/> 16
6	Management of ongoing tube feeding.	1. Diagnosis AND 2. Directive [registered nurse or medical practitioner or allied health professional]	<input type="checkbox"/> 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	<input type="checkbox"/> 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 Parkinsonism)
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—unspecified)
- 0910 Cerebrovascular disease^{2,3}
- 0911 Subarachnoid haemorrhage^{2,3}
- 0912 Intracerebral haemorrhage^{2,3}
- 0913 Other intracranial haemorrhage^{2,3}
- 0914 Cerebral infarction^{2,3}
- 0915 Stroke (CVA)—cerebrovascular accident unspecified^{2,3}
- 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, arteriolembolism 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)	1611	Fracture of femur (includes hip (neck of femur))
1305	Other soft tissue/ muscle disorders (includes rheumatism)	1612	Fracture of lower leg and foot
1306	Osteoporosis	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)
1399	Other disorders of the musculoskeletal system and connective tissue n.o.s. or n.e.c. (includes osteomyelitis)	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)
Diseases of the genitourinary system		Symptoms and signs n.o.s or n.e.c⁴	
1401	Kidney and urinary system (bladder) disorders (includes nephritis renal failure, cystitis; excludes urinary tract infection and incontinence)	1701	Abnormal blood-pressure reading, without diagnosis
1402	Urinary tract infection	1702	Cough
1403	Stress/ urinary incontinence (includes stress, overflow, reflex and urge incontinence)	1703	Breathing difficulties/ shortness of breath
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))	1704	Pain
Congenital malformations, deformations and chromosomal abnormalities		1705	Nausea and vomiting
1501	Spina bifida	1706	Dysphagia (difficulty in swallowing)
1502	Deformities of joints/ limbs—congenital	1707	Bowel/ faecal incontinence
1503	Down's syndrome	1708	Unspecified urinary incontinence
1504	Other chromosomal abnormalities	1709	Retention of urine
1505	Congenital brain damage/ malformation	1710	Jaundice (unspecified)
1599	Other congenital malformations and deformations n.o.s. or n.e.c.	1711	Disturbances of skin sensation (includes pins and needles, tingling skin)
Injury, poisoning and certain other consequences of external causes		1712	Rash and other nonspecific skin eruption
1601	Injuries to the head (includes injuries to ear, eye, face, jaw, acquired brain damage)	1713	Abnormal involuntary movements (includes abnormal head movements, tremor unspecified, cramp and spasm, twitching n.o.s)
1602	Injuries to arm/ hand/ shoulder (includes, dislocations, sprains and strains)	1714	Abnormalities of gait and mobility (includes ataxic and spastic gait, difficulty in walking n.e.c)
1603	Injuries to leg/ knee/ foot/ ankle/ hip (includes dislocations, sprains and strains)	1715	Falls (frequent with unknown aetiology)
1604	Amputation of the finger/ thumb/ hand/ arm/ shoulder—traumatic	1716	Disorientation (confusion)
1605	Amputation of toe/ ankle/ foot/ leg—traumatic	1717	Amnesia (memory disturbance, lack or loss)
1606	Fracture of neck (includes cervical spine and vertebra)	1718	Dizziness and giddiness (light-headedness, vertigo n.o.s.)
1607	Fracture of rib(s), sternum and thoracic spine (includes thoracic spine and vertebra)	1719	Restlessness and agitation
1608	Fracture of lumbar spine and pelvis (includes lumbar vertebra, sacrum, coccyx, sacrum)	1720	Unhappiness (worries n.o.s.)
1609	Fracture of shoulder, upper arm and forearm (includes clavicle, scapula, humerus, radius, ulna)	1721	Irritability and anger
1610	Fracture at wrist and hand level	1722	Hostility
		1723	Physical violence

1724	Slowness and poor responsiveness	n.e.c. not elsewhere classified
1725	Speech and voice disturbances	n.o.s. not otherwise specified
1726	Headache	¹ In any analysis of 'diseases of the nervous system' code 0500 'dementia in Alzheimer's disease' should be grouped with 0600
1727	Malaise and fatigue (includes general physical deterioration, lethargy and tiredness)	
1728	Blackouts, fainting, convulsions	² In any analysis of 'cerebrovascular disease' code 0605 transient cerebral ischaemic attacks (TIAs) should be grouped with 0910
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)	³ Transient cerebral ischaemic attacks (TIAs) should be coded to 0605
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.)	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
1899	Has other health condition not elsewhere specified	

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

Funding instrument → Score → Funding model

Diagnoses

- Mental & Behavioural
- Medical

Used for minimum data set, support of other ratings and Behaviour Supplement

Activities of Daily Living

1. Nutrition	} Each question's A, B, C or D has a SCORE. The total score determines the level.	} High (≥ 88)
2. Mobility		
3. Personal Hygiene		
4. Toileting		
5. Continence		
		Medium (≥ 62)
		Low (≥ 18)

Behaviour

6. Cognitive Skills	} Each question's A, B, C or D has a SCORE. The total score determines the level.	} High (≥ 50)
7. Wandering		
8. Verbal Behaviour		
9. Physical Behaviour		
10. Depression		
		Medium (≥ 30)
		Low (≥ 13)

Complex Health Care

11. Medication	} A, B, C or D applied to a MATRIX equals the SCORE	} High (= 3)
12. Complex Health Care		
		Medium (= 2)
		Low (= 1)