APPENDICES

Appendix 1

OVERVIEW OF STANDARDS FOR AGED CARE FACILITIES

(Department of Health and Family Services, 1997)

Standards Overview			
Standard 1: Management Systems, Staffing and Organisational Development	Standard 2: Health and Personal Care	Standard 3: Resident Lifestyle	Standard 4: Physical Environment and Safe Systems
1.1 Continuous improvement	2.1 Continuous improvement	3.1 Continuous improvement	4.1 Continuous Improvement
1.2 Regulatory Compliance	2.2 Regulatory Compliance	3.2 Regulatory Compliance	4.2 Regulatory Compliance
1.3 Education and Staff Development	2.3 Education and Staff Development	3.3 Education and Staff Development	4.3 Education and Staff Development
1.4 Comments and Complaints	2.4 Clinical Care	3.4 Emotional Support	4.4 Living Environment
1.5 Planning and Leadership	2.5 Specialised Nursing Care Needs	3.5 Independence	4.5 Occupational Health and Safety
1.6 Human Resource Management	2.6 Other Health and Related Services	3.6 Privacy and Dignity	4.6 Fire, Security and Other Emergencies
1.7 Inventory and Equipment	2.7 Medication Management	3.7 Leisure Interests and Activities	4.7 Infection Control
1.8 Information Systems	2.8 Pain Management	3.8 Cultural and Spiritual Life	4.8 Catering, Cleaning and Laundry Services
1.9 External Services	2.9 Palliative Care	3.9 Choice and Decision Making	
	2.10 Nutrition and Hydration	3.10 Resident Security of Tenure and Responsibilities	
	2.11 Skin Care		
	2.12 Continence Management		
	2.13 Behavioural Management		
	2.14 Mobility, Dexterity and Rehabilitation		
	2.15 Oral and Dental Care		
	2.16 Sensory Loss		
	2.17 Sleep		

Appendix 2

CENTER FOR HEALTH SYSTEMS RESEARCH ANALYSIS QUALITY INDICATORS VERSION 6.3

(chsra.wisc.edu, 2000)

(All spelling in American English, the language in which the original document is written)

DOMAIN: ACCIDENTS

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
1. Incidence of new fractures[1] 1.1A0001	**Numerator:** Residents with new fractures on most recent assessment **Denominator:** Residents who did not have fractures on the previous assessment	MOST RECENT ASSESSMENT: New hip fractures (J4c is checked on most recent assessment and J4c is not checked on previous assessment) OR Other new fractures (J4d is checked on most recent assessment and J4d is not checked on previous assessment)	No adjustment
2. Prevalence of falls 1.2A0004	**Numerator:** Residents who had falls on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Fall within past 30 days (J4a is checked)	No adjustment

[1]QI was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly. In some cases this has resulted in a change to the title of the QI.

DOMAIN: BEHAVIORAL/EMOTIONAL PATTERNS

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
3. Prevalence of behavioral symptoms affecting others 2.1A0005	**Numerator:** Residents with behavioral problems affecting others on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT Behavioral symptoms affecting others: Verbal abuse (E4b-Box A>0); OR physically abusive (E4c-Box A>0) OR socially inappropriate/disruptive behavior (E4d-Box A>0)	High Risk[1]: [Presence of Cognitive Impairment (see Glossary) ON THE MOST RECENT ASSESSMENT OR [Psychotic disorders 13=ICD9 CM 295.00 – 295.9; 297.00 – 298.9 or i1GG SCHIZOPHRENIA IS CHECKED)] or [Manic-depressive (13 = ICD9 CM 296.00 – 296.9 or I1ff is checked)][2] at the MOST RECENT OR ON THE MOST RECENT **FULL** ASSESSMENT Low Risk: All others at MOST RECENT ASSESSMENT Note: When the most recent assessment is a Quarterly Assessment, we will 'carry forward' information about psychotic disorders and manic depression from the most recent **FULL** assessment

[1] Risk adjustment was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly.

[2] Instructions relative to the completion of item I3 (ICD-9 codes) are ambiguous. Pending clarification from HCFA, we recommend that this item include all diagnoses: from the last 90 days that are related to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring or risk of death.

DOMAIN: BEHAVIORAL/EMOTIONAL PATTERNS

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
4. Prevalence of symptoms of depression [1] 2.2A0008	**Numerator:** Residents with symptoms of depression on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT Symptoms of Depression: Sad mood (E2=1 or 2) and [at least 2 symptoms of functional depression] *Symptoms of functional depression:* *<u>Symptom 1</u> distress (E1a=1or 2-resident made negative statements);* *<u>Symptom 2</u> agitation or withdrawal (E1n=1 or 2 repetitive physical movements) or (E4e-Box A = 1, 2 or 3 resists care) or (E1o=1or2-withdrawl from activity), or (E1p=1 or 2 – reduced social activity);* *<u>Symptom 3</u> wake with unpleasant mood (E1j=1or2) or not awake most of the day (N1d is checked), or awake 1 period of the day or less and not comatose (N1a+N1b+N1c<1 and B1=0);* *<u>Symptom 4</u> suicidal or has recurrent thoughts of death (E1g=1 or 2);* *<u>Symptom 5</u> weight loss (K3a=1).*	No adjustment

[1] QI was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly. In some cases this has resulted in a change to the title of the QI.

DOMAIN: BEHAVIORAL/EMOTIONAL PATTERNS

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
5. Prevalence of symptoms of depression without antidepressant therapy[1] 2.3A0011	**Numerator:** Residents with symptoms of depression on most recent assessment and no antidepressant therapy **Denominator:** All residents on most recent assessment	Depression: See Glossary AND No antidepressant (O4c=0)	No adjustment.

[1]QI was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly. In some cases this has resulted in a change to the title of the QI

DOMAIN: CLINICAL MANAGEMENT

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
6. Use of 9 or more different medications[1] 3. 1A0015	**Numerator:** Residents who received 9 or more different medications on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT O1 (number of medications) > 9	No adjustment

[1] QI was modified (from the original MDS+ definition) to reflect lack of detailed drug data from Section U.

DOMAIN: COGNITIVE PATTERNS

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
7. Incidence of cognitive impairment[1] 4.1AOO16	**Numerator:** Residents who were newly cognitively impaired on most recent assessment **Denominator:** Residents who were not cognitively impaired on previous assessment	MOST RECENT ASSESSMENT Cognitively impaired PREVIOUS ASSESSMENT: Does not have Cognitive impairment For definition of Cognitive impairment see Glossary	No adjustment

[1] QI was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly. In some cases this has resulted in a change to the title of the QI.

DOMAIN: ELIMINATION/INCONTINENCE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
8. Prevalence of Bladder or Bowel Incontinence 5.1A0018	**Numerator:** Residents who were frequently incontinent or incontinent on most recent assessment **Denominator:** All residents except as noted in exclusion	MOST RECENT ASSESSMENT: Bladder incontinence (H1b=3 or 4); OR Bowel incontinence (H1a=3 or 4) EXCLUDE: Residents who are Comatose (B1=1); OR have indwelling catheter (H3d is checked); OR have an ostomy (H3i is checked) at MOST RECENT ASSESSMENT	High Risk[1]: Severe cognitive impairment (see Glossary); OR Totally ADL dependent in mobility ADL's (G1 a, b, e-Box A self performance = 4 in all areas) at MOST RECENT ASSESSMENT Low Risk: All others at MOST RECENT ASESSMENT

[1] Risk adjustment was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly.

DOMAIN: ELIMINATION/INCONTINENCE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
9. Prevalence of occasional or frequent Bladder or Bowel Incontinence without a toileting plan 5.2A0020	**Numerator:** Residents without toileting plan on most recent assessment **Denominator:** Residents with frequent incontinence or occasionally incontinent in either bladder or bowel on most recent assessment	MOST RECENT ASSESSMENT: No scheduled toileting plan and no bladder retraining program (Neither H3a nor H3b is checked) Occasional or frequent bladder incontinence (H1b=2 or 3) OR bowel incontinence (H1a = 2 or 3)	No adjustment
10. Prevalence of indwelling catheters 5.3A0021	**Numerator:** Indwelling catheter on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Indwelling catheter (H3d is checked)	No adjustment[1]

[1] Risk adjustment (included in the original MDS+ definition) cannot be defined because certain information was not available on the MDS 2.0 Quarterly.

DOMAIN: ELIMINATION/INCONTINENCE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
11. Prevalence of fecal impaction 5.4A0023	**Numerator:** Residents with fecal impaction on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Fecal impaction (H2d is checked)	No adjustment

DOMAIN: INFECTION CONTROL

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
12. Prevalence of urinary tract infections 6.1A0024	**Numerator:** Residents with urinary tract infections on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Urinary tract infection (12j is checked)	No adjustment

DOMAIN: NUTRITION/EATING

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
13. Prevalence of weight loss 7.1A0026	**Numerator:** Proportion of residents with weight loss of 5% or more in the last 30 days or 10% or more in the last 6 months on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Weight loss (K3a=1)	No adjustment

DOMAIN: PHYSICAL FUNCTIONING

TITLE	DESCRIPITION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
16. Prevalence of bedfast residents 8.1A0030	**Numerator:** Residents who are bedfast on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Bedfast (G6a is checked)	No adjustment

DOMAIN: PHYSICAL FUNCTIONING

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
17. Incidence of decline in late loss ADLs 8.2A0031	**Numerator:** Residents showing ADL decline in self-performance between previous and most recent assessment a) One level decline in two or more late loss ADLs Or b) Two level decline in one or more late loss ADLs **Denominator:** All residents who have most recent and previous assessments (excluding those who cannot decline because they are already totally dependent or who were comatose on the previous assessment)	At least ONE level decline in TWO or more of the following: bed mobility, transfer, eating, toileting. G1 a, b, h, i coding pattern Box A: Previous Most Recent 0 – 1, 2, , 3, or 4. 1 – 2, 3, or 4 2 – 3 or 4 3 – 4 OR At least a TWO level decline in ONE or more of the following: bed mobility, transfer, eating, toileting. G1 a, b, h, i coding pattern Box A: Previous Most Recent 0 – 2, 3, 4 1 – 3, 4 2 – 4 Note: A value of 8 is equal to missing for purposes of defining the change in ADL EXCLUDE: Residents who are totally dependent on ADL. (G1a-j Box A – all items = 4 or 8) OR comatose (B1=1) on PREVIOUS ASSESSMENT	No adjustments[1]

[1] Risk adjustment (included in the original MDS+ definition) cannot be defined because certain information was not available on the MDS 2.0 Quarterly.

DOMAIN: PHYSICAL FUNCTIONING

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
18. Incidence of decline in ROM[1] 8.A0034	**Numerator:** Residents with increases in functional limitation in ROM between previous and most recent assessments **Denominator:** All residents with previous and most recent assessments, with the exclusion noted	Functional limitation in ROM (G4a-f-Box A>0) in most recent assessment is greater than the functional limitation in ROM on the previous assessment Most Recent Previous [SUM G4a-f] > [SUM G4a-f] Box A Exclude: residents with maximal loss of ROM at previous assessment (Sum G4a-f, Box A, is 12 on previous assessment)	No adjustment[2]

[1] QI was modified (from the original MDS+ definition) to reflect changes in assessment items from contractures to ROM.
[2] Risk adjustment (included in the original MDS+ definition) cannot be defined because certain information was not available on the MDS 2.0 Quarterly.

DOMAIN: PHYCHOTROPIC DRUG USE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
19. Prevalence of antipsychotic use, in the absence of psychotic and related conditions 9.1A0037	**Numerator:** Residents receiving antipsychotics on most recent assessment **Denominator:** All residents on most recent assessment, except those with psychotic or related conditions (see exclusion)	MOST RECENT ASSESSMENT: Antipsychotics (O4a>1) EXCLUDE[1]: Residents with one or more psychotic disorders (I3=295.00-295.9; 297.00-298.9 or I1gg schizophrenia is checked); OR Tourette's (I3=307.23); OR Huntington's (I3=333.4)[2] ON THE MOST RECENT FULL ASSESSMENT; OR with hallucinations (J1i is checked) ON MOST RECENT ASSESSMENT Note: When the most recent assessment is a Quarterly Assessment, we will carry forward information about psychotic disorders, Tourettes and Huntington's from the most recent **full** assessment	High Risk[3]: Cognitive impairment AND Behavior problems at MOST RECENT ASSESSMENT. (see Glossary for definitions) Low Risk: All others on MOST RECENT ASSESSMENT

[1] Exclusion was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly.

[2] Instructions relative to the completion of item I3 (ICD-9 codes) are ambiguous. Pending clarification from HCFA, we recommend that this item include all diagnoses from the last 90 days that are related to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

[3] Risk adjustment was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly.

DOMAIN: PHYCHOTROPIC DRUG USE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
20. Prevalence of anti-anxiety / hypnotic use 9.3A0043	**Numerator:** Residents receiving anti-anxiety or hypnotics on most recent assessment **Denominator:** All residents on most recent assessment, except those with psychotic or related conditions (see exclusion)	MOST RECENT ASSESSMENT: Anti-anxiety / hypnotics (O4b or O4d >1) EXCLUDE[1]: Residents with one or more psychotic disorders (I3=295.00-295.9; 297.00-298.9 or I1gg schizophrenia is checked); OR Tourette's (I3=307.23); OR Huntington's (I3=333.4)[2] ON THE MOST RECENT FULL ASSESSMENT; OR with hallucinations (J1i is checked) ON MOST RECENT ASSESSMENT Note: When the most recent assessment is a Quarterly Assessment, we will carry forward information about psychotic disorders, Tourettes and Huntington's from the most recent **full** assessment	No adjustment

[1] Exclusion was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 Quarterly.

[2] Instructions relative to the completion of item I3 (ICD 9 codes) are ambiguous. Pending clarification from HCFA we recommend that this item include all diagnoses: from the last 90 days that are related to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

DOMAIN: PSYCHOTROPIC DRUG USE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
21. Prevalence of hypnotic use more than two times in last week[1] 9.4A0047	**Numerator:** Residents who received hypnotics more than 2 times in last week on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: The use of more than 2 hypnotic drugs in the last 7 days (O4d>2)	No adjustment

[1] QI was modified (from the original MDS+ definition) because detailed drug data (Section U) were not available.

DOMAIN: QUALITY OF LIFE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
22. Prevalence of daily physical restraints 10.1A0051	**Numerator:** Residents who were physically restrained daily on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASSESSMENT: Daily physical restraints (P4c or d or e = 2)	No adjustment
23. Prevalence of little or no activity 10.2A0052	**Numerator:** Residents with little or no activity on most recent assessment **Denominator:** All residents (excluding comatose) on most recent assessment	MOST RECENT ASSESSMENT: Little or no activity (N2 = 2 or 3) EXCLUDE: Residents who are comatose (B1=1)	No adjustment

DOMAIN: SKIN CARE

TITLE	DESCRIPTION	MDS 2.0 QUARTERLY VARIABLE DEFINITION	RISK ADJUSTMENT
24. Prevalence of Stage 1-4 pressure ulcers 12.1A0054	**Numerator:** Residents with pressure ulcers (stage 1-4) on most recent assessment **Denominator:** All residents on most recent assessment	MOST RECENT ASESSMENT: Pressure ulcer (M2a>0, or I3=ICD 9 CM 707.0)[2]	High Risk [1] Impaired transfer or bed mobility (G1a or b = 3 or 4 Box A) OR Comatose (B1=1), OR Malnutrition (I3=ICD 9 CM 260, or 261, or 262 or 263.0 or 263.1 or 263.2 or 263.8 or 263.9)[2] OR end stage disease (J5c is checked) MOST RECENT ASESSMENT Low Risk All others on MOST RECENT ASSESSMENT

[1] Risk adjustment was modified (from the original MDS+ definition) because certain information was not available on the MDS 2.0 quarterly.

[2] Instructions relative to the completion of item I3(ICD9 codes) are ambiguous. Pending clarification from HCFA, we recommend that this item include all diagnoseS: from the last 90 days that are related to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

QI GLOSSARY

Behavior problems. Defined as one or more of the following less than daily or daily: verbally abusive (E4b-Box A>0), physically abusive (E4c-Box A>), or socially inappropriate disruptive behavior (E4d-Box A>0).

Cognitive impairment. Any impairment in daily decision making ability (B4>0) AND has short term memory problems (B2a=1).

Severe cognitive impairment. Decision making ability is severely impaired (B4=3) AND has short term memory problems (b2a=1)

DEPRESSION
Symptoms of depression:
Sad mood (E2=1 or 2) and [at least 2 symptoms of functional depression];

Symptoms of functional depression:

Symptom 1 distress (E1a= 1 or 2 resident made negative statements);

Symptom 2 agitation or withdrawal (E1n= 1 or 2 – repetitive physical movements), or (E4e-Box A = 1, 2, or 3 resists care), or (E1o= 1or 2 withdrawal from activity) or (E1p=1 or 2 reduced social activity);

Symptom 3 wake with unpleasant mood (e1j=1 or 2), or not awake most of the day (N1d is checked), or awake 1 period of the day or less and not comatose (N1a+N1b+N1c<1 and B1=0);

Symptom 4 suicidal or has recurrent thoughts of death (E1g=1 or 2);

Symptom 5 weight loss (K3a=1).

Appendix 3

ETHICS COMMITTEE DOCUMENTS PERTAINING TO THE COMMENCEMENT OF THE *QUALITY OF CARE FOR NURSING HOME RESIDENTS'* PROJECT

(All documents were presented on Department of Health Studies Letterhead.)

APPENDIX 3.1
LETTER OF INVITATION TO PARTICIPATE IN THE PROJECT

Dear Proprietor

I am seeking your assistance in an exciting venture that could have a significant impact on aged care in Australia. The University of New England, in association with partners in the aged care industry, is conducting a study entitled *Quality of Care for Nursing Home Residents* during the next three years. The aim of this project is to develop comprehensive measures and clinical indicators, to identify and monitor quality of care for nursing home residents. A representative sample of 400 Commonwealth funded nursing homes has been developed with assistance from the Australian Bureau of Statistics, and your facility has been selected from these.

The project involves ten case studies of residential facilities, followed by a national survey. I am the project researcher, and my name is Lyndall Spencer. I am a Registered Nurse, presently enrolled in the Doctor of Philosophy degree, which is supervised by Dr Helen Waite and Dr Mary Courtney, Senior Lecturers in the Department of Health Studies.

My purpose in writing to you is to invite you to participate in the project as one of the ten case study facilities. The advantages of being involved in the pilot study include the opportunity to make a major contribution to the quality of care for residents in aged care facilities across the country. In addition, your facility will be one of the benchmark organisations on which the standards of quality care indicators will be founded. Further, as part of an industry sponsored project, you will have the satisfaction of co-operating with your colleagues to enhance the standing of your industry in the community, through research based practice.

If you agree to participate, members of your organisation will be asked about your current approaches to quality care for residents. Participation may take the form of discussions with residents and their families, management and personnel, observations of daily routines and document analysis. I would be interested to examine the ways in which management structures, staffing mix,

data collection and legislative obligations, among other factors, contribute to care outcomes. For your information, I have enclosed a copy of the Information Sheet, which I would distribute to all interested parties. In addition, there is a copy of the Informed Consent Form, which all case study participants would need to sign, before I was able to proceed to talk to them individually.

All information would remain completely confidential, and neither your organisation, nor its individual members, will be identified in any way in the results. I anticipate the entire case study will take approximately one week, and I will schedule all my activities at times and in places suitable to the facility. Your organisation would be free to withdraw its consent to participate at any time.

During the course of the project, should you have any cause for concern, you may contact the Human Research Ethics Committee at the following address:

The Secretary
Human Research Ethics Committee
Research Services
University of New England
Armidale NSW 2351
Phone: 067 732 352; Fax: 067 733 543

Should you have any questions concerning the study, please contact:
Dr Helen Waite
Senior Lecturer
Department of Health Studies, University of New England
Armidale NSW 2351
Phone: 067 733 673; Fax 067 733 666

Or

Lyndall Spencer
Department of Health Studies, University of New England
Armidale NSW 2351
Phone: 067 733 654; Fax 067 733 666

I look forward to your reply in due course, and thank you in anticipation for your support for this project.

Yours sincerely

LYNDALL SPENCER
Postgraduate Student

APPENDIX 3.2
INFORMATION SHEET FOR PARTICIPANTS IN *QUALITY OF CARE FOR NURSING HOME RESIDENTS' PROJECT* CASE STUDIES

(Copies of this information sheet were provided to the facilities in advance of the case study to alert potential participants to the nature of the work being undertaken. Additional copies were given to all individuals who agreed to participate, in association with the Informed Consent Form at Appendix 3.3)

The University of New England, in association with partners in the aged care industry, is conducting a study entitled *Quality of Care For Residents*, around Australia during the next three years. The aim of the research is to develop comprehensive measures and clinical indicators to identify and monitor quality of care for residents. This is being undertaken because the current means of measuring quality care, by the Standards Monitoring Teams and similar task forces, give little recognition to resident expectations, nursing perspectives, or institutional constraints.

The project involves ten case studies of residential facilities, followed by a national survey of over 200 nursing homes. When doing the case studies, the researcher will talk to members of every department in your nursing home, and observe the care being given to your residents. She will also examine some of the documentation associated with that care. The whole process will last about one week. Interviews with individual personnel are expected to last approximately 30-45 minutes.

Participation in the case studies will be by means of a taped discussion with the researcher, about the things that influence the quality of care for residents in nursing homes. All information will be completely confidential, and neither the home nor individual residents nor staff will be identified in any way in the results. Those who participate will be given a code number and any information which could link the names and numbers will be stored in a separate place from the records themselves. Participants will be free to withdraw from the project at any time, and any information which has already been collected will be destroyed if you so wish. Once the study is completed the researcher will return to your home to tell you the results, or provide you with a brief written report about the outcome of the project.

If you have any questions concerning this project please contact Lyndall Spencer, Department of Health Studies, University of New England, Armidale, NSW 2351, Phone 067 733 654 or Fax 067 733 666.

APPENDIX 3.3

PLAIN LANGUAGE STATEMENT AND CONSENT FORM FOR CASE STUDY PARTICIPANTS

(To be read in conjunction with the Information Sheet)

My name is Lyndall Spencer and I am a registered nurse conducting a project entitled *Quality of Care for Nursing Home Residents*. This study has been jointly funded by the Commonwealth Government, through the University of New England, and members of the aged care industry. Your nursing home is one of the facilities participating in the research.

Your involvement is crucial to the results of this project, because it will ensure that the views and experiences of those who are actively involved in the delivery of care on a regular basis are taken into account. Our conversation, which may be taped, would last between 30 minutes and one hour, and I would be interested to learn about the things that influence quality of care for residents in nursing homes. The discussion would be completely confidential, and neither you nor your nursing home would be identified in the results. You would be free to withdraw at any time, and any information which has been collected would be destroyed if you so wish.

During the visit to your nursing home, I will also observe the care given to residents, and examine documents about them. I will always ask permission before doing so, and if you do not wish me to be present at any time, just ask me to leave.

If you decide to be involved in this research, please read and complete the following statement:

I, ..., have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that research data gathered from the study may be published, provided my name is not used.

....
Participant Date

....
Investigator Date

Appendix 4

DOCUMENTS ASSOCIATED WITH PHASE 1 OF THE *QUALITY OF CARE FOR NURSING HOME RESIDENTS'* PROJECT

APPENDIX 4.1 (a) (i-ii)
STRUCTURED COMPONENTS OF IN-DEPTH INTERVIEWS WITH RESIDENTS

The contents of Appendices 4.1 (a) (i-ii) were administered by the researcher as part of the introduction to the in-depth interviews that were to follow:

APPENDIX 4.1 (a) (i)
SELF REPORTED HEALTH STATUS

My health is				
Excellent	Good	Reasonable	Fair	Poor

APPENDIX 4.1 (a) (ii)
RESIDENT NURSING HOME SATISFACTION LEVELS
(Adapted from Kruzich et al. 1992, 32(3): 342)

QUESTION	AGREE	DON'T KNOW	DISAGREE
The food is good here			
My room and surrounds are clean			
I can keep as many personal possessions as I want in my room			
I can see a doctor as often as I like			
Most of the staff have the skills to provide the care I need			
At night I can go to bed whenever I want to			
The amount of noise here bothers me			
When I need help someone comes within a reasonable time			
I have enough privacy here			
This is a cheerful place			
I can decide what clothes I wear every day			
When I have a complaint something is done about it			
Life is boring here			
Some of my personal things have disappeared from my room			
Most of the staff show a personal interest in me			
I get called by the name I prefer			
I can have a bath or a shower whenever I want to			
The staff sit and chat with me as often as I want			
Life is better here than I expected when I first arrived			

APPENDIX 4.1 (a) (iii)
IN-DEPTH INTERVIEW GUIDE - RESIDENTS AND /OR THEIR REPRESENTATIVES

The interviews themselves were unstructured except for the contents of Appendices 4.1 (a) (i-ii). (Family members were not invited to answer the Self Report Health Status on behalf of their loved ones. If the resident could not provide the 'Report' him or her self, the question was not asked.) Interviews occupied between 30 minutes and one hour, and were recorded using written notes, following permission being granted from the informant. Some demographic data had been harvested from the resident's records prior to the interviews, which avoided the necessity to ask questions of a personal nature, such as age, and matters that residents may not know, such as their RCS care category. In addition, residents were invited to comment on some or all of the following:

- The personal care they received
- Their activities of daily living
- The social support they receive from their families
- Their perceptions of the care staff
- Their relocation experiences
- The things they miss the most from their previous life
- The things that they enjoy most and least about their current life
- Their perceptions of the quality of the care they received.

The items listed in Appendices 4.1 (a) (i-ii) frequently generated additional topics about which residents or their families also expressed a view.

APPENDIX 4.1 (b)
INTERVIEW GUIDE FOR DISCUSSIONS WITH NON MANAGERIAL STAFF

All interviews with staff were unstructured. They were held in a quiet location recommended by the informant, and took between 30 minutes and one hour. The information was recorded, in handwriting, with the permission of the informant, and a copy was offered to the contributor, once it had been transcribed. Topics that were discussed included some or all of the following

- The nature of their work
- The manner in which they set their priorities
- The nature of the compromises that were necessary each day, and how they were achieved
- The degree of flexibility that was possible within the standard routines of daily care giving
- The supervision they received
- Their personal views on quality care and their recommendations about how to achieve it
- Their suggestions about indicators to be monitored and why
- Their education standards and views about further education including in-service education provided by the facility
- Aspects of the built environment which aided or hindered the execution of their duties
- The manner in which they dealt with 'difficult' residents (the definition of 'difficult' was determined by the informant)
- The manner in which they dealt with death and bereavement, and whether they felt they were supported by management.

APPENDIX 4.1 (c)
INTERVIEW GUIDE FOR DISCUSSION WITH MANAGERIAL PERSONNEL

All interviews with managers were unstructured. They were held in a quiet location recommended by the informant, usually the manager's office, and took between one and one and a half hours. On several occasions there was a need to conduct supplementary interviews later in the visit. The information was recorded, in handwriting, with the permission of the informant and a copy was offered to the contributor, once it had been transcribed. Topics that were discussed included some or all of the following. The formal in-depth interviews were in addition to courtesy conversations which were held at the time the researcher commenced the case study, and when she left the facility for the last time on the final day.

- The organisation's Philosophy, as it influences the manager's individual position
- The impact of Government policies such as accreditation and certification
- The role of regulators and views about self-regulation
- Human resource management issues such as
    - RN/resident ratios
    - Staff education levels
    - Facility support for staff education
- Funding issues and their impact on the quality of care that can be offered
- Merits or otherwise in undertaking QA programs such as ISO9002 in advance of accreditation
- Statistics kept by the home, including who decides what should be collected, who performs the analysis, what is the follow-up to problems identified by data collected
- Complaints and comments policies
- Continuous improvement and the systems in place to ensure that it is achieved
- The manager's suggestions about clinical and other indicators that should be incorporated into the Australian Quality Matrix, and the reasons for their inclusion
- The role of the Board, if there is one
- Personal support (if any) provided by their employing agency to the managers and how this could be improved.

APPENDIX 4.2(i)
PARTICIPANT OBSERVATION NOTES FROM ONE DAY IN THE CASE STUDIES SHADOWING THE DUTY RN

STUDY SITE NUMBER: 9
DATE: 18 JANUARY 1998

TIME	ACTIVITY	COMMENTS
2.45 pm	Arrival for afternoon shift. Permission to enter facility from DON. Introduction to the RN with whom I was working.	RN expressed interest in study. Said she was quite happy to have me working with her. She will be responsible for 26 residents during the 8 hours she is here. There will be 3 assistant nurses to support her. One diversional therapist is on for whole home until 9 pm plus a chef and 2 kitchen hands on until 6.30 pm
3.00 pm	Handover with all afternoon shift	I had been in the facility for several days at this point and the staff were used to having me around. No one expressed any concern about my presence.
3.15 pm	Checked the DDs with morning staff	Documentation in DD book identical with that in QLD. No missing signatures or incorrect amounts recorded.
3.30 pm	Attend to PEG feed	This is a gravity drip set-up, and requires more frequent inspections than the machine driven systems. AINs commence 'sponge round'.
4.00 pm	LMO to see one of his patients	Take dressing down for LMO inspection. No changes in treatments or other orders
4.30 pm	Commence 5 pm drug round	RN seems very familiar with all residents names, personal preferences, and has appropriate strategies for dealing with those who are resistive to meds.
5.00 pm	Do BGLs on insulin dependent diabetic and give insulin. All NIDD on Diabex get their tabs now too.	This resident's blood sugars are 'all over the place' and the regimen includes the provisor that if it gets below 5 mmols the LMO is to be called, and the injection withheld. Not a problem today, the results were 12.4. Diabex given in 'thickened fluids' if individuals not able to swallow tablet.. RN checked that PEG feed was completed. First group of AINs to their own tea.
5.30 pm	Drug round continued by RN, kitchen staff deliver food trolleys to wards, AIN staff collect trays of those who need to be fed.	I was particularly interested to observe the AINs feeding residents because yesterday I had seen one nurse feeding three people simultaneously at lunch time! (See yesterday's notes) The afternoon group were more careful and did not do this (in my presence at least). DON came by to say she was off and check that everything was OK. Second group of AINs to their own tea.
6 pm	Meal served in main dining room to those who are able to feed themselves	Residents distributed around the dining room in tables of either 4 or 6. There was quite a lot of chat between dinner companions in two of the tables, rather less in some of the others. As all of these residents are cognitively in tact, the RN was able to give out her medications without too many problems. Some took longer to swallow their tablets than others but the RN was very patient and encouraging. She also did the 'right' thing and took the pulse of the two on Digoxin.

Continued next page

6.15 pm	Drug round completed, RN (& I) helped with the feeds	The RN fed a resident located close by the nurses station so that she could see what was going on and be available for anyone who needed her.
6.30 pm	Kitchen staff leave. All RNs to their evening meal	Much chat and hilarity in staff room between evening RN staff. This group obviously work well together, and have been a 'team' for several years. They rotate through the various wards, but the afternoon shift seems pretty stable. From time to time nurses come in for assistance with different problems etc.
7.00 pm	All staff, including RNs take residents to DT program	There are fewer group activities at night, the DT program is more 1:1, with massages etc. RN talks to family members.
7.30 pm	Next PEG feed put up. Sedation and night medication round commenced. AINs put non DT residents to bed	Two residents have MS Contin 5 mg to settle. DDs checked with 2 RNs. AINs ask each resident if they would like to go to bed now. They clean the teeth of those who said yes, or reminded them to clean their own teeth if they were mobile/independent. Putting people to bed is a major undertaking and takes well over an hour, because those who are not mobile require hoists, lifters or other assistive devices. Those who are not cognitively in tact need taking to the toilet or being reminded to go to the toilet.
8.00 pm	Supper prepared and distributed by an AIN in each ward.	Because those who are independent have dinner at 6PM supper is not a major production here. The 'supper nurse' must give the diabetics something to eat and drink, and others may chose to have supper or not. From my observations there was plenty of bread, butter, jam and biscuits for those who became hungry during the night.
8.30 pm	Activities program completed	AINs took residents back to their rooms. There was one night shower for the nurses to do before this particular resident went to bed.
9 pm	'Short shift' AINs depart RN commences documentation	The RN thanks 'her' nurses for the work they have done today as they leave. 'Documentation' involves writing material in the residents notes concerning the day's activities, and in one case, the continuation of the RCS assessment period records. AINs answer buzzers from the floor, and only interrupt the RN if really necessary. The RN tells me that she had planned to commence writing up one of her Care Plans this afternoon, but having me with her, and the general work load, meant that she has not had time to do so. She will take the material home. She checks the PEG feed which is running behind a bit, possibly due to the resident's position.
9.45 pm	'Long shift' staff have a cup of tea in the staff room.	Technically this is a 'break' from duty. However all staff including the RNs answer bells and attend to problems as they arise during their 'break'. PEG feed finally through, about half an hour over time. This is the final one for the afternoon shift, although another one is put up at midnight.
10.15 pm	Night staff RN reports for duty	The afternoon RN gives the night RN a handover
10.30 pm	Night duty AINs commence work	All afternoon RNs and all night staff attend handover. Afternoon nurses continue to answer bells until handover is finished.
10.45 pm	All remaining afternoon staff off duty.	It has been a relatively peaceful shift, and followed traditional time schedules and activities. I did not observe anything untoward, and felt they had a reasonable day

APPENDIX 4.2(ii)
'UNOBTRUSIVE WATCHING'
PARTICIPANT OBSERVATION NOTES FROM ONE DAY IN THE CASE STUDIES

STUDY SITE NUMBER: 7
DATE: 10 DECEMBER 1997
TIME: 2.00 PM
EVENT: RESIDENTS' COMMITTEE MEETING

(The Chairman of the Residents' Committee invited the researcher to attend their regular monthly meeting. The home accommodated 108 high care residents, in the private for-profit sector in a capital city.)

Although the meeting was scheduled to commence at 2.00 pm, all those who were coming had assembled by 1.30 pm. Nine residents and two family members attended. A member of the managerial team was also present to give a report but departed before any 'confidential' items were discussed. The activities officer acted as the Committee Secretary and took the minutes. The meeting was held in an alcove off the main dining room, which was relatively quiet and away from the other activities of the day.

The meeting commenced with the Chairman thanking those who had attended, and the minutes of the previous meeting were read. He also welcomed me to the meeting, but did not ask if anyone had any objections to my presence. I raised the matter myself but no one said anything, and they appeared to forget that I was there almost immediately. While there were fewer than 10% of residents in attendance, it did not seem to matter that a quorum had not been reached. In addition, I didn't notice any publicity or other information displayed around the home to invite others to attend. When I spoke to the Chairman afterwards he told me that they 'didn't bother' with such things because 'nobody much is really interested'. In contrast to his somewhat authoritarian approach, the Chairman and all the meeting participants seemed to behave with considerable courtesy towards each other throughout the hour-long gathering.

A gesture was made towards traditional meeting protocol when the Chairman commented in what would have been the 'Business Arising' [from the minutes of the previous meeting] section of the agenda that their request for 'more bread and butter with each meal' had been passed on to the 'Matron'. However, as discussions about food appeared to occupy the majority of the meeting it seemed to me that this was a Standing Item on every meeting agenda.

The Deputy Director of Nursing, representing the managerial team, gave a report including showing the group some blueprints for extensions to the building, to take place when the laundry was outsourced. It lasted about 10 minutes, and concluded with him asking if there were any comments or questions. One family member complained about damage done to their loved one's personal laundry, including the destruction of a 'satin nightdress'. The DDON provided a non-committal answer. He referred the family to the resident handbook, which included a disclaimer about delicate items of clothing and the recommendation to take such objects home for laundering. He also indicated that the proposed use of a commercial laundry meant

that the situation was unlikely to improve, and suggested that the family member buy her mother more substantial items in the future. At no time did he express regret or apologise for the situation.

Following the departure of the DDON, the group discussed the forthcoming Christmas party to be held a week before Christmas, and the decision by 'the Matron' to charge $2.50 for each guest who accompanied residents to lunch on 25 December. Several meeting attendees disapproved of this extra charge, although it did not seem unreasonable to me because the small amount involved would barely cover the cost of the ingredients.

One matter which received universal approval was the visit by students from a nearby college choir who were going to sing carols to the residents on the forthcoming Saturday afternoon. Everyone said they were looking forward to this visit, and hoped there would be an opportunity to join in the singing.

A complaint was made about the evening meal, in which only soup and salad or sandwiches were offered on the menu. One of the attendees also claimed that she preferred a hot dinner in the evening rather than at lunch time, as was the practice in this home. Apparently, the home had offered to keep the midday meal and reheat it, but the resident considered that this was an unsatisfactory solution. The Chairman suggested that it was unlikely that this routine would change, because 'they' would have to pay overtime, if a cook was rostered to prepare a cooked evening meal as well as the lunch time menu. However, he also told the group that he would take the matter up with the DON and report back to the resident concerned as soon as he had an answer, but 'don't hold your breath' he advised her.

Another matter concerned the unstable nature of the hot water system. Sometimes it was extremely hot, and at others it was barely warm. The Chairman said that he had not experienced the problem himself, but that as he arose at 6 am he was probably one of the first into the showers. He also thought it would have been more sensible to discuss this when the DDON was present, but that he would make a note of the complaint and bring it up with the DON or handyman when he next saw him.

There was no other business, and the meeting concluded at 2.45 pm. The next meeting was scheduled for a month from the day.

During the course of the meeting several other residents had wandered in and out of the room but none had asked what was going on, nor had they been invited to stay and participate. The activities officer, acting as Minute Secretary, told me that while she took notes in pencil at the time of the meeting, she typed the minutes either that day or the day after, to make sure that she remembered everything which had to be included. Copies of them were distributed to the Chairman and the DON and made available to anyone who wanted to read them in a folder in her office. She could not remember the last time anyone other than the participants themselves had every asked to read them. She also prepared the Newsletter, and included the major items in this publication which was distributed to all residents once a month.

APPENDIX 4.3
FIELD NOTES FROM ONE DAY IN THE CASE STUDY IN A REMOTE RURAL SETTING

STUDY SITE NUMBER: 4
DATE: 7 NOVEMBER 1997
PROGRAM:

TIME	ACTIVITY	COMMENTS
8.30 am	Arrival for 2nd day of case study. Permission to enter facility and morning greetings with DON and PA	
9–10 am	Participant observation in physiotherapy clinic, in the company of the therapist and the Aboriginal Liaison Officer	Some residents reluctant to undertake physio. 'Persuasion' to do so, pretty strong.
10.30 am	Morning tea with facility QA officer, (a Level 2 RN)	
11-11.30 am	Interview with EN, who is a Caucasian woman married to an Aboriginal man	She works from 7- 2.30 each day. Other than her caring duties, she fulfils a number of functions including representing the home on the community committee run by the police. Her 'wish list' includes more casual respite for community seniors, to give their carers a break, more accommodation on site for family members, and staff development sessions once a fortnight.
11.30 – 12.15 pm	Help with feeds	
12.30 – 1 pm	Lunch in staff room	
1-1.45 pm	Interview with long term resident, who had been there in excess of 5 years. She is an Aboriginal lady who told me that she had been educated at a Mission School.	Mrs C's English is very good seeing that she is over 80. Her children had all died of lifestyle related conditions such as diabetes, but her granddaughter takes a close interest in her well-being.
2–.45 pm	Participant observation in music therapy session with DT	This was extremely interesting. The facility is built in an H shape, and the music therapy offered was of two types. On one 'arm' of the H country and western style music was available using CDs, and the radio. On the other 'arm' traditional Aboriginal music was played on a tape recorder. The DT advised me that she always 'knew' when her residents were 'near the end' because they altered their music preferences (and their locations) from the C&W to the traditional music
3 pm	Attend staff hand over	Answer questions about the study
3.30 pm	Thank DON for having me today. Get approval for tomorrow's program	Home to write up notes

Appendix 5

UNE
The University of
NEW ENGLAND

School of Health

QUALITY CARE FOR RESIDENTS IN AUSTRALIAN NURSING HOMES SURVEY

We need your help.
Please take 10 minutes to complete this important survey.

QUESTIONS ABOUT YOUR RESIDENTS AND FACILITY

Q1. What description best applies to your residential service?

Stand alone nursing home ❑

Nursing home co-located with hostel only ❑

Nursing home co-located with independent living (self care) units only ❑

Nursing home co-located with ILUs and hostel ❑

Other, please specify _____

Q2. What description best applies to the proprietorship of your facility?

Private-for-profit ❑

Not for profit - church organisation ❑

Not for profit - community or charitable organisation ❑

State government home ❑

Other, please specify _____

Q3. What is the postcode of your facility?

Postcode _____

Q4. How many approved beds does your facility contain?

Permanent _____

Respite _____

Other, please describe _____

Q5. How many residents are in your home?

High care _____

Low care _____

Other, please describe _____ _____

Q6. What was your occupancy rate in 1998?

Rate _____

Q7. Within your overall bed total, do you have any specialised services?

Q7(a) Dementia Care

Yes ❑

No ❑

How many beds? _____

Q7(b) Other eg Rehabilitation or Palliative Care

Yes ❑

No ❑

How many beds? _____

Q8. What is the ethnic background of the majority of your residents?

Please indicate one

Predominantly Anglo Celts ❑

Predominantly Aboriginal or Torres Strait Islander ❑

Predominantly European, Mediterranean, or Arabic ❑

Predominantly Asian ❑

Mixed ethnic origins ❑

Q9. Has your building received Commonwealth Certification?

Yes ❑

No ❑

Q9(a) If your answer to Q 9 was No, what year do you anticipate this will occur?

Year _____

Q10. Has your facility received Commonwealth Accreditation?

Yes ❑

No ❑

Q10(a) If your answer to Q 10 was No, what year do you anticipate this will occur?

Year _____

Q11. Has your facility adopted a quality assurance program such as IS09000 or EQUIP/ACHS?

Yes ❑

No ❑

QUESTIONS ABOUT YOUR STAFF

Q12. How many registered nurses do you employ?

Full time _____

Part time _____

Q13. How many enrolled nurses, personal care workers and assistant nurses do you employ?

Full time _____

Part time _____

Q14. How many environmental services personnel such as cooks, cleaners, laundry workers, or maintenance workers do you employ?

Number _____

Q15. On what basis do you employ the following personnel?

Please state number of personnel

Therapist	Full time	Part time	Sessions	Casual	Nil
Physiotherapist					
Occupational therapist					
Podiatrist					
Activities officer					
Hairdresser					
Massage/aroma/other					

Q16. What is your overall staff turn over rate?

Please indicate one only

1-5% ❑

6-10% ❑

11-20% ❑

Greater than 20% ❑

Q17. Approximately what percentage of your RNs have completed or are undertaking university qualifications?

Percent _____%

Q18. Approximately what percentage of your RNs have undertaken some gerontology/geriatric training eg a College of Nursing Course or post graduate diploma?

Percent _____%

Q19. Approximately what percentage of your personal care or assistant nurse staff have completed any formal training, such as a TAFE course?

Percent _____%

Q20. How many hours of in-service training are your nursing care staff required to complete each year?

RN Hours _____

Personal Carer/Assistant Nurse Hours _____

QUESTIONS ABOUT YOUR PRACTICES AND PROCEDURES

Phase 1 of this study identified three dimensions to quality – the clinical, physical and social apsects of care are all important. We would be interested to know what data you regularly collect to monitor quality in each of these three areas.

Q21. Do you routinely collect data on the following topics, and if so how frequently?

TOPIC	YES	NO	FREQUENCY Daily	Weekly	Monthly	Annually
Pressure ulcer rates	❑	❑	❑	❑	❑	❑
Incontinence rates	❑	❑	❑	❑	❑	❑
Infection rates	❑	❑	❑	❑	❑	❑
Skin integrity	❑	❑	❑	❑	❑	❑
Medication errors	❑	❑	❑	❑	❑	❑
Resident fall rates	❑	❑	❑	❑	❑	❑
Residents accidentslincidents	❑	❑	❑	❑	❑	❑
Resident restraint rates	❑	❑	❑	❑	❑	❑
Staff/visitor accident/incident	❑	❑	❑	❑	❑	❑

Q22. Why do you start collecting statistics on a routine basis?

Commonwealth or State Government regulations ❑

High incidence of events eg resident falls ❑

Issues with potential legal ramifications ❑

Current research interests of staff or management ❑

Q23. When a problem is detected, eg increased medication errors, do you instigate a monitoring program?

Yes ❑

No ❑

Q24. Recognising that each situation will vary, in general how long would you continue to monitor a recently detected problem, before you take preventive action?

1 week ❑

1 month ❑

2-5 months ❑

6-11 months ❑

1 year or more ❑

Q25. Which of the following programs do you routinely offer individual residents who need or want them?

Program	*YES*	*NO*
Activities programs outside the home	❑	❑
Bowel management program	❑	❑
Community volunteer program	❑	❑
Continence management program	❑	❑
Falls management program	❑	❑
Family participation in resident care	❑	❑
Hydration management program	❑	❑
Medication regimen reviews	❑	❑
Pressure care management program	❑	❑
Support program for spiritual well-being	❑	❑

Q26. How regularly are these programs reviewed?

Program	*Frequency*		
	Weekly	*Monthly*	*Quarterly*
Activities programs outside the home	❑	❑	❑
Bowel management program	❑	❑	❑
Community volunteer program	❑	❑	❑
Continence management program	❑	❑	❑
Falls management program	❑	❑	❑
Family participation in resident care	❑	❑	❑
Hydration management program	❑	❑	❑
Medication regimen reviews	❑	❑	❑
Pressure care management program	❑	❑	❑
Support program for spiritual well-being	❑	❑	❑

Q27. Does your facility have a formal written policy to aid quality control in the following areas?

Area	*Yes*	*No*	*Don't know*
Complaints procedure	❑	❑	❑
Emergency procedures	❑	❑	❑
Family participation in resident care	❑	❑	❑
Food preparation	❑	❑	❑
Food presentation	❑	❑	❑
Infection control	❑	❑	❑
Laundry procedures	❑	❑	❑
Manual handling	❑	❑	❑
Resident privacy	❑	❑	❑

Q28. Which of the following strategies do you use to measure resident satisfaction?

Strategies	*Yes*	*No*	*Don't know*
Consultations with individual residents	❑	❑	❑
Regular consultations with resident committees	❑	❑	❑
Resident surveys on a regular basis	❑	❑	❑
Suggestion box or similar devices	❑	❑	❑
Discussions with family for their feedback	❑	❑	❑

Q29. Are protocols to measure resident satisfaction incorporated into formal guidelines such as your management plan or similar document?

Yes ❑

No ❑

IN A NATION SUCH AS AUSTRALIA, RESIDENTS MAY BE DRAWN FROM MANY COUNTRIES OR CULTURES OF ORIGIN

Q30. Does your organisation have a formal policy to support cultural sensitivities in, for example, your Mission Statement or Strategic Plan?

Yes ❑

No ❑

Q31. Do you, as an individual, encourage residents to express their cultural traditions. For example would you permit the performance of an aboriginal smoking ceremony (a form of exorcism) following the death of an aboriginal resident?

Always ❑ Usually ❑ Sometimes ❑ Occasionally ❑ Never ❑

INSTITUTIONAL CONSTRAINTS AND AGED CARE POLICIES MAY ALSO INFLUENCE THE QUALITY OF CARE PROVIDED IN NURSING HOMES.

Q32. To what extent does the design of your building influence the quality of care you deliver?

Please indicate one only

The design of my building

Impedes the delivery of quality care to a very large extent ❑

Impedes the delivery of quality care to a limited extent ❑

Has no influence on the quality of care we deliver ❑

Enhances the delivery of quality care to some extent ❑

Enhances the delivery of quality care to a considerable extent ❑

Q33. To what extent are the grounds or gardens in your facility adequate and secure for resident and staff exercise and relaxation?

Please indicate one only

The grounds and gardens of my facility

Restrict resident and staff exercise and relaxation to a very large extent ❑

Restrict resident and staff exercise and relaxation to some extent ❑

Have no influence on resident and staff exercise and relaxation ❑

Enhance resident and staff exercise and relaxation to some extent ❑

Enhance resident and staff exercise and relaxation to a considerable extent ❑

Q34. What do you consider to be the optimal arrangement for resident bed and bath rooms to achieve high quality of life?

Please indicate one only

Single rooms with ensuite bathrooms ❑

Double/twin rooms with one bathroom between two residents ❑

Three or four beds per room with one bathroom ❑

Bathrooms separate to bedrooms ❑

Q35. In your opinion, does co-location with other services influence quality outcomes for the better?

Yes ❑

No ❑

Q36. In your opinion what is the optimal size nursing home?

Please indicate one

Less than 50 beds ❑

Between 50 and 100 beds ❑

More than 100 beds ❑

Q37. Has the preparation for Certification and Accreditation compromised the quality of the care you can offer your residents?

Yes ❑

No ❑

Q38. Do the inspectorial functions associated with the achievement and maintenance of Commonwealth standards interrupt the delivery of quality care to residents?

Yes ❑

No ❑

Q39. In your opinion, is the communication flow between Government departments and care providers adequate, to ensure facilities are fully informed in a timely manner ?

Yes ❑

No ❑

Q40. Do current funding arrangements adequately meet the needs of facilities to provide high quality care?

Yes ❑

No ❑

Q41. Do you have any problems recruiting registered nurses?

Always ❑ Usually ❑ Sometimes ❑ Occasionally ❑ Never ❑

Q42. Do you have any problems recruiting other categories of staff?

Always ❑ Usually ❑ Sometimes ❑ Occasionally ❑ Never ❑

Q43. In your experience does formal aged care training make a difference to the quality of care provided by staff to residents? Yes No

Q43 (a) If your answer to Q 43 was Yes, please nominate the categories of staff to whom this applies.

RNs with specialist gerontological qualifications ❑

Personal care workers or assistant nurses with TAFE type training ❑

Other, please describe _____

WE WOULD LIKE TO KNOW SOMETHING ABOUT YOU PLEASE.

Q44. Where did you complete your original professional training?

Hospital School of Nursing ❑

University ❑

Other, please describe _____

Q45. If you are hospital trained, have you completed a transition, or conversion course to obtain a university qualification?

Yes ❑

No ❑

Q46. How long have you worked in aged care?

Less than 12 months ❑

Between 1 and 5 years ❑

Between 6 and 10 years ❑

More than 10 years ❑

Q47. Do you have any specialised training or qualifications in aged care?

Yes ❑

No ❑

Q48. Does your employer subsidise your attendance at aged care conferences or seminars?

Yes ❑

No ❑

Q49. What year were your born?

Year ❑

Q50. What is your gender?

Male ❑

Female ❑

Please return your questionnaire in the envelope provided, to reach Lyndall Spencer on or before 31 March 1999.

Thank you very much for your valuable contribution.

Appendix 6

PHASE 2 OF THE *QUALITY OF CARE FOR NURSING HOME RESIDENTS'* PROJECT

(All invitations were presented on Department of Health Studies Letterhead.)

LETTER OF INVITATION TO PARTICIPATE IN THE NATIONAL SURVEY

(These invitations were addressed personally to individuals who had been recruited by phone in advance of the questionnaire being distributed)

Dear Ms/Mr .....

Thank you for taking my recent phone call concerning the national postal survey of aged care facilities in Australia. As I mentioned, the University of New England, in association with partners in the aged care industry, is conducting a study entitled *Quality of Care for Residents,* the aim of which is to develop comprehensive measures and clinical indicators, to identify and monitor quality of care for nursing home residents. A representative sample of 400 Commonwealth funded nursing homes has been developed with assistance from the Australian Bureau of Statistics, and your facility has been selected from these.

My purpose in writing to you is to invite you to participate in the project as one of the national survey respondents. The advantages of being involved in the study include the opportunity to make a major contribution to the quality of care for residents in aged care across the country. In addition, your facility will be one of the benchmark organisations on which the new standards of quality care indicators will be founded. Further, as part of an industry sponsored project, you will have the satisfaction of co-operating with your colleagues to enhance the standing of your industry in the community, through research based practice.

The role you can play is to complete the enclosed questionnaire, which the pilot study suggests will take between 10 and 15 minutes, place it in the reply paid envelope, and return it to me by (*specified date).* All information will remain completely confidential, and neither your organisation, nor you as an individual, will be identified in any way in the results.

The project has the approval of the University's Human Research Ethics Committee, which may be contacted at the following address:

The Secretary
Human Research Ethics Committee
Research Services
University of New England
Armidale NSW 2351
Phone: 067 732 352; Fax: 067 733 543

Should you have any questions concerning the study, please contact:

Associate Professor Victor Minichiello
Head of the Department of Health Studies,
University of New England
Armidale NSW 2351
Phone: 067 733952; Fax 067 733 666

Or

Lyndall Spencer
Department of Health Studies, University of New England
Armidale NSW 2351
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I look forward to your reply, and thank you in anticipation for your support for this project.

Yours sincerely

LYNDALL SPENCER
Investigator

Enc.

Appendix 7

FREQUENCY DISTRIBUTIONS OF ALL RESPONSES TO THE NATIONAL SURVEY (N = 208)

Q 1. What description best applies to your residential service?

TYPE	N	%
Stand alone nursing home	110	53.9
Nursing home co-located with hostel only	25	12.3
Nursing home co-located with independent living units only (ILUs)	5	2.5
Nursing home co-located with hostel and ILUs	39	19.9
Other	25	12.3
Missing values	4	

Q 2. What description best applies to the proprietorship of your facility?

TYPE	N	%
Private for profit	87	42.6
Not-for-profit church home	44	21.6
Not-for-profit community/charitable home	46	22.5
State government or ATSIC home or long stay unit attached to hospital	23	11.3
Other	4	2.0
Missing values	4	

Q 3. What is the postcode of your facility?
There were 195 different answers to this question.

Q 4. How many approved beds does your facility contain?

Permanent beds: Mean 62 beds, Median 48 beds, Mode 30 beds,
Min. 10 beds, Max. 580 beds,
Missing values 8.

Respite beds: 0 respite beds = 121 homes, 1 respite bed = 41 homes,
2 respite beds = 27 homes, 3 respite beds = 10 homes,
4 respite beds = 1 home, 5 respite beds = 2 homes,
6 respite beds = 2 homes, 10 respite beds = 1 home,
Missing values = 3.

Other beds: 0 other beds = 193, 1 other bed = 2, 2 other beds = 2.
Eleven other homes had non-approved beds,
which ranged from 3 to 64 in number.

Q 5. How many residents are in your home?

High Care — Mean 49.8, Median 40, Mode 30,
Min. 2 high care residents, Max. 260 high care residents,
Missing values = 6.

Low Care — Mean 13.7, median 0, mode 0,
Min. 0 low care residents, Max. 320 low care residents.

Q 6. What was your occupancy rate in 1998?

Mean = 97.8%, Median = 99%, Mode = 99%,
Min. 24%, Max. 100%,
Missing values = 20.

Q 7. Within your overall bed total, do you have any specialised services?

Dementia beds: Yes = 88 (42.7%), No = 109 (52.9%), Missing values = 11,
Rehab/Palliative: Yes = 37 (17.9%), No = 151 (73.1%), Missing values = 20.

Q 8. What is the ethnic background of the majority of your residents?

RESIDENTS COUNTRY OF ORIGIN	N	%
Predominantly Anglo Celts residents	178	88
Predominantly Aboriginal or Torres Straight Islander residents	1	0.5
Predominantly European, Mediterranean or Arabic residents	8	4.0
Predominantly Asian residents	Nil	
Residents of mixed ethnic origins	15	7.5
Missing values	6	

Q 9. Has your building received Commonwealth certification?

ANSWER	N	%
Yes	193	94.1
No	12	5.9
Missing values	3	

Q 10. Has your building received Commonwealth accreditation?

ANSWER	N	%
Yes	7	3.5
No	192	96.5
Missing values	9	

(It should be recalled that this survey was conducted in January and February 1999. All facilities must be accredited by 1 January 2001 because Commonwealth subsidies for the unaccredited homes will cease on that date.)

Q 11. Has your facility adopted a quality assurance program such as ISO 9000 or ACHS/EQUIP?

ANSWER	N	%
Yes	113	56.5
No	87	43.5
Missing values	8	

Q 12. How many registered nurses do you employ?

Full time: Mean = 2.3 RNs, Median = 2, Mode = 1,
Min. = 0, Max. = 32,
23% of respondent homes employ no full time RNs.

Part time: Mean = 11.2, Median = 9, Mode = 8,
Min. = 1, Max. = 96,
Missing values = 12.

Q 13. How many enrolled nurses, personal care workers, and assistant nurses do you employ?

Full time: Mean = 3.2, Median = 3, Mode = 2,
Min. = 0, Max. = 60.

Part time: Mean = 29.1, Median = 25, Mode = 30,
Min. = 1, Max. = 167,
Missing values = 18.

Q 14. How many environmental services personnel do you employ?

Part time: Mean = 15.25, Median =13.5, Mode = 10 & 20,
(there were two equal peaks in this analysis),
Min. = 2, Max. = 72,
Missing values = 30.

None of the respondent homes employed environmental services personnel on a full time (38 hours per week) basis.

Q 15. On what basis do you employ the following personnel?

THERAPIST	FULL TIME	PART TIME	SESSIONS	CASUAL	NIL
Physiotherapist *	3	76	83	27	3
Occupational therapist	7	43	24	23	64
Podiatrist	1	29	130	27	4
Activities officers	50	99	4	5	3
Hair dresser	1	28	49	20	60
Alternative therapies	1	28	49	20	60

- 12 homes employ physios in more than one capacity eg 1 ft and 1 pt
- 16 homes did not answer this question in regard to physiotherapists
- 71 homes did not answer this question in regard to occupational therapists
- 11 homes did not answer this question in regard to podiatrists
- 47 homes did not answer this question in regard to activities officers
- 22 homes did not answer this question in regard to hairdressers
- 50 homes did not answer this question in regard to alternative therapists.

Q 16. What is your staff turnover rate?

RATE	N	%
1 – 5%	131	66.5
6 – 10%	46	23.4
11 – 20%	18	9.1
> 20%	2	1.0
Missing values	11	

Q 17. Approximately what percentage of your RNs has completed or is undertaking university qualifications?

Mean = 19%, Median = 10%, Mode = 10%,
Min. = 0%, Max. = 100% (2 homes claimed 100%),
Missing values = 141.

Q 18. Approximately what percentage of your RNs has undertaken some gerontology training?

Mean = 16%, Median = 10%, Mode = 10%,
Min. = 0%, Max. = 100% (3 homes claimed 100%),
Missing values = 156.

Q 19. Approximately what percentage of your personal care or assistant nurse staff has completed any formal training such as a TAFE course?

Mean = 44.7%, Median = 40%, Mode = 30%,
Min. = 0%, Max. = 100% (2 homes claimed 100%).

Q 20. How many hours of in-service training is your nursing staff required to complete each year?

RN Hours: Mean = 20.8, Median = 16, Mode = 12,
Min. = 2, Max = 100 (4 homes claimed 100 in service hours).

Other care staff: Mean = 19.1, Median = 12, Mode = 12,
Min = 2, Max = 100, (3 homes claimed 100 in-service hours).

Q 21. Do you routinely collect data on the following topics, and if so how frequently?

INDICATOR	YES %	NO %	DAILY %	WEEK %	MONTH %	YEARLY %
Pressure ulcer rates	68.0	32.0	22.4	8.6	62.1	6.9
Incontinence rates	73.5	26.5	16.3	8.1	63.7	11.9
Infection rates	79.8	20.2	11.7	9.1	74.7	4.5
Skin integrity	77.5	22.5	30.8	8.9	53.4	6.8
Medication errors	92.9	7.1	21.4	11.5	61.0	6.5
Resident fall rates	94.1	5.9	22.1	5.8	66.8	5.3
Resident accidents / incidents	97.5	2.5	23.4	5.6	67.5	3.6
Resident restraint rates	68.0	32.0	23.6	5.7	63.4	7.3
Staff / visitor Accidents / incidents	93.0	7.0	19.4	3.8	70.4	6.5

Q 22. Why do you start collecting statistics on a routine basis?

REASON FOR COLLECTING	N	%
Government regulation	30	15.8
High incidence of events	8	4.2
Issues with potential legal ramifications	11	5.8
Current research interests of staff or management	46	24.2
Other reasons	95	50.0
Missing values	18	

Q 23. When a problem is detected, eg increased medication errors, do you instigate a monitoring program?

MONITORING	N	%
Yes	192	96
No	8	4
Missing values	8	

Q 24. Recognising that each situation will vary, in general how long would you continue to monitor a recently detected problem, before you take preventive action?

HOW LONG MONITORED	N	%
1 week	116	59.5
1 month	65	33.3
2-5 months	10	5.2
6-11 months	1	0.5
1 year or more	3	1.5
Missing values	13	

Q 25 & 26. Which of the following programs do you routinely offer individual residents who need or want them, and how regularly are these programs monitored?

PROGRAMS	YES %	NO %	WEEKLY %	MONTHLY %	QUARTER %
Activities outside the home	87.1	12.9	11.6	45.3	43.0
Bowel management program	99.0	1.0	30.4	51.5	18.0
Community volunteer program	86.4	13.6	10.5	22.8	66.0
Continence management	100.0	Nil	24.1	57.4	17.9
Falls management	87.4	12.6	23.8	56.5	19.6
Family participation	98.0	2.0	15.2	38.0	46.7
Hydration management	85.6	14.4	40.1	40.7	19.1
Medication regimen review	94.1	5.9	13.2	45.5	40.7
Pressure care program	94.5	5.5	39.2	44.8	16.0
Support for spiritual well-being	90.5	9.5	19.8	36.7	43.5

Q 27. Does your facility have a formal written policy to aid quality control in the following areas?

AREA	YES	%	NO	%	DON'T KNOW	%
Complaints procedure	198	97.5	4	2.0	1	0.5
Emergency procedure	197	97.0	5	2.5	1	0.5
Family participation	154	78.6	41	20.9	1	0.5
Food preparation	175	88.0	19	9.5	5	2.5
Food presentation	156	79.6	33	16.8	7	3.6
Infection control	189	94.5	11	5.5	Nil	Nil
Laundry procedures	168	84.8	25	12.7	5	2.5
Manual handling	189	93.6	12	5.9	1	0.5
Privacy	189	93.6	12	5.9	1	0.5

Q 28. Which of the following strategies do you use to measure resident satisfaction?

AREA	YES	%	NO	%	DON'T KNOW
Consultations with individual residents	192	98.0	4	2.0	Nil
Regular consultations with Residents' Committee	184	93.9	12	6.1	Nil
Resident surveys on a regular basis	150	78.5	40	21.0	1 (0.5%)
Suggestion box or similar device	143	75.7	46	24.3	Nil
Family feedback	198	99.0	2	1.0	Nil

- 12 homes did not answer the question about consultations with individual residents
- 12 homes did not answer the question about consultations with residents' committees
- 17 homes did not answer the question about surveys
- 19 homes did not answer the question about devices
- 8 homes did not answer the question about family feedback

Q 29. Are protocols to measure resident satisfaction incorporated into formal guidelines such as your management plan or similar documents?

WRITTEN PROTOCOLS	N	%
Yes	149	74.1
No	52	25.9
Missing values	7	

Q 30. Does your organisation have a formal policy to support cultural sensitivities in, for example, your Mission Statement or Strategic Plan?

FORMAL POLICY	N	%
Yes	146	72.0
No	57	28.0
Missing values	5	

Q 31. Do you as an individual, encourage residents to express their cultural traditions?

SUPPORT CULTURAL PRACTICES	N	%
Always	122	61.9
Usually	50	25.4
Sometimes	14	7.1
Occasionally	8	4.1
Never	3	1.5
Missing values	11	

Q 32. To what extent does the design of your building influence the quality of care you deliver?

DESIGN OF MY BUILDING	N	%
Impedes the delivery of quality care to a very large extent	32	15.6
Impedes the delivery of quality care to a limited extent	66	32.2
Has no influence on the quality of care we deliver	33	16.1
Enhances the delivery of quality care to some extent	36	17.6
Enhances the delivery of quality care to a considerable extent	38	18.5
Missing values	3	

Q 33. To what extent are the grounds or gardens in your facility adequate and secure for resident and staff exercise and relaxation?

GROUNDS AND GARDENS	N	%
Restrict resident and staff exercise and relaxation to a large extent	19	9.3
Restrict resident and staff exercise and relaxation to a limited extent	42	20.5
Have no influence on resident and staff exercise and relaxation	14	6.8
Enhance resident and staff exercise and relaxation to some extent	66	32.2
Enhance resident and staff exercise and relaxation to a considerable extent	64	31.2
Missing values	3	

Q 34. What do you consider to be the optimal arrangement for resident bed and bath rooms to achieve high quality of life?

BED AND BATH ROOMS	N	%
Single rooms with en suite bathrooms	107	52.5
Double/twin rooms with one bathroom between two residents	74	36.3
Three or four beds per room with one bathroom	9	4.4
Bathrooms separate to bed rooms	14	6.8
Missing values	4	

Q 35. In your opinion, does co-location with other services influence quality outcomes for the better?

CO-OOCATION	N	%
Yes	154	79
No	41	31
Missing values	13	

Q 36. In your opinion, what is the optimal size nursing home?

OPTIMAL SIZE	N	%
Less than 50 beds	106	52.2
Between 50 and 100 beds	91	44.8
More than 100 beds	6	3.0
Missing values	5	

Q 37. Has the preparation for Certification and Accreditation compromised the quality of the care you can offer your residents?

COMPROMISED	N	%
Yes	53	26
No	151	74
Missing values	4	

Q 38. Do the inspectorial functions associated with the achievement and maintenance of commonwealth standards interrupt the delivery of quality care to residents?

INTERRUPT	N	%
Yes	53	26
No	151	74
Missing values	4	

Q 39. In your opinion, is the communication flow between Government departments and care providers adequate, to ensure facilities are fully informed in a timely manner?

INFORMED	N	%
Yes	68	33.3
No	136	66.7
Missing values	4	

Q 40. Do the current funding arrangements adequately meet the needs of facilities to provide high quality care?

ADEQUATE FUNDS	N	%
Yes	30	15.2
No	168	84.8
Missing values	10	

Q 41. Do you have any problems recruiting registered nurses?

RN RECRUITMENT DIFFICULTIES	N	%
Always	47	23.0
Usually	43	21.1
Sometimes	66	32.4
Occasionally	27	13.2
Never	21	10.3
Missing values	4	

Q 42. Do you have any problems recruiting other categories of staff?

NON RN RECRUITEMENT DIFFICULTIES	N	%
Always	8	3.9
Usually	23	11.3
Sometimes	81	39.9
Occasionally	41	20.3
Never	50	24.6
Missing values	5	

Q 43. In your experience, does formal aged care training make a difference to the quality of the care provided by staff to residents?

TRAINING AND QUALITY	N	%
Yes	186	91.2
No	18	8.8
Missing values	4	

Q 44. Where did you complete your professional training?

PROFESSIONAL TRAINING	N	%
Hospital School of Nursing	184	90.6
University	16	7.9
Other	3	1.5
Missing values	5	

Q 45. If you are hospital trained, have you completed a transition or conversion course to obtain a university qualification?

UNIVERSITY TRANSITION	N	%
Yes	96	51.3
No	91	48.7
Missing values	21	

Q 46. How long have you worked in aged care?

LENGTH IN YEARS	N	%
Less than 12 months	5	2.4
Between 1 and 5 years	30	14.6
Between 6 and 10 years	33	16.2S
More than 10 years	137	66.8
Missing values	3	

Q 47. Do you have any specialised training or qualifications in aged care?

SPECIALISED TRAINING	N	%
Yes	134	66.0
No	69	34.0
Missing values	5	

Q 48. Does your employer subsidise your attendance at aged care conferences or seminars?

SUBSIDISED	N	%
Yes	172	86.0
No	28	14.0
Missing values	8	

Q 49. What year were you born?

The average age of informants was 50 years, with two being born in 1934 (65 years) and one born in 1975 (24 years). The most frequently occurring birth year was 1953.

Q 50. What is your gender?

GENDER	N	%
Male	25	12.3
Female	179	87.7
Missing values	4	

Appendix 8

RESIDENT CLASSIFICATION SCALE

(Department of Health and Family Services, 1998)

QUESTION WEIGHTINGS

The weightings that apply to each question on the Resident Classification Scale are:

NUMBER	QUESTION	RESPONSE WEIGHTINGS			
		A	B	C	D
1	Communication	0.00	0.28	0.36	0.83
2	Location change	0.00	1.19	1.54	1.82
3	Meals and drinks	0.00	0.67	0.75	2.65
4	Personal Hygiene	0.00	5.34	14.17	14.61
5	Toileting	0.00	5.98	10.65	13.70
6	Bladder management	0.00	2.22	3.822	4.19
7	Bowel management	0.00	3.32	5.72	6.30
8	Understanding & undertaking living activities	0.00	0.79	1.11	3.40
9	Problem wandering or intrusive behaviour	0.00	0.80	1.58	4.00
10	Verbally disruptive or noisy	0.00	1.19	1.75	4.60
11	Aggressive physically	0.00	2.34	2.69	3.05
12	Emotional dependence	0.00	0.28	1.50	3.84
13	Danger to self or others	0.00	1.11	1.54	1.98
14	Other behaviour	0.00	0.91	1.82	2.61
15	Social and human needs – care recipient	0.00	0.95	1.98	3.01
16	Social and human needs – family and friends	0.00	0.28	0.55	0.91
17	Medication	0.00	0.79	8.55	11.40
18	Technical & complex nursing procedures	0.00	1.54	5.54	11.16
19	Therapy	0.00	0.71	1.46	2.93
20	Other services	0.00	0.71	1.46	2.93

THE RANGE OF POINTS FOR EACH CATEGORY

The total score of the 20 questions allocates the resident to a funding category ranging from 1, being the highest, to 8, being the lowest. The range of points for each funding category is:

Greater than 81.01 points	Level 1
69.61 to 81.00 points	Level 2
56.01 to 69.60	Level 3
50.01 to 56.00	Level 4
39.81 to 50.00	Level 5
28.91 to 38.80	Level 6
10.61 to 28.90	Level 7
0 to 10.60	Level 8

QUESTION 1. COMMUNICATION

This question refers to the degree of assistance that the care recipients need in communicating with staff, relatives and friends, and other care recipients for whatever reason. It measures the additional effort taken by staff to facilitate effective communication where care recipients have:

- Hearing loss not remedied by aids (or where there is resistance to the use of an aid);
- Visual impairment, not remedied by spectacles or contact lenses;
- Speech impairments;
- Language difficulties (for example, care recipients with little or no English proficiency who do not live in their ethno-specific environment); and
- Comprehension problems, which contribute to communication difficulties.

It also takes into account the effort involved in cleaning and fitting hearing aids, spectacles and lenses.

If the care recipient has no difficulty with communication, record A.
Where a care recipient requires assistance with cleaning and fitting aids, record B.
Where facility staff are required to spend additional time listening, speaking slowly and clearly, encouraging a care recipient to communicate or occasionally use non-verbal cues, record C.
Where a care recipient requires assistance with communication from facility staff on almost all occasions to communicate by translating or interpreting, or non verbally – for example, signing or using communication aids, including talking boards or computers, record D.

QUESTION 1. COMMUNICATION

RATING	VALUE	COMMUNICATION
No difficulty	A	Requires no assistance
Some difficulty	B	Requires assistance with cleaning and fitting of aids
Major difficulty	C	Requires additional time listening, speaking slowly and clearly, encouraging communication or occasionally using non-verbal cues
Extensive difficult	D	Requires assistance to communicate by translating or interpreting OR Requires communication by non-verbal means on almost all occasions

Questions 2 to 8 relate to independence in the activities of daily living

QUESTION 2. MOBILITY

This question refers to the degree of assistance required by a care recipient with regard to mobility. This includes:

- Assistance with walking, on a one-to-one basis, including the provision of supervision, encouragement or physical support;
- Assistance in the use of mobility aids, including wheel chairs, and walking frames; and
- Assistance with moving to and from chairs, wheelchairs, beds or toilets.

Moving care recipients to and from beds and chairs etc. is covered in this question. Extensive manual handling for maintenance of skin integrity, for example, frequent changing of the position of a chair fast or bed fast care recipient, is covered in Question 18.

If the care recipient usually changes location independently, record A. If the care recipient requires assistance from staff for transfers or if the care recipient needs to be accompanied or supervised when walking, record B. Supervision includes escorting and directing for purposeful mobility. If a care recipient is unable to walk, self-wheels or is wheeled by staff, and has no other assistance needs meriting a D rating, record B.

If the care recipient requires assistance from staff for transfers and also needs to be accompanied or supervised when walking, record C. Where a care recipient does not need to be accompanied or supervised when walking except over wet patches on, say, a bathroom floor, this would be insufficient to satisfy the requirements for a C rating.

If the care recipient requires considerable assistance or encouragement from staff in order to maintain mobility, record D.

If the care recipient requires staff to use lifting equipment, including lifting straps, to assist with location change or, where the use of lifting equipment is not feasible, more than two staff would be required for transfer, record D.

QUESTION 2. MOBILITY

RATING	VALUE	MOBILITY
No assistance	A	Usually independent
Some assistance	B	Requires assistance from staff for transfers; OR Needs to be accompanied or supervised when walking
Major assistance	C	Requires assistance from staff for transfers AND needs to be accompanied or supervised when walking
Extensive assistance	D	Requires major assistance (as above) and encouragement from staff in order to maintain mobility; OR Requires lifting equipment for transfers

QUESTION 3. MEALS AND DRINKS

This question refers to the degree of assistance that the care recipient requires with eating and drinking.

If the care recipient eats and drinks independently, only requiring observation, record A.

The clinical nursing aspects of tube feeding are covered in question 18.

In this question:

Limited Individual Assistance means setting up to enable the care recipient to then manage independently. This may include some prompting but no other assistance.

Individual Assistance means prompting and assisting with eating for some elements of the meal, for example, starting or finishing off the meal.

One-to-one Individual Assistance means one to one individual assistance with eating and drinking. This means full assistance with eating or encouraging the care recipient to maintain independent function.

QUESTION 3. MEALS AND DRINKS

RATING	VALUE	MEALS & DRINKS
No assistance or not applicable	A	Eats and drinks independently, observation only.
Some assistance	B	Requires limited individual assistance.
Major assistance	C	Requires individual assistance with eating or drinking.
Extensive assistance	D	Requires one to one individual assistance with all meal time activities

QUESTION 4. PERSONAL HYGIENE

This question refers to the degree of assistance that the care recipient requires with showering, and washing, dressing and undressing and personal hygiene, including all grooming activities and the routine application of moisturisers for dry skin.

If the care recipient attends to his/her personal hygiene independently, record A.

If the care recipient has difficulty with these activities and requires staff to spend time to enable him/her to shower and wash, dress and undress and complete his/her grooming, record B, C, or D depending on the degree of assistance given.

In this question, where staff are required to encourage or persuade the care recipient on a one-to-one basis to optimise self care function, record D. This includes where a care recipient requires extensive support to enable him/her to be able to see to his/her personal hygiene requirements.

When two staff are required to carry out most activities, record D.

Requires Assistance with Some Activities means that the care recipient is able to shower or wash self, under supervision or to complete some activities without assistance but requires limited help with others, for example, fastening buttons, cleaning teeth, putting on shoes.

Requires Staff to Carry Out Most Activities means that the care recipient can only complete limited aspects of personal hygiene, for example, washing face or hands or combing hair, and staff complete the rest of the tasks associated with personal hygiene.

Optimise Self Care means that the care recipient is as independent as is practicable in seeing to his/her own personal hygiene requirements.

QUESTION 4. PERSONAL HYGIENE

RATING	VALUE	PERSONAL HYGIENE
No assistance	A	Attends to personal hygiene independently
Some assistance	B	Requires assistance with some activities
Major assistance	C	Requires 1 staff to carry out all activites
Extensive support	D	Requires staff to encourage or persuade the care recipient on a one-to-one basis to optimise self care function OR Requires 2 staff to carry out most activities

QUESTION 5. TOILETING

This question refers to the degree of assistance that the care recipient requires to use a toilet. This includes any kind of toilet such as a commode, urinal, bedpan, or continence sheet (kylie or bluey) used for a planned episode of evacuation of the bowel or bladder.

This question covers the interventions requires to assist the care recipient to

- Use the toilet
- Attend to personal hygiene related to the toileting function; and
- Adjust clothing.

If the care recipient attends to toileting independently or if the care recipient cannot use any kind of toilet, record A.

Note that care of catheters and colostomies are covered in question 18. However, toileting aspects associated with a care recipient who has a catheter or a stoma bag, for example, emptying drainage bags, personal hygiene and adjusting clothing, are covered in this question. When assessing ability to use the toilet, do not include location change, which is assessed in question 2.

For a care recipient with a catheter or a colostomy, emptying a drainage bag and the associated adjustment of clothing and attending to personal hygiene, record B.

Setting up means preparing the care recipient who then uses the toilet and attends to personal hygiene. It may require positioning of the care recipient on the toilet.

Some Assistance means minor adjustment of clothing.

Major Assistance means that staff spend time and effort in encouraging and persuading the care recipient to be independent as far as he/she is able, rather than staff undertaking the activities.

Extensive Assistance means staff are required to carry out all activities related to the toileting process.

QUESTION 5. TOILETING

RATING	VALUE	TOILETING
No assistance	A	Attends to toileting independently or cannot use any kind of toilet
Some assistance	B	Requires setting up and some assistance
Major assistance	C	Requires staff to encourage and persuade care recipient to optimise self care function
Extensive assistance	D	Requires staff to carry out all functions.

QUESTION 6. BLADDER MANAGEMENT

This question relates to continence of urine and maintenance of continence of urine and the reduction of incontinence. If the care recipient maintains continence independently and needs no program to remain continent, record A. If the care recipient is able to remain continent of urine or have incontinence reduced, only because of the care provided by the staff, record B, C, or D. Where a care recipient would be occasionally incontinent and his/her continence is supported by prompting only, or using continence aids, record B. Where a care recipient is frequently incontinent and this cannot be improved by a continence program and continence aids such as pads, or urinary drainage systems are used at all times and are the only procedures used, record C. Where a care recipient would be frequently incontinent, but his/her continence level is optimised through an individualised continence program, record D.

A continence program is based on an individualised assessment of the continence state, with planning, implementation and evaluation guidelines. A program means more interventions than pads only, or prompting only – for example maintaining adequate fluid intake, bladder retraining, habit training, or scheduled toileting, and be drawn from information in the care recipient's continence assessment.

Prompting means reminding care recipient to go to the toilet.
Bladder Retraining means progressive lengthening or shortening of toileting intervals.
Habit Training means using a flexible toileting schedule based on care recipient's pattern of incontinence. Reinforcement techniques may be used.
Scheduled Toileting means toileting to a fixed schedule while care recipient is awake.
Occasionally incontinent means once a day or less.
Frequently incontinent means twice or more a day.

QUESTION 6. BLADDER MANAGEMENT

RATING	VALUE	BLADDER MANAGEMENT
Not applicable	A	Continent of urine
Some support	B	Would be occasionally incontinent but continence supported by prompting only, OR Wears external continence aids occasionally
Major support	C	Wears incontinence aids at all times related to frequent incontinence that cannot be improved by a continence program, OR Incontinent but, for behavioural or other reasons cannot use continence aids
Extensive support	D	Would be frequently incontinent but has an individualised continence program in place to optimise continence level

QUESTION 7. BOWEL MANAGEMENT

This question relates to continence of faeces and maintenance of continence of faeces and the reduction of incontinence. Stoma care (including colostomy care) is covered in question 18. Routine emptying of colostomy drainage bags, personal hygiene and adjustment of clothing are covered in question 5. If the care recipient maintains continence of faeces independently and needs no program to remain continent, record A. If the care recipient is able to remain continent of faeces, or have incontinence reduced, only because of the care provided by the staff, record B, C, or D. If appropriate appliances such as pads are the only procedure used, record B. If the care recipient is on a bowel management program for the prevention of constipation, record C.

A **bowel management program** includes monitoring and recording bowel activity, and may include any or all of the following: maintaining adequate fluid intake, laxatives and aperients, stool softeners or fibre supplements, high fibre diet, suppositories, or enemas, exercise or massage. If the care recipient would usually be incontinent but has an individualised continence program in place to optimise his/her continence level, record D. For this care recipient, a bowel management program may also be in place. A **continence management program** is based on an individualised assessment of the continence state, with planning, implementation and evaluation guidelines. A program means more interventions than pads only, or prompting only – for example, individualised habit training or scheduled toileting, and be drawn from information in the care recipient's continence assessment.

Prompting means reminding care recipient to go to the toilet.
Habit Training means using a flexible toileting schedule based on care recipient's pattern of incontinence. Reinforcement techniques may be used.
Scheduled Toileting means toileting to a fixed schedule while care recipient is awake.

QUESITON 7. BOWEL MANAGEMENT

RATING	VALUE	BOWEL MANAGEMENT
Not applicable	A	Continent of faeces
Some support	B	Wears continence aids at all times related to frequent incontinence that cannot be improved by a continence program
Major support	C	Constipation is prevented or continence level maintained by a bowel management program
Extensive support	D	Would usually be incontinent but has an individualised continence management program in place to optimise continence level

QUESTION 8. UNDERSTANDING AND UNDERTAKING LIVING ACTIVITES

This question relates to the care recipient's ability to remember, understand, plan for, initiate and perform general living activities, and to react appropriately to information provided.

If the care recipient has no difficulty with understanding and undertaking living activities, record A. If the care recipient requires staff to assist him/her to remember, understand, plan for, initiate and perform activities such as deciding whether or not and when to initiate activities such as eating drinking, grooming and personal hygiene, or with whom to initiate social interaction, record B, C, or D, according to the level of support required.

If the care recipient needs cues and reminders to understand and react appropriately, and can do so for a short period, record B.

If the care recipient has major difficulty remembering and understanding information, and requires frequent repetition and reminding to undertake and complete most activities, record C.

If a care recipient cannot remember and understand information and needs to be assisted to perform all living activities, or is unable to respond to any prompts for physical or cognitive reasons, record D.

QUESTION 8. UNDERSTANDING AND UNDERTAKING LIVING ACTIVITIES

RATING	VALUE	UNDERSTANDING & UNDERTAKING
No difficulty	A	Understands and undertakes living activities independently
Some difficulty	B	Needs cues or prompting to initiate, undertake or complete living activities
Major difficulty	C	Has major difficulty ascertaining, initiating, undertaking or completing most living activities and requires repetition and reminding
Extensive difficulty	D	Cannot undertake living activities and needs to be shown or have explained every time, OR Unable to respond to any prompts

BEHAVIOUR

This section, which contains Questions 9 to 14, relates to a care recipient's care needs ***in addition to support for daily living activities*** caused by the care recipient's behaviour.

Ratings are related to staff time and effort in overcoming or reducing the impact of the behavioural problems. Ratings should be based on interventions implemented to prevent or reduce this occurrence. Examples of interventions are vigilant observation, mechanisms to distract the care recipient at times or in circumstances where there is an assessed risk of the behaviour occurring or special behavioural programs. The interventions should be individually tailored for the resident.

The need for the intervention must previously have been determined during assessment and recorded as needing monitoring (for B), or monitoring and supervision (for C or D). Interventions are designed to prevent recurrence or reduce the level of the behaviour.

If the care recipient has no behavioural problems, record A for these questions.

Where a resident requires monitoring because of irregular and short-lived occurrences of the behaviour and the interventions are required to be implemented only for these occurrences, record B.

Where interventions are implemented for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C.

When supervision and intervention is required daily, record D.

Monitoring means being aware of the circumstances in which the care recipient has engaged in the behaviour in the past, and observing the care recipient to be aware when similar circumstances occur, so that the appropriate intervention may be taken to prevent the recurrence of the behaviour.

Supervision means ensuring that specific situations or triggers that are likely to give rise to the behaviour do not occur, or are managed in ways to minimise the likelihood of occurrence.

Daily means during a 24 hour period.

An example of monitoring only, and therefore a B rating, is when a care recipient becomes agitated during stormy weather. The staff would be aware when stormy weather occurred or was forecast and take special care during that time to reassure and calm the care recipient until the stormy weather passed. There is little likelihood of the need for an intervention beyond the duration of the storm.

An example of monitoring for recurrence and then supervision on less than a daily basis, and therefore a C rating, is when a care recipient becomes physically aggressive after being visited by a particular relative. The care recipient may need supervision after the departure of the relative, but after a few days the need for supervision would be reduced until it was not required until the next visit.

QUESTION 9. PROBLEM WANDERING OR INTRUSIVE BEHAVIOUR

This question relates to the care recipient wandering, absconding or, while wandering, interfering with other people or their belongings. This may include a care recipient who makes repeated attempts to leave the facility or someone who goes uninvited into any areas within or outside the facility where his/her presence is unwelcome or inappropriate – for example, kitchens or other residents' rooms. It may also include someone who wanders into areas resulting in staff spending time seeking, finding, and guiding the person back to his/her proper location, or someone who goes into another room and takes things from draws or cupboards.

Note that this question does not cover circumstances where a care recipient through verbal disruption, noisiness or physical aggression, interferes with or disrupts other persons in the facility. These are covered in questions 10 and 11.

Monitoring the behaviour of all care recipients, as a matter of course, to ensure they do not wander into other residents' rooms or interfere with others or their belongings would not justify a rating other than A. However, a B, C, or D rating would be justified where a care recipient, for example, has previously been assessed as having wandered into other care recipients' rooms causing a disturbance or taking items not belonging to him/her. The rating would therefore be appropriate when there is a likelihood of recurrence, and staff are required to observe the care recipient and to put in place an intervention to prevent him/her from wandering into someone else's room. A D rating would be appropriate where a care recipient is assessed as being likely to wander or interfere with others or others' belongs at any time of the day or night (this behaviour would have been documented previously) and an intervention is in place to manage this potential occurrence.

When a resident requires monitoring because of occasional, irregular and short-lived occurrences of behaviour and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, Supervision, and Daily are defined according to the criteria above.

QUESTION 9. PROBLEM WANDERING OR INTRUSIVE BEHAVIOUR

RATING	VALUE	PROBLEM WANDERING
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESTION 10. VERBALLY DISRUPTIVE OR NOISY

This question includes abusive language and verbalised threats directed at a care recipient, visitor or member of the staff. It also includes a care recipient who indulges in behaviour that causes sufficient noise to disturb other people. That noise may be either, or a combination of both, vocal or non-vocal noises, such as rattling furniture or other objects. The rating should be

based on the effort required to put in place interventions that are taken to prevent this potential recurrence.

Monitoring the language of all care recipients, as a matter of course would not justify a rating other than A. However a B, C, or D rating would be justified where a care recipient has been assessed previously as having been verbally disruptive, for example, around meal times, requiring staff to ensure that he/she is attended in the manner most likely to avoid or reduce this outcome.

The rating would not be justified merely because all metallic items that can be clanged together have been removed. The rating would be appropriate where a care recipient has previously been assessed as, for example, making significant degrees of noise and the objects used to create that noise are modified by staff intervention to reduce the degree of noise created.

Where a resident requires monitoring because of occasional, irregular and short-lived occurrences of the behaviour and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, supervision and daily are defined according to criteria outlined above.

QUESTION 10. VERBALLY DISRUPTIVE OR NOISY

RATING	VALUE	VERBAL DISRUPTION & NOISE
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESITON 11. PHYSICALLY AGGRESSIVE

This question includes any physical conduct that is threatening and has the potential to harm a care recipient, visitor or member of staff. It includes, but is not limited to, hitting, pushing, kicking or biting. The rating should be based on the effort required to put in place interventions that are taken to prevent its potential recurrence.

The need for the intervention must previously have been determined during assessment and recorded as needing monitoring (for B), or monitoring and supervision (for C or D). Interventions are designed to prevent recurrence or reduce the level of the behaviour.

Monitoring the behaviour of all care recipients, as a matter of course would not justify a rating other than A. However a B, C, or D rating would be justified where a care recipient has been assessed previously as having been physically disruptive, for example, around bed times, requiring staff to implement interventions. The rating would also be appropriate if an intervention was put in place to modify the behaviour of the care recipient at times or in circumstances where there is a higher risk of physical aggression.

Where a resident requires monitoring because of occasional, irregular and short-lived occurrences of the behaviour and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, supervision and daily are defined according to criteria outlined above.

QUESTION 11. PHYSICAL AGGRESSION

RATING	VALUE	PHYSICAL AGGRESSION
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESTION 12. EMOTIONAL DEPENDENCE

This question is limited to the following behaviours:

- Active and passive resistance other than physical aggression;
- Attention seeking;
- Manipulative behaviour; and
- Withdrawal.

This question does not relate to group activities which are covered in question 15.

It applies to one-on-one interventions required to respond to, manage and alleviate demanding behaviours or resistance to other necessary care activities. Such interventions might include considerable additional personal attention to calm the care recipient after visitors depart, or carefully scheduled activities designed to distract the care recipient when he/she is at a particular risk of adopting these behaviours. The rating should be based on the effort required to implement the interventions to prevent the potential recurrence of the behaviour. It also applies to one-on-one interventions to manage withdrawal or depression.

The need for the intervention must previously have been determined during assessment and recorded as needing monitoring (for B), or monitoring and supervision (for C or D). Interventions are designed to prevent recurrence or reduce the level of the behaviour.

Where a resident requires monitoring because of occasional, irregular and short-lived occurrences of the behaviour, and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, supervision and daily are defined according to criteria outlined above.

QUESTION 12. EMOTIONAL DEPENDENCE

RATING	VALUE	EMOTIONAL DEPENDENCE
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESTION 13. DANGER TO SELF OR OTHERS

This question covers high risk behaviour which includes behaviour requiring supervision or intervention and strategies to minimise the danger. Examples of such behaviour include unsafe smoking habits, walking without required aids, leaning out of windows, self-mutilation and suicidal tendencies.

This question is about behaviour and does not apply where a care recipient has a medical condition that might lead to injury, for example, through fitting or loss of consciousness. It does not apply to a range of behaviours which might in the longer term be considered as damaging, or health reducing, such as smoking generally or non compliance with a special diet. It applies where there is an imminent risk of harm. The question excludes acts of physical aggression which are covered in question 11. The rating should be based on the effort required to implement interventions to prevent this potential occurrence.

The need for the intervention must previously have been determined during assessment and recorded as needing monitoring (for B), or monitoring and supervision (for C or D). Interventions are designed to prevent recurrence or reduce the level of the behaviour.

Monitoring the behaviour of all care recipients, as a matter of course would not justify a rating other than A. However a B, C, or D rating would be justified where a care recipient has been assessed previously as, for example, endangering themselves or others, requiring staff to supervise the care recipient to identify when this may re-occur, and then take preventive action.

Where a resident requires monitoring because of occasional, irregular and short-lived occurrences of the behaviour, and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, supervision and daily are defined according to criteria outlined above.

QUESTION 13. DANGER TO SELF OR OTHERS

RATING	VALUE	DANGER TO SELF OR OTHERS
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESTION 14. OTHER BEHAVIOUR

This question covers behaviour not already covered in questions 9 to 13, that requires staff to spend time and effort in addition to support for daily activities.

Examples of behaviour to be included in this question are not given, as it is intended as a 'catch all' for any other behaviour not covered by questions 9 to 13. The rating should be based on the effort required to implement interventions to prevent this potential recurrence.

The need for the intervention must previously have been determined during assessment, and recorded as needing monitoring (for B), or monitoring and supervision (for C or D). Interventions are designed to prevent recurrence or reduce the level of the behaviour.

Monitoring the behaviour of all care recipients, as a matter of course would not justify a rating other than A. However a B, C, or D rating would be justified where a care recipient has been assessed previously as for example, exhibiting a certain behaviour requiring staff to ensure the care recipient is supervised, or employ an intervention to avoid that behaviour occurring.

Where a resident requires monitoring because of occasional, irregular and short-lived occurrences of the behaviour, and the interventions are required to be implemented only for these occasional occurrences, record B. Where interventions are implemented intermittently, for a period of time and then relaxed, but monitoring and supervision for recurrence are required, record C. When supervision and intervention is required daily, record D.

Monitoring, supervision and daily are defined according to criteria outlined above.

QUESTION 14 OTHER BEHAVIOUR

RATING	VALUE	OTHER BEHVIOUR
Not applicable	A	Does not require monitoring
Occasionally	B	Requires monitoring but not regular supervision
Intermittently	C	Requires monitoring for recurrence and then supervision on less than a daily basis
Extensively	D	Requires monitoring for recurrence and supervision on a daily basis

QUESTION 15. SOCIAL AND HUMAN NEEDS – CARE RECIPIENT

This question relates to the care recipient's need for support other than physical care. The time and effort taken by staff to give guidance and emotional support to the care recipient are covered in this question. The care recipient's social, cultural and religious needs and chosen lifestyle preferences are covered in this question. The management of withdrawal due to depression is not covered in this question. This is covered in question 12. Activities which are part of a program claimed for in question 19 'therapy' or in question 20 'Other services' are not covered in this question. The time taken to give guidance and emotional support to relatives and friends of the care recipient is not covered in this question. It is covered in question 16.

For routine in-house group activities such as watching television, playing bingo, group singing and craftwork, record A.

Examples of activities covered in this question are:

- Conversation and board games (individual activities);
- Reading to the visually impaired;
- Group activities requiring one or more staff with a group of care recipients including outings, attendance at church and escorting groups to clinics; and
- Accompanying a care recipient to external appointments.

For extensive (more than 30 minutes on each day) one-on-one recreational, social, cultural, or religious activities, including providing counselling or support for palliative care and highly disabled care recipients, record D.

Some minor support means the care recipient is assisted by staff to participate in a group activity, other than routine, in-house activities, at least once a week or in a one-to-one activity at least once in a 21-day period. In this case record B.

Major support means the care recipient is assisted by staff to participate in a group activity, other than routine, in-house activities, on at least a daily basis, or in a one-to-one activity at least weekly. In this case record C.

Extensive support means staff dedicate at least 30 minutes a day for the above activities in a one on one situation with the care recipient. In this case record D.

QUESTION 15. SOCIAL AND HUMAN NEEDS - CARE RECIPIENT

RATING	VALUE	SOCIAL AND HUMAN NEEDS
No support	A	Requires no specific support
Some support	B	Requires some minor support
Major support	C	Requires major support
Extensive support	D	One-on-one support for activities for more than 30 minutes daily

QUESTION 16. SOCIAL AND HUMAN NEEDS – FAMILIES AND FRIENDS

This question relates to activities related to the care recipient, involving one or more staff members interacting with families, friends or the community. The activity may or may not involve the care recipient.

Guidance and other activities not related to the care recipient are not covered in this question.

Activities such as giving guidance and emotional support, care planning, legal or guardianship matters, cultural and religious matters are covered in this question. This would include support to family and friends where the care recipient requires such care as palliative care, a continence program, management of problem behaviours and care for increasing dementia.

Community is used in this question to refer to community groups such as church groups, social groups, including groups or bodies of cultural significance to the care recipient. It does not refer to linkages with medical professions – for example, doctors, dentists, podiatrists, etc.

In this question:

Some means less frequently than weekly.

Major means at least weekly but not daily.

Extensive means support on a daily basis.

QUESTION 16. SOCIAL AND HUMAN NEEDS – FAMILIES & FRIENDS

RATING	VALUE	SOCIAL AND HUMAN NEEDS
No support	A	Requires no specific support
Some support	B	Requires support less frequently than weekly
Major support	C	Requires support weekly or more often
Extensive support	D	Requires support daily or more often.

QUESTION 17. MEDICATION

This question refers to medication(s) administered on a regular basis. Infrequent, less than weekly, administration of oral analgesic medication(s) are not covered by this question. Injections such as influenza vaccination or multi-vitamin injections are not covered by this question. This question assumes that administration of medication(s) will be carried out in accordance with requirements in relevant State/Territory legislation. This question includes prescribed eye and ear drops, nebulisers, metered aerosols, turbuhalers, canisters and inhalers, the application of transdermal medication patches, other topically applied medication(s), and rectally or vaginally administered prescribed medication(s).

The question excludes intravenous infusions which are covered in question 18. However, intravenous drug administration through a cannula or hypodermic are included in rating D. The question excludes aperients, which are covered in question 7.

In this question, where a care recipient would be rated as a B rating, but he/she is resistant to medication administration, for example, because of dementia, and staff are required to spend time and effort in giving significant encouragement (greater than prompting and reminding), record C.

Assist means giving the correct medication(s) to the care recipient, in the correct manner, at the appropriate times and ensuring that medication(s) is ingested.

Administer means providing physical assistance so that the care recipient completes the ingestion or taking of prescribed medication(s).

A controlled drug means a Schedule 8 drug. In some states this may be called a dangerous drug. In some states or territories, this may include Schedule 4D drugs, where there is a legal requirement for the recording and storage of Schedule 4D drugs to be the same as for Schedule 8 drugs.

QUESTION 17. MEDICATION

RATING	VALUE	MEDICATION
No assistance	A	Care recipient self manages medication
Some assistance	B	Requires staff to give medication to the care recipient, the care recipient takes the medication him/her self and staff confirm that the medication has been ingested
Major assistance	C	Requires staff to administer and assist with the taking of prescribed medication, OR Care recipient is resistant to medication administration and staff are required to give significant encouragement (greater than prompting or reminding)
Complete assistance	D	Requires daily administration of a controlled drug, OR Requires staff to administer s/c, i/m, or i/v drug at least daily

QUESTION 18. TECHNICAL AND COMPLEX NURSING PROCEDURES

This question relates to technical and complex nursing procedures. The following lists of procedures are indicative but not exhaustive. This question assumes that procedures in List 1 will be carried out in accordance with requirements in relevant State/Territory legislation.

LIST 1 INCLUDES:

- Maintenance of skin integrity including changing of position of a chair fast or bed fast resident;
- Eye care other than eye drops which are covered in question 17;
- Assistance with nebulisers, metered aerosols, turbuhalers, canisters and inhalers;
- Oral hygiene (excluding cleaning teeth, which is covered in question 4);
- Blood pressure measurement;
- Blood sugar measurement;
- Simple wound dressings;
- Tube feeding and cleaning of tube following feeding;
- Catheter care other than insertion or removal of a catheter, including perineal/penile toilets and change of drainage bag;
- Stoma maintenance including replacement of stoma bags and wafer maintenance;
- Oxygen therapy, where the supply of oxygen is continuous and has been prescribed by a medical practitioner, or where the care recipient is capable of self managing oxygen;

- Implementation of a pain management or palliative care program (more than regular or 'PRN' analgesic);
- Care and fitting of prosthesis; and
- Anti-embolic stockings.

Note that if (say) assistance with a nebuliser is given twice a day, and care and fitting of a prosthesis is given twice a day, and blood pressure is measured once a day, then this totals five procedures daily.

For procedures such as dressings, anti-embolic stockings and prosthesis, the putting on (say) at the beginning of the day is one procedure, and the taking off at (say) the end of the day is one procedure. For an occasion of removal and immediate replacement, this occasion is one procedure. For an occasion of removal and replacement where replacement is not immediate, for example, removal before a shower and replacement after a shower, removal is one procedure and replacement is one procedure.

If a procedure or procedures from List 1 total 1 to 3 times daily, record B.
If a procedure or procedures from List 1 total 4 to 6 times daily, record C.
If a procedure or procedures from List 1 total more than 6 times daily, record D.
If a combination of procedures from Lists 1 and 2 total more than 6 times daily, record D.

This question assumes that procedures in List 2 will be carried out by a registered nurse or other health professional appropriate to the particular procedure, based on initial and ongoing assessment, planning and management of the care recipient's care by a registered nurse. Examples include medical practitioners, stoma therapists, physiotherapists, speech pathologists or qualified practitioners from palliative care teams.

LIST 2 INCLUDES:

- Establishment and supervision of a complex pain management or palliative care program including monitoring and managing any side effects;
- Insertion, care and maintenance of tubes including intravenous and naso-gastric tubes;
- Establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters;
- Establishing and reviewing a stoma care program;
- Complex wound management;
- Suppositories;
- Risk management procedures relating to acute or chronic infectious conditions;
- Special feeding for care recipients with dysphagia (difficulty with swallowing);
- Suction airways;
- Tracheostomy care;
- Enema administration;
- Oxygen therapy which requires ongoing supervision due to variable need; and
- Dialysis treatment.

Note that if (say) suctioning of airways is carried out twice a day and special feeding is carried out twice a day, and an enema is given once per day, then this totals five procedures daily.

If a procedure or procedures from List 2 totals 1 to 3 times daily, record C.

If a procedure or procedures from List 2 totals more than 3 times daily, record D.

If a procedure or procedures from Lists 1 and 2 totals more than 6 times daily, record D.

QUESTION 18. TECHNICAL AND COMPLEX NURSING PROCEDURES

RATING	VALUE	TECHNICAL & COMPLEX PROCEDURES
No assistance	A	No procedures are provided
Some assistance	B	A procedure or procedures from List 1 totalling 1 to 3 procedures per day
Major assistance	C	A procedure or procedures from List 2 totalling 1 to 3 procedures daily, OR A procedure or procedures from List 1 totalling 4 to 6 procedures daily
Extensive assistance	D	A procedure or procedures from List 2 totalling more than more than 3 procedures daily, OR A procedure or procedures from Lists 1 & 2 totalling more than 6 procedures daily

QUESTION 19. THERAPY

This question relates to therapy provided to care recipients where the facility provides the therapy, or the facility pays for the therapy, and the therapy is documented as a care need. The therapist should meet the requirements for full membership of the therapist's national or state body OR be a registered nurse for physical therapy. These therapies comprise:

- Physiotherapy;
- Physical therapy developed by registered nurses, for example, passive movements for unconscious or severely disabled care recipients, and techniques such as pelvic floor exercises to promote continence;
- Occupational therapy;
- Diversional therapy; and
- Speech therapy.

Music therapy and aromatherapy are not claimed for this question, but are covered in question 20 'Other services'.

The therapist's role is to individually assess the care recipient's need for the therapy and to develop a personalised therapy plan. The program does not need to be implemented by the therapist, but may be implemented by a staff member *at the direction of the therapist.* However, it is the role of the therapist to regularly evaluate, by assessment, the effectiveness of the therapy program.

If the care recipient requires no therapy, record A. If a therapy program is provided one or two times a week, record B. This might be to maintain the care recipient's existing level of function. If a therapy program is provided three times or more per week, but not daily, record C. This might be to improve or to minimise loss of the care recipient's existing level of function, correct a deficit, or in the case of physiotherapy, maintain or minimise loss of joint range of movement or prevent contractures.

If a therapy program is provided in either daily blocks, or three or more times per week in large blocks of time (at least 30 minutes duration), record D. Therapy provided by different categories of therapists is added together to determine the frequency of the provision of therapy.

QUESTION 19. THERAPY

RATING	VALUE	THERAPY
No support	A	No therapy required
Some support	B	Therapy provided 1 or 2 times per week
Major support	C	Therapy provided 3 times per week
Extensive support	D	Therapy program provided either daily or at least 3 times per week in large blocks of time

QUESTION 20. OTHER SERVICES

This question relates to services provided to care recipients where the facility provides the services, or the facility pays for the service, and the service is documented, as a care need. These services are other than those covered in questions 1 to 19. These include, but are not restricted to, services provided by:

- Psychologist;
- Dietician;
- Podiatrist;
- Social worker;
- Music therapist; and
- Aroma therapist.

The provider of these services individually assesses the care recipient's need for the service and develops a personalised plan for the provision of the service(s). The program may be implemented by other staff; however, it is the role of the provider to regularly evaluate, by assessment, the effectiveness of the program.

If the care recipient requires no other services or less frequently than weekly, record A. If other services are provided one or two times a week, record B. If other services are provided three times or more a week, but not daily, record C. If other services are provided daily, record D. Services provided by the above providers are added together to determine the frequency of the provision of services.

QUESTION 20. OTHER SERVICES

RATING	VALUE	OTHER SERVICES
No support	A	No other services required
Some support	B	Other services provided 1 or 2 times a week
Major support	C	Other services provided 3 or more times per week but not daily
Extensive support	D	Other services provided daily