



Australian Government
Department of Health and Ageing

**FEEDBACK FROM THE DEPARTMENT OF HEALTH AND AGEING
ON ACFI REVIEWS, JUNE 2009**

The following information was prepared by the Department of Health and Ageing (the Department) after initial reviews in facilities across Australia. This information provides advice to assist facilities improve the accuracy of funding claims under the Aged Care Funding Instrument (ACFI).

General comments

Overall, while Review Officers (ROs) have found ACFI Answer Appraisal Packs (ACFI Packs) contain a high error rate these consist predominantly of clerical errors or failure to comply with documentation requirements. Few errors suggest any significant misunderstanding or incorrect interpretation of the instrument.

Many errors found by ROs are systemic and of a nature that can easily be rectified, for example, not signing or dating the ACFI Packs. There has also been a high rate of errors that could have been avoided if the *ACFI User Guide* had been consulted.

Summary of Common Errors and feedback

The most common error in the ACFI Pack has been that the appraiser details have not been completed for assessments such as those required for Behaviour Records and Continence Records.

It is important that facilities ensure that:

- assessment documents, such as behaviour and continence records are signed and dated;
- the appraiser details have been completed; and
- arithmetic is checked of assessments where the claim depends on the total score.

Source documents

In a number of facilities it has been found that medical diagnoses are not signed or dated. This issue obviously lies with the medical practitioner or person who has prepared the diagnosis. Facilities should be encouraged when seeking a diagnosis to obtain a date and signature.

A further issue relating to the use of source documents is that facilities are filing source documents in the ACFI Pack that do not match the diagnoses listed. For instance, both the Mental and Behavioural Diagnosis and Medical Diagnosis sections require the ACFI Appraiser to tick what source documents are filed in the ACFI Pack – while generally the ACFI Pack does not require much in the way of additional documentation, it is appropriate to include source documents to support a diagnosis. Time is saved for both the ROs and facility staff if these are included in the ACFI Packs.

It is important that facilities ensure that:

- the diagnosis codes entered are based on the source documents and they are ACAP codes from Appendix 1 of the *ACFI User Guide*;
- only diagnosed medical conditions that have an impact on the current care needs of the resident are to be listed at the Medical Diagnosis section of the ACFI Pack. Resolved or well controlled conditions that do not have a discernable impact on a resident's care needs at the time of appraisal should not be listed;
- where the maximum Behaviour Supplement is being claimed, a Mental and Behavioural Diagnosis must be filed and it must be currently impacting on the resident's care needs;
- the Mental and Behavioural Diagnoses have specific codes that are outlined in the *ACFI User Guide*, pp. 13-14 and any diagnosis listed must have been completed or reconfirmed within the past 12 months;
- in filling in assessments or records such as the continence or behaviour record, the ACFI appraiser will be responsible for the availability of a signature log for the period the record or assessment was completed, however, the signature log is not required to be filed in the ACFI Pack; and
- if a directive is required, it must be filed in the ACFI Pack.

Continence

A number of facilities have claimed a resident's usual need is for scheduled toileting but ROs have found no evidence of incontinence prior to implementation of the toileting program, that is, there was no support for the need for scheduled toileting. If a facility is claiming a B, C or D rating for Question 5 for a resident who has a scheduled toileting program, it must provide documentary evidence of incontinence prior to the implementation of the program. Examples of such evidence include the Aged Care Client Record (ACCR), or a flowchart completed prior to the scheduled toileting being implemented.

Complex Health Care Procedures

A resident's assessed need for ongoing health care procedures and activities are appraised at ACFI Question 12. This excludes temporary nursing interventions such as for skin tears. The *ACFI User Guide*, p. 36, clearly stipulates the qualifications of health professionals from whom the directives should be obtained: nurse practitioner, registered nurse, medical practitioner or allied health professional.

Other errors

ROs have found errors that indicate that the *ACFI User Guide* had not been referred to for guidance, for example, inappropriate forms of the Cornell Scale for Depression in Dementia were used, others were incomplete, were incorrectly scored or scores were not added up correctly. Details of administration of medication were not completed or were recorded incorrectly, especially the timing of the delivery of medications. Not all medication can be claimed; in some cases unprescribed medication had been claimed. Only those behaviours described in Appendix 2 of the *ACFI User Guide*, pp. 44 can be claimed under the ACFI – the behaviour description of symptoms is set out against the behaviour code to be used in the behaviour record e.g. W1 for interfering while wandering, V1 for verbal refusal of care or P1 for physically threatening or doing harm to self or others or property (note: this information is also found in the ACFI Assessment Pack, pp. 6).

The *ACFI User Guide* should always be referred to while completing any of the ACFI appraisals. Often facilities with the lowest error rates are those that have relied most heavily on the *ACFI User Guide*.

It is also important that the integrity of the mandatory assessment forms is maintained:

- if a facility uses their own assessment forms, these forms must contain the same information as those in the ACFI Assessment Pack; and
- if a facility is using an electronic version of these Assessments, the electronic version must contain the same information as those in the ACFI Assessment Pack.

Documentation Requirements in General

Details of the documentary evidence required to support each claim is listed on pages 7, 9, 10 and 11 of the *ACFI User Guide*, with further details of the documentation required for some questions, such as ACFI 12, listed on the relevant pages. Please note that if the evidence is listed as required, it must be included in the ACFI Pack.

For some questions, the form of this evidence is not specified. For example, evidence of prior incontinence to support a claim in ACFI 5 for scheduled toileting may be found in a copy of a page from the Progress Notes, or a directive to support a claim in ACFI 12 may be a copy of a Care Plan page.

Additional documentation should NOT be included in the ACFI Pack if it is not specified as required. For example, Progress Notes are not required evidence and at review will be removed from the ACFI Pack and not read by the RO unless later requested for clarification.

For some questions, additional documentary evidence may be required to be provided at review. This includes records of treatments and other documentary evidence to support a claim. Such documents, if required, will be requested by the RO at the time of the review.

If a RO is unable to support a claim using the available documentation, a request may be made for additional documentation. This may occur where the claim appears to be incongruent with the care recipient's diagnoses and other claims and the RO needs to see evidence to explain the apparent incongruence.