ASSESSMENT TOOLS

SOCIAL, CULTURAL AND SPIRITUAL DOMAIN

PHYSICAL HEALTH DOMAIN

FUNCTIONAL ABILITY DOMAIN

COMMUNICATION DOMAIN

COGNITIVE AND MENTAL HEALTH DOMAIN
SOCIAL, CULTURAL AND SPIRITUAL
SOCIAL, CULTURAL AND SPIRITUAL DOMAIN

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KEY TO ME

Important Message

This document is designed to be answered by the person concerned. Another person should only be asked for her or his assistance when an individual has not been able to answer the questions for her or himself.

Information contained in this document is private and confidential. It is for sharing with staff to enable them to give appropriate care and support. It will not be shared with anyone except authorised staff.

To enable staff to provide personalised care and activities for you (your relative), we value your input and that of family and friends to this questionnaire. Please answer the questions as you feel comfortable and able to do so. Staff will maintain the confidentiality of this material and will use it sensitively.

PERSONAL DETAILS

Surname:........................................................................................................................................................................
Maiden name:................................................................................................................................................................
Given name:.................................................................................................................................................................
Preferred name: ............................................................................................................................................................
Date and place of birth: ................................................................................................................................................
When growing up lived where? .....................................................................................................................................
Went to school where? .................................................................................................................................................
Did you (this person) pursue any further studies? ........................................................................................................
What was your (her/his) occupation? ...........................................................................................................................
Did you enjoy the work? ................................................................................................................................................
.......................................................................................................................................................................................
Have you retained any occupational skills? ....................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

PARENTS & SIBLINGS

Mother’s name: ...............................................................................................................................................................
Occupation: .................................................................................................................................................................
Closeness to/feelings about mother: ............................................................................................................................
.......................................................................................................................................................................................
Father’s name: ............................................................................................................................................................
Occupation: .................................................................................................................................................................
Closeness to/feelings about father: ............................................................................................................................... 
Brother’s name(s): ........................................................................................................................................................
Closeness to/feelings about brother(s): ............................................................................................................................
Sister’s name(s):............................................................................................................................................................
.......................................................................................................................................................................................

Closeness to/feelings about sister(s):................................................................................................................................
.......................................................................................................................................................................................

Any continuing contact with these members of the family? ...............................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

SPOUSE/PARTNER
Name: ................................................................................... Maiden Name: .................................................................
Occupation:....................................................................................................................................................................
Where & when married:................................................................................................................................................
.......................................................................................................................................................................................

Special memories? .........................................................................................................................................................
.......................................................................................................................................................................................

RELATIONSHIPS (How do you feel (does he/she react) before and after visits?)
Children
Names:...........................................................................................................................................................................
.......................................................................................................................................................................................

Are they/were they close? .............................................................................................................................................

Do they keep in regular contact? ...................................................................................................................................

Grandchildren
Names:...........................................................................................................................................................................
.......................................................................................................................................................................................

Do they keep in regular contact? ...................................................................................................................................

Great Grandchildren
Names:...........................................................................................................................................................................
.......................................................................................................................................................................................

Do they keep in regular contact? ...................................................................................................................................

Nieces & Nephews
Names:...........................................................................................................................................................................
.......................................................................................................................................................................................

Do they keep in regular contact? ...................................................................................................................................
Close Friends & Neighbours
Names: ................................................................. ................................................................. ................................................................. .................................................................
Do they keep in regular contact? ................................................................. ................................................................. ................................................................. .................................................................

ABILITIES/ACTIVITIES
Do/did you play a musical instrument? ................................................................. ................................................................. ................................................................. .................................................................
Do you enjoy (details about types of music, songs, books etc.) ................................................................. ................................................................. ................................................................. .................................................................
Music? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Singing? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Reading? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Poetry? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Concerts/Theatre? ......................................................................................................... ................................................................. ................................................................. .................................................................
Drawing? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Cards? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Favourite film/radio/TV programs? ................................................................................................. ................................................................. ................................................................. .................................................................
Do you miss your pet(s)? ................................................................................................. ................................................................. ................................................................. .................................................................
Do/did you play any sport/games? ................................................................................................. ................................................................. ................................................................. .................................................................
What were you best at? ................................................................................................. ................................................................. ................................................................. .................................................................
Special achievements of your lifetime? ................................................................................................. ................................................................. ................................................................. .................................................................
What work leisure or domestic activities gave/give the most enjoyment or sense of accomplishment? ................................................................................................. ................................................................. ................................................................. .................................................................
Which can you still enjoy doing? ................................................................................................. ................................................................. ................................................................. .................................................................
Well? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Partially? ......................................................................................................................... ................................................................. ................................................................. .................................................................
Is there any person, topic or event that is really special? ................................................................................................. ................................................................. ................................................................. .................................................................
Is there any person, topic or event that you do not want to talk about? (It is important for care staff to be aware of any occasions in a person’s life that caused extreme distress because these may surface again at any time especially if a person is later affected by dementia) ................................................................................................. ................................................................. ................................................................. .................................................................

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ASSESSMENT TOOLS 65
HABITS/SOCIAL RELATIONSHIPS
How do you (include descriptions of facial expressions, posture, gestures, stance)

Show approval? ...............................................................................................................................................................
.......................................................................................................................................................................................

Show pleasure? ...............................................................................................................................................................
.......................................................................................................................................................................................

Express anger? ...............................................................................................................................................................
.......................................................................................................................................................................................

Express grief? ...................................................................................................................................................................
.......................................................................................................................................................................................

Let off steam? ...................................................................................................................................................................
.......................................................................................................................................................................................

What kind of praise is suitable? .......................................................................................................................................
.......................................................................................................................................................................................

Do you (does he/she);

Like physical contact? .......................................................................................................................................................
.......................................................................................................................................................................................

Like to be hugged? ...........................................................................................................................................................
.......................................................................................................................................................................................

Shake hands? ...................................................................................................................................................................
.......................................................................................................................................................................................

Is the company of others welcome? ..............................................................................................................................
.......................................................................................................................................................................................

or,

Would you prefer others to keep their distance? ...........................................................................................................
.......................................................................................................................................................................................

How do you feel about people coming into your/her/his room? ..................................................................................
.......................................................................................................................................................................................

.......................................................................................................................................................................................
.......................................................................................................................................................................................

Reproduced with permission from Beverly Giles, 2003
Name: 
DOB: 
Room No: 

HABITS/ROUTINES
(provide details re: type of assistance required eg. prompt, guide or demonstrate)

What was the usual time of the day for a bath or shower?

How many times a week?

Are you able to: Bath or shower—without assistance?

with assistance?

........................................................................................................................................................................

Use the toilet? lavatory? (circle the familiar one) or other? without assistance?

with assistance?

........................................................................................................................................................................

Dress/undress—without assistance?

with assistance?

What is your favourite food?

Favourite drink?

Is there a special food or drink that you remember being given when sick or sad?

Do you:

Identify with a specific ethnic group?

Speak and understand English?

Another language?

Engage in cultural practices that should be continued?

Describe

Is religion important to you? If so provide details of past practices.

Does your family celebrate special occasions? eg. Easter, Christmas, Mother’s Day, Father’s Day, Others, ANZAC Day. Did you serve in a war zone?

If yes, give details

How were special occasions celebrated?
What are some examples of happy memories from childhood?

Are there any family anecdotes or jokes you would enjoy sharing/talking about?

What can staff say or do that might make you laugh?

What could be done that might make you feel more "at home"?

Completed by:       Signature       Date

/       /
ACTIVITY THERAPY ASSESSMENT

Resident Profile

Date of Birth .......................................................... Place of Birth ..............................................................

Reason for Placement ........................................ Goal .................................................................

Mode of Transportation to Activities .................................................................
Precautions/Allergies ........................................................................................................
Diet .............................................................................................................................
Physio ...................................................... OT ........................................ Speech Therapy ............................................

Activity Pursuits & Related Abilities

(C) Indicates Current over last seven days (P) Indicates young adulthood to admission

Occupations: .............................................................................................................................

Education: .............................................................................................................................

Schools attended: ...................................................................................................................

Politics: .....................................................................................................................................

Cards/other games: ..................................................................................................................

Crafts/Arts: .............................................................................................................................

Exercise/Sports: .....................................................................................................................

Music: .......................................................................................................................................

Reading: .....................................................................................................................................

Writing: .....................................................................................................................................

Eyesight: ..........................................................Small Print □ Large Print □ is desirable

Needs mail read? Yes □ No □ If yes, resident gives permission for ............................................................. to read mail.

Trips/Shopping: ........................................................................................................................

Walking/Wheeling Outdoors: .....................................................................................................

Watching TV: ............................................................................................................................

Intergenerational activities desired: ................................................................................................

Pets: ...........................................................................................................................................

Gardening: ...............................................................................................................................

Cooking: ....................................................................................................................................

Other life involvements: ............................................................................................................

NAME:  

DOB:  

ROOM NO:  

PLACE ID:  

PLACE TO LABEL HERE

PHOTO:  

HERE
Use of Hands: (Right) ......................................................... (Left) .................................................................

Preferred activity setting: ☐ Own Rm ☐ Day/Activity Rm ☐ Inside/Outside ☐ Community Setting ☐ None

Group & individual activities resident states he/she will participate in: .................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

More or different activity preferences/choices not currently offered: .................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Resident’s perception of current abilities/interests: ..................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Significance of resident’s time awake & time spent in activities: ...........................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Support Systems

(C) Indicates current over last seven days (P) Indicates young adulthood to admission

Marital Status ................................................. Name of Spouse .................................................................

Relationship with spouse .................................................................
.......................................................................................................................................................................................

Relationship with children .................................................................
.......................................................................................................................................................................................

Spiritual/Religious activities .................................................................

Involvement patterns .................................................................
.......................................................................................................................................................................................

Organisational memberships & community involvement .................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Other support systems .................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Living arrangements prior to facility placement .................................................................
.......................................................................................................................................................................................

Identification with past roles & lifestyle .................................................................
.......................................................................................................................................................................................
Psychosocial & Cognitive Functioning

Orientation

Memory: Recent

Remote

Communication

Hearing

Response to Interview(s)

Observations regarding specific mood & behaviour

Primary Strengths & Weaknesses

Strengths

Weaknesses

Other Comments:

DOB: Room No:
Leisure Interest Survey

I prefer to spend my free time:
☐ Alone ☐ with friends ☐ with others ☐ I don’t know

My favourite time of year is:
☐ Spring ☐ Summer ☐ Autumn ☐ Winter
I like it because

My favourite time of day is:
☐ Morning ☐ Afternoon ☐ Evening
I like it because

I am busiest on:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

I am sometimes bored on:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

When I have free time I like to:
I like it because

Places I prefer to do things:
☐ In the facility ☐ In my room ☐ In the lounge ☐ Outdoors ☐ In the community

What is one activity you did when you were younger that you would like to do again?

Name one current activity you would like to continue doing?

What activity do you do that takes a lot of energy?

What activity do you do that relaxes you?

Do you have an activity you would like to do that you have never had the opportunity to do before?

Tick the activities you would be interested in observing or participating in:
☐ games ☐ art/music ☐ outdoor ☐ religious
☐ exercises ☐ service ☐ collecting ☐ crafts
☐ sports ☐ entertainment ☐ other

Completed by: [Signature] [Date]
PHYSICAL HEALTH DOMAIN

Medication

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Pain

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ASSESSMENT OF A RESIDENT’S ABILITY TO SELF-ADMINISTER MEDICATIONS

NOTE: In assessing the ability of the resident to safely and effectively administer some or all of his/her medications, consideration of the risk/benefit to the resident of self-administration must be considered. The provision of appropriate information eg Consumer Medication Information or information on the correct method of administration may significantly enhance a person’s understanding of the purpose of their medications, identification of side effects, storage requirements and other issues relevant to assisting the resident to self-administer medications. As such, a negative response to any of the questions of this assessment form does not necessarily preclude a resident from self administration, rather it may indicate the need for the implementation of strategies to facilitate the ability of the resident to self medicate safely and effectively. The facility has a duty of care to minimise the risk of adverse outcomes by unsafe or ineffective self-administration.

These questions should be answered in the context of self administration of medication

1. Does the resident wish to self medicate? □ Yes □ No
2. Was the resident self medicating at home? □ Yes □ No
3. Was the resident using a dose administration aid at home? □ Yes □ No
4. Is the resident oriented in time and place? □ Yes □ No
5. Does the resident have a history of alcohol or drug abuse? □ Yes □ No
6. Does the resident have any cognitive disabilities? □ Yes □ No
7. Does the resident have gross/fine motor skills deficit? □ Yes □ No
8. Is the resident able to communicate effectively? □ Yes □ No
9. Does the resident have a visual impairment? □ Yes □ No
10. Can the resident open the following:
    - Bottles with normal lids? □ Yes □ No
    - Bottles with child resistant closures? □ Yes □ No
    - Foil packets? □ Yes □ No
    - Boxes? □ Yes □ No
    - Dose administration aids? □ Yes □ No
11. Can the resident unlock and open the drawer in which their medications would be stored? □ Yes □ No
12. Can the resident read the labels on their medications? □ Yes □ No
13. Does the resident understand what the medication(s) is for? □ Yes □ No
14. Does the resident know what to do if they:
    - Miss a dose? □ Yes □ No
    - Take a wrong dose? □ Yes □ No

Assessment of a Resident’s Ability to Self-administer Drugs

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Can the resident identify the medication?</td>
<td></td>
<td></td>
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<tr>
<td>16 Can the resident prepare the correct amount of medication?</td>
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<tr>
<td>(eg expel enough ointment from tube to be applied to affected area)</td>
<td></td>
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<tr>
<td>17 Can the resident administer eye drops/ointments?</td>
<td></td>
<td></td>
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<tr>
<td>18 Can the resident administer ear drops?</td>
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</tbody>
</table>

It may be necessary to assess the resident’s use/delivery of other medications (eg per vagina or per rectum, patches, inhalers etc). Please document the resident’s ability to self-administer any other medications prescribed that have not been covered.

Comments:....................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Are there any strategies which may assist the resident to self-administer?   |     |    |

If Yes, list these strategies.......................................................................................................................................... 
.......................................................................................................................................................................................
.......................................................................................................................................................................................
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Is the resident capable of self-administering any of their medications?     |     |    |

If Yes, list the medications which the resident may self-administer
.......................................................................................................................................................................................
.......................................................................................................................................................................................
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Initial assessment: Date: / / 
Name of authorised person Signature Date / /

Is the resident capable of self-administering medications?                 |     |    |

Review: Date: / / 
Name of authorised person Signature Date / /

A resident’s ability to self-administer medications should be reviewed at regular intervals (eg every 3–6 months) or if a change in the resident’s medical condition, hospitalisation or changes in medication occurs or if the medication regimen becomes more complicated.
**BRIEF PAIN INVENTORY**

1. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

2. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last week.

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<tr>
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<th>10</th>
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<tbody>
<tr>
<td>No Pain</td>
<td>Pain as bad as you can imagine</td>
<td></td>
<td></td>
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3. Please rate your pain by circling the one number that best describes your pain at its **least** in the last week.

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<tbody>
<tr>
<td>No Pain</td>
<td>Pain as bad as you can imagine</td>
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4. Please rate your pain by circling the one number that best describes your pain on the **average**.

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<tr>
<td>No Pain</td>
<td>Pain as bad as you can imagine</td>
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5. Please rate your pain by circling the one number that tells how much pain you have **right now**.

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<tr>
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<td>Pain as bad as you can imagine</td>
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</table>
6. What kinds of things make your pain feel better (for example, heat, medicine, rest)?

7. What kinds of things make your pain worse (for example, walking, standing, lifting)?

8. What treatments or medications are you receiving for your pain?

9. In the last week, how much relief have pain treatments or medications provided?
   Please circle the one percentage that most shows how much relief you have received.
   

10. If you take pain medication, how many hours does it take before the pain returns?
    □ Pain medication doesn’t help at all        □ Four hours
        □ One hour                                □ Five to twelve hours
        □ Two hours                               □ More than twelve hours
        □ Three hours                             □ I do not take pain medication

11. Tick the appropriate answer for each item.
    I believe my pain is due to:
    □ The effects of treatment (for example, medication, surgery, radiation, prosthetic device).
    □ My primary disease (meaning the disease currently being treated and evaluated).
    □ A medical condition unrelated to primary disease (for example, arthritis).

12. For each of the following words, tick yes or no if that adjective applies to your pain.
    Aching □ Yes □ No    Exhausting □ Yes □ No
    Throbbing □ Yes □ No    Tiring □ Yes □ No
    Shooting □ Yes □ No    Penetrating □ Yes □ No
    Stabbing □ Yes □ No    Nagging □ Yes □ No
    Gnawing □ Yes □ No    Numb □ Yes □ No
    Sharp □ Yes □ No    Miserable □ Yes □ No
    Tender □ Yes □ No    Unbearable □ Yes □ No
    Burning □ Yes □ No
### Brief Pain Inventory


13. Circle the one number that describes how, during the past week, pain has interfered with your:

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<th>A. General Activity</th>
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<td>Does not interfere</td>
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<th>C. Walking Ability</th>
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<th>G. Enjoyment of life</th>
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Completed by: ____________________  Signature: ____________________  Date: / / 
# Pain Assessment in Advanced Dementia (PAINAD)

<table>
<thead>
<tr>
<th>Item Definitions</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breathing</strong></td>
<td>Normal</td>
<td>Occasional laboured breathing. Short period of hyperventilation</td>
<td>Noisy laboured breathing. Long period of hyperventilation</td>
<td>Score</td>
</tr>
<tr>
<td>Independent of Vocalisation</td>
<td>None</td>
<td>Occasional moan or groan. Low-level speech with negative or disapproving quality</td>
<td>Cheyne-Stokes respirations. Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
<td>Score</td>
</tr>
<tr>
<td><strong>Facial expression</strong></td>
<td>Smiling, or inexpressive</td>
<td>Sad. Frightened. Frown.</td>
<td>Facial grimacing</td>
<td>Score</td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to consol, distract or reassure</td>
<td>Score</td>
</tr>
</tbody>
</table>

Completed by: ______________ Signature: ______________ Date: ______________

The PAINAD measures pain in noncommunicative residents and is based on a five items. The range of scores is 0–10 (0 being no pain).

**Item definitions**

**Breathing**

1. Normal breathing is characterised by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional laboured breathing is characterised by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterised by intervals of rapid deep breaths lasting a short period of time.
4. Noisy laboured breathing is characterised by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.

5. Long periods of hyperventilation is characterised by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterised by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnoea (cessation of breathing).
ASSESSMENT TOOLS

Body Language

1. Relaxed is characterised by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterised by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distress pacing is characterised by activity that seems unsettled. There may be a fearful, worried or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterised by restless movement. Squirming about or wriggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.
5. Rigid is characterised by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).
6. Fists clenched is characterised by tightly closed hands. They may be opened and close repeatedly or held tightly shut.
7. Knees pulled up is characterised by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. Pulling or pushing away is characterised by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. Striking out is characterised by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Facial Expression

1. Smiling or inexpressive. Smiling is characterised by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterised by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterised by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. Frown is characterised by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterised by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Consolability

1. No need to console is characterised by a sense of well being. The person appears content.
2. Distracted or reassured by voice or touch is characterised by a disruption in the behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterised by the inability to soothe the person or stop a behaviour with words or actions. No amount of comforting, verbal or physical, will alleviate the behaviour.

Name: 
DOB: 
Room No: 

Negative Vocalisation

1. None is characterised by speech or vocalisation that has a neutral or pleasant quality.
2. Occasional moan or groan is characterised by mournful or murmuring sounds, wails or laments. Groaning is characterised by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterised by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated troubled calling out is characterised by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterised by mournful or murmuring sounds, wails or laments in much louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterised by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Pain Assessment in Advanced Dementia (PAINAD)

ABBYEY PAIN SCALE

For measurement of pain in people with dementia who cannot verbalise

How to use scale:
While observing the resident, score questions 1 to 6.

Name of person completing the scale: ..........................................................................................................................

Date: ......................................... Time: ............................................ Designation: ..........................................................

Latest pain relief given was ............................................................................ at .................................................... hrs.

Q1 Vocalisation
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3 Q1= □

Q2 Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3 Q2= □

Q3 Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 Q3= □

Q4 Behavioural change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3 Q4= □

Q5 Physiological change
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 Q5= □

Q6 Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3 Q6= □

Add scores for 1–6 and record here

Total Pain Score= □

Now tick the box that matches the Total Pain Score

<table>
<thead>
<tr>
<th>0–2</th>
<th>3–7</th>
<th>8–13</th>
<th>14+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Finally, tick the box which matches the type of pain

Chronic | Acute | Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002
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VISUAL ANALOGUE PAIN SCALES

Pain as bad as it could be
Extreme pain
Severe pain
Moderate pain
Mild pain
Slight pain
No pain

Cited in Abraham & Synder (2001)
HUSKISSON VISUAL ANALOGUE SCALE

Pain as bad as it could be

| No pain |

Pain as bad as it could be

| Severe | Moderate | Slight |

Huskisson as cited in McDowell & Newell (1996) reproduced with permission from Oxford University Press
# RESIDENTIAL CARE SERVICES SKIN INTEGRITY ASSESSMENT

## Past history
- Pressure ulcer
- Leg ulcer
- Sensitivities
- Other

## Health status
- Diabetes
- Poor circulation
- Poor nutrition
- Obese
- Thin
- Oedema
- Yes
- No
- Other

## Skin
- Dry skin
  - Arms
  - Legs
  - Torso
- Tissue-paper skin
  - Arms
  - Legs
  - Torso
- Excoriation or reddened areas
  - Groin
  - Abdominal flap
  - Under breasts
  - Axilla
  - Neck
  - Hands
- Rash or allergies
  - Arms
  - Legs
  - Torso
- Other

---

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Residential Care Services Skin Integrity Assessment

Bruises

☐ Arms  ☐ Legs  ☐ Torso

Other

(comment) ...........................................................................................................................................................................

Show bruises, wounds, scars, excoriations, rashes, skin tears on diagram

Hair

☐ Stringy  ☐ Dull  ☐ Dry  ☐ Thinning

☐ Lustrous  ☐ Shiny  ☐ Bald

Condition of scalp

☐ Healthy  ☐ Dry  ☐ Scaly

Other

(comment) ...........................................................................................................................................................................

Nails

Fingernails

☐ Ingrown  ☐ Overgrown  ☐ Thickened

☐ Brittle  ☐ Discoloured  ☐ Corns or callouses

Toenails

☐ Ingrown  ☐ Overgrown  ☐ Thickened

☐ Brittle  ☐ Discoloured  ☐ Corns or callouses

☐ Overlapping  ☐ Hammer toe  ☐ Hallus vagus

Completed by: [ ] Signature [ ] Date [ ] / [ ] / [ ]

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RESIDENTIAL CARE SERVICES
WOUND ASSESSMENT AND PROGRESS CHART

Diabetes: ☐ Yes ☐ No

State type & management: ...........................................................

Smoker: ☐ Yes ☐ No

Respiratory illness: ☐ Yes ☐ No

Anaemia: ☐ Yes ☐ No

Nutritional status (e.g., poor appetite, underweight, nil orally PEG feed)

Type of wound (describe): ............................................................

Duration of wound: .................................................................

Quality of surrounding skin
☐ Inflamed ☐ Macerated ☐ Friable ☐ Dry ☐ Crusty ☐ Fragile

Other (state): ..............................................................................

Wound microbiology:
Swab taken: ☐ Yes ☐ No If yes, date taken: ___/___/____

Result: ......................................................................................

Sensitivities: ............................................................................

Antibiotics required: ☐ Yes ☐ No If yes, type & dosage: ..............

Allergies to dressings ☐ Yes ☐ No

Specify: ...................................................................................

Dressings

<table>
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<tr>
<th>Date</th>
<th>Cleansing agent</th>
<th>Primary dressing</th>
<th>Secondary dressing</th>
<th>Bandage/retention dressing</th>
<th>Frequency for change</th>
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Phillipines

Type of wound
☐ Skin tear  ☐ Surgical  ☐ Other
☐ Pressure ulcer  ☐ Diabetic
☐ Leg ulcer  ☐ Skin Cancer

Colour of wound
Estimate record % of wound surface that is covered by the corresponding colour
B Black
Y Yellow
R Red

Volume of exudate
N None
S Small
M Moderate
H Heavy

Odour
L Nil
O Offensive

Wound depth score
Score  Description
1  superficial/epidermal layer
2  extending to dermal layer
3  extending to subcutaneous layer
4  extending to muscle/tendon/bone

Location (detail on diagram)

Instructions: Draw wound at each review (e.g., weekly, fortnightly etc) not at each dressing change

Completed by: [ ]
Signature: [ ]
Date: / /
<table>
<thead>
<tr>
<th>Review date</th>
<th>Dimension (draw wound &amp; show measurement)</th>
<th>A ↔ cm</th>
<th>B ↑ cm</th>
<th>Depth score</th>
<th>Colour</th>
<th>Volume of exudate</th>
<th>Pain</th>
<th>Comments</th>
<th>Sign &amp; date</th>
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Residential Care Services—Wound Assessment and Progress Chart

With permission from Vision Australia Fountain Slightly adapted
BRADEN RISK ASSESSMENT SCALE

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Residents with established pressure ulcers should be reassessed periodically.

Sensory Perception

Ability to respond meaningfully to pressure-related discomfort

1 Completely Limited
Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR limited ability to feel pain over most of body surface.

2 Very Limited
Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort in over 1/2 of body.

3 Slightly Limited
Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.

4 No Impairment
Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

Moisture

Degree to which skin is exposed to moisture

1 Constantly Moist
Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.

2 Very Moist
Skin is often, but not always, moist. Linen must be changed at least once a shift.

3 Occasionally Moist
Skin is occasionally moist, requiring an extra linen change approximately once a day.

4 Rarely Moist
Skin is usually dry. Linen only required changing at routine intervals.
Activity

Degree of physical activity

1 Bedfast
Confined to bed.

2 Chairfast
Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.

3 Walks occasionally
Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.

4 Walks frequently
Walks outside the room at least twice a day and inside room at least once very 2 hours during waking hours.

Mobility

Ability to change and control body position

1 Completely Immobile
Does not make even slight changes in body or extremity position without assistance.

2 Very Limited
Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.

3 Slightly Limited
Makes frequent though slight changes in body or extremity position independently.

4 No Limitations
Makes major and frequent changes in position without assistance.
Nutrition

Usual food intake pattern

1 Very Poor
Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is nil by mouth and/or maintained on clear fluids or I.V.’s for more than 5 days.

2 Probably Inadequate
Rarely eats complete meals and generally eats only about 1/2 of any food offered. Protein intake includes 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.

3 Limited
Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy product) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN regimen which probably meets most nutritional needs.

4 Excellent
Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

Friction and Shear

1 Problem
Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.

2 Potential Problem
Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.

3 No Apparent Problem
Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.

NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers.

15 or 16 = low risk; 13 or 14 = moderate risk, 12 or less = high risk

Completed by: ____________________________ Signature: ____________________________ Date: ________/_______/_______
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WATERLOW PRESSURE UCLER RISK SCALE

Circle scores in table, add total. Several scores per category can be used.

<table>
<thead>
<tr>
<th>Build/weight for height</th>
<th>Skin type visual risk areas</th>
<th>Sex/age</th>
<th>Special risks</th>
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<tbody>
<tr>
<td>Build/weight for height</td>
<td></td>
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<tr>
<td>Average .................. 0</td>
<td>Healthy ....................... 0</td>
<td>Male ......................... 1</td>
<td>Tissue malnutrition</td>
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<tr>
<td>Above average........... 1</td>
<td>Tissue paper .................. 1</td>
<td>Female ......................... 2</td>
<td>e.g. Terminal</td>
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<tr>
<td>Obese ................... 2</td>
<td>Dry ............................ 1</td>
<td>40-49 .......................... 1</td>
<td>cachexia ...................... 8</td>
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<td>Below average .......... 3</td>
<td>Oedematous ..................... 1</td>
<td>50-64 .......................... 2</td>
<td>Cardiac failure ............ 5</td>
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<td>Clammy (temp) ............... 1</td>
<td>65-74 .......................... 3</td>
<td>Peripheral</td>
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<td>Discoloured .................. 2</td>
<td>75-80 .......................... 4</td>
<td>vascular disease .......... 5</td>
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<td>Broken spot .................. 3</td>
<td>81+ ............................ 5</td>
<td>Anaemia ...................... 2</td>
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<tr>
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<th>Mobility</th>
<th>Appetite</th>
<th>Neurological Deficit</th>
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<tr>
<td>Complete/</td>
<td>Fully ............... 0</td>
<td>Average ................. 0</td>
<td>e.g. Diabetes, MS, C.V.A,</td>
</tr>
<tr>
<td>Catheterised ........ 0</td>
<td>Restless/Fidgety .... 1</td>
<td>Poor ......................... 1</td>
<td>Motor sensory Paraplegia</td>
</tr>
<tr>
<td>Occasionally</td>
<td>Apathetic ............. 2</td>
<td>N.G. Tube/</td>
<td>Moderate ................ 4</td>
</tr>
<tr>
<td>Incontinent ......... 1</td>
<td>Restricted .......... 3</td>
<td>Fluids only ............. 2</td>
<td>Mod-severe ................ 5</td>
</tr>
<tr>
<td>Cath/incontinent of faeces .... 2</td>
<td>Inert/Traction .... 4</td>
<td>NBM/anorexic ............ 3</td>
<td>Severe .................... 6</td>
</tr>
<tr>
<td>Doubly incontinent  3</td>
<td>Chairbound .......... 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Surgery/ Trauma</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic—below waist, spinal .......... 5</td>
<td>Cytotoxics ............... 4</td>
</tr>
<tr>
<td>On table&gt;</td>
<td>High dose Steriods</td>
</tr>
<tr>
<td>2 hours................ 5</td>
<td>Anti-inflammatory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>10+ at risk</th>
<th>15+ High risk</th>
<th>20+ Very high risk</th>
<th>Total</th>
</tr>
</thead>
</table>

COMPLETED BY: [Signature] [Date]
If the resident falls into any of the risk categories then preventative care is required.

**Prevention:**

**PREVENTATIVE AIDS:**

**Special Mattress/Bed:**
- 10+ Overlays or specialist foam mattresses.
- 15+ Alternating pressure overlays, mattresses and bed systems.
- 20+ Bed Systems: Fluidised, bead, low air loss and alternating pressure mattresses.

*Note: Preventive aids cover a wide spectrum of specialist features. Efficacy should be judged, if possible, on the basis of independent evidence.*

**Cushions:**

No patient should sit in a wheelchair without some form of cushioning. If nothing else is available—use the patient’s own pillow.
- 10 + 10cm Foam cushion.
- 15+ Specialist gel and/or foam cushion.
- 20+ Cushion capable of adjustment to suit individual patient.

**Bed Clothing:**

Avoid plastic draw sheets, incontinent pads and tightly tucked in sheets/sheet covers, especially when using specialist bed and mattress overlay systems.

Use duvet—plus vapour permeable cover.

**NURSING CARE**

**General:**

Frequent changes of position, lying/sitting. Use of pillows.

**Pain:**

Appropriate pain control.

**Nutrition:**

High protein, vitamins, minerals.

**Patient Handling:**

Correct lifting technique: Hoists, Monkey Pole, Transfer Devices.

**Patient Comfort Aids:**

Real sheepskins, Bed Cradle

**Operating Table:**

Cover plus adequate protection

Theatre/A&E Trolley Skin Care:

General Hygiene, NO rubbing, cover with an appropriate dressing.

If treatment is required first remove pressure.
## Wound classification:

### STIRLING PRESSURE SORE SEVERITY SCALE (SPSSS)

#### Stage 0
No clinical evidence of a pressure sore.
- **0.1** Healed with scarring.
- **0.2** Tissue damage not assessed as a pressure sore.

#### Stage 1
Discolouration of intact skin.
- **1.1** Non blanchable erythema with increased local heat.
- **1.2** Blue/purple/black discolouration—The sore is at least Stage 1 (a or b).

#### Stage 2
Partial thickness skin loss or damage.
- **2.1** Blisters
- **2.2** Abrasion
- **2.3** Shallow ulcer, undermining of adjacent tissue.
- **2.4** Any of these with underlying blue/purple/black discolouration or induration. The sore is at least Stage 2 (a, b or c + d for 2.3, + e for 2.4).

#### Stage 3
Full thickness skin loss involving damage of subcutaneous tissue, not extending to underlying bone, tendon or joint capsule.
- **3.1** Crater, without undermining adjacent tissue.
- **3.2** Crater, with undermining of adjacent tissue.
- **3.3** Sinus, the full extent of which is uncertain.
- **3.4** Necrotic tissue masking full extent of damage. The sore is at least Stage 3 (b, +/- e, f, g + h for 3.4).

#### Stage 4
Full thickness loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or capsule.
- **4.1** Visible exposure of bone tendon or capsule.
- **4.2** Sinus assessed as extending to same. (b, +/- e, f, g, h, i).

### Guide to types of dressing/treatment

- **a** Semi-permeable membrane
- **b** Hydrocolloid
- **c** Foam dressing
- **d** Hydrogel
- **f** Alginate rope/ribbon
- **g** Foam cavity filler
- **h** Enzymatic debridement
- **i** Surgical debridement

---

**Completed by:**

**Signature**

**Date**

/ /
**Norton Scale for Predicting Risk of Pressure Ulcer**

**Overview:**
The Norton scale can be used to predict if a patient is at risk for development of a pressure ulcer.

The five basic categories are: Physical Condition, Mental Condition, Activity, Mobility and Incontinence. Each category is scored on a scale of 1–4 (where 1 denotes least favourable and 4 denotes most favourable) with overall scores ranging from a maximum of 20 to a minimum of 5.

**Instructions for use:**
1. Assess the patient’s condition and circle score accordingly (1–4).
2. Total the scores together.
3. A total score of 16 or below indicates a patient is at risk and preventative measures should be taken. The lower the total, the higher the risk.
4. Assess the patient regularly.

**Norton Scale Assessment**

<table>
<thead>
<tr>
<th>Physical condition</th>
<th>Mental condition</th>
<th>Activity</th>
<th>Mobility</th>
<th>Incontinent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Alert</td>
<td>Ambulant</td>
<td>Full</td>
<td>Not</td>
</tr>
<tr>
<td>Fair</td>
<td>Apathetic</td>
<td>Walks with help</td>
<td>Slightly limited</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Poor</td>
<td>Confused</td>
<td>Chairbound</td>
<td>Very limited</td>
<td>Usually urine</td>
</tr>
<tr>
<td>Very Bad</td>
<td>Stuporous</td>
<td>Bedfast</td>
<td>Immobile</td>
<td>Urine &amp; Faeces</td>
</tr>
</tbody>
</table>

Total

Completed by: ___________  Signature: ___________  Date: ___________ / ___________ / ___________
# MINI NUTRITIONAL ASSESSMENT MNA®

Gender: ........................................... Date: ................................................... Age: ..........................................................

Weight, kg: ................................... Height: ...........................................................

Complete screening by filling in the boxes with the appropriate numbers.

Add the numbers, from the screening section. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

## Screening

| A | Has food intake declined over the last 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? | 0 = severe loss of appetite  
1 = moderate loss of appetite  
2 = no loss of appetite |
|---|---|---|
| B | Weight loss during last 3 months | 0 = weight loss greater than 3 kg  
1 = does not know  
2 = weight loss between 1 and 3 kg  
3 = no weight loss |
| C | Mobility | 0 = bed or chair bound  
1 = able to get out of bed/chair but does not go out  
2 = goes out |
| D | Has suffered psychological stress or acute disease in the past 3 months | 0 = yes  
2 = no |
| E | Neuropsychological problems | 0 = severe dementia or depression  
1 = mild dementia  
2 = no psychological problems |
| F | Body Mass Index (BMI) (weight in kg) / (height in m²) | 0 = BMI less than 19  
1 = BMI 19 to less than 21  
2 = BMI 23 or greater |

**Screening score** (subtotal max 14 points)

12 points or greater: normal—not at risk—no need to complete assessment

11 points or below: Possible malnutrition—continue assessment

## Assessment

| G | Lives independently (not in a nursing home or hospital) | 0 = no  
1 = yes |
|---|---|---|
| H | Takes more than 3 prescription drugs per day | 0 = no  
1 = yes |
| I | Pressure sores or skin ulcers | 0 = yes  
1 = no |
| J | How many full meals does the resident eat daily? | 0 = 1 meal  
1 = 2 meals  
2 = 3 meals |
| K | Selected consumption markers for protein intake
• At least one serving of dairy products (milk, cheese, yoghurt) per day? | ☐ Yes  
☐ No |
• Two or more servings of legumes or eggs per week? | ☐ Yes  
☐ No |
• Meat, fish or poultry everyday | ☐ Yes  
☐ No |
| L | Consumes two or more servings of fruits or vegetables per day? | 0 = no  
1 = yes |
| M | How much fluid (water, juice, coffee, tea, milk…) is consumed per day? | 0.0 = less than 3 cups  
0.5 = 3 to 5 cups  
1.0 = more than 5 cups |
Name:  
DOB:  
Room No:  

**N** Mode of feeding

- 0 = unable to eat without assistance
- 1 = self-fed with some difficulty
- 2 = self-fed without any problem

**O** Self view of nutritional status

- 0 = view self as being malnourished
- 1 = is uncertain of nutritional state
- 2 = views self as having no nutritional problem

**P** In comparison with other people of the same age, how do they consider their health status?

- 0.0 = not as good
- 0.5 = does not know
- 1.0 = as good
- 2.0 = as better

**Q** Mid-arm circumference (MAC) in cm

- 0.0 = MAC less than 21
- 0.5 = MAC 21 to 22
- 1.0 = MAC 22 or greater

**R** Calf circumference (CC) in cm

- 0 = CC less than 31
- 1 = CC 31 or greater

**Assessment** (max. 16 points)

**Screening score**

**Total Assessment** (max 30 points)

**Malnutrition Indicator Score**

- 17 to 23.5 points at risk of malnutrition
- Less than 17 points malnourished

Completed by:  
Signature:  
Date: / /
**RESIDENT NUTRITION DATA CARD**

Age: .......................................................... Gender: ..........................................................

Current medical history: ................................................................................................................................................
.......................................................................................................................................................................................
Medications: ..................................................................................................................................................................
.......................................................................................................................................................................................

---

**Dietary Assessment**

**Type of Diet:**
- [ ] Full
- [ ] High protein/high energy
- [ ] Diabetic
- [ ] Vegetarian
- [ ] Other

**Texture:**
- [ ] Soft
- [ ] Cut up
- [ ] Minced
- [ ] Pureed

**Allergies:** ........................................................................................................................................................................

**Food likes:** ......................................................................................................................................................................

**Food dislikes:** ..................................................................................................................................................................

**Appetite:** ....................................................................................................................................................................... 

**Chewing and Swallowing Ability:** ..................................................................................................................................
.......................................................................................................................................................................................

**Dexterity:** ....................................................................................................................................................................... 

---

**Eating Assessment**

**Does resident require assistance to be fed?:**
- [ ] Yes
- [ ] No

**If yes**
- [ ] Some assistance
- [ ] Total assistance

**Does the resident require special utensils?**
- [ ] Yes
- [ ] No

**If yes**
- [ ] 2 handed mug
- [ ] Angled spoon
- [ ] Cup with lid
- [ ] Coupe
- [ ] Straw
- [ ] Plate surround

---

Reproduced with permission from the Best Practice Food and Nutrition Manual for Aged Care Facilities, Bunney, C & Bartel, R, Central Coast Health NSW.
### Weight Assessment (see Ideal Body Weight Chart for healthy weight range)

**Weight on entry:** ............................................................................................................................................................

**Height on entry:** ............................................................................................................................................................

**Within health weight range?** ..........................................................................................................................................

**Weight history:** ...............................................................................................................................................................

<table>
<thead>
<tr>
<th>Date</th>
<th>Measured weight</th>
<th>Measured height</th>
<th>Healthy weight range (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>

### Malnutrition Risk Guidelines (MAG)

(weight loss is in the last six months)

**High Risk:**

- BMI < 18.5
- BMI 18.5–20 plus weight loss of 3.2kg or more
- BMI > 20 plus weight loss of 6.4kg or more

**Medium Risk:**

- BMI 18.5–20 plus weight loss less than 3.2kg
- BMI >20 plus weight loss 3.2–6.4kg

**Low Risk:**

- BMI <20 and no weight loss

**Tick the resident’s risk category:**

- [ ] High
- [ ] Medium
- [ ] Low

**Completed by:**

**Signature**

**Date**

/ /
IDEAL BODY WEIGHT CHART

<table>
<thead>
<tr>
<th>Height (Metres)</th>
<th>Ideal weight range (BMI: 22-27)</th>
<th>Kilograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.37</td>
<td>41–51</td>
<td></td>
</tr>
<tr>
<td>1.40</td>
<td>43–53</td>
<td></td>
</tr>
<tr>
<td>1.42</td>
<td>45–55</td>
<td></td>
</tr>
<tr>
<td>1.45</td>
<td>46–57</td>
<td></td>
</tr>
<tr>
<td>1.47</td>
<td>48–59</td>
<td></td>
</tr>
<tr>
<td>1.50</td>
<td>49–61</td>
<td></td>
</tr>
<tr>
<td>1.52</td>
<td>51–63</td>
<td></td>
</tr>
<tr>
<td>1.55</td>
<td>53–65</td>
<td></td>
</tr>
<tr>
<td>1.57</td>
<td>54–67</td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>56–69</td>
<td></td>
</tr>
<tr>
<td>1.63</td>
<td>58–71</td>
<td></td>
</tr>
<tr>
<td>1.65</td>
<td>60–74</td>
<td></td>
</tr>
<tr>
<td>1.68</td>
<td>62–76</td>
<td></td>
</tr>
<tr>
<td>1.70</td>
<td>64–78</td>
<td></td>
</tr>
<tr>
<td>1.73</td>
<td>66–81</td>
<td></td>
</tr>
<tr>
<td>1.75</td>
<td>68–83</td>
<td></td>
</tr>
<tr>
<td>1.78</td>
<td>70–85</td>
<td></td>
</tr>
<tr>
<td>1.80</td>
<td>72–88</td>
<td></td>
</tr>
<tr>
<td>1.83</td>
<td>74–90</td>
<td></td>
</tr>
<tr>
<td>1.85</td>
<td>76–93</td>
<td></td>
</tr>
<tr>
<td>1.88</td>
<td>78–95</td>
<td></td>
</tr>
<tr>
<td>1.91</td>
<td>80–98</td>
<td></td>
</tr>
<tr>
<td>1.93</td>
<td>82–101</td>
<td></td>
</tr>
<tr>
<td>1.96</td>
<td>84–103</td>
<td></td>
</tr>
<tr>
<td>1.98</td>
<td>86–106</td>
<td></td>
</tr>
</tbody>
</table>

If height cannot be accurately measured in the standing position, it may be calculated using knee height, and applying the formula below. Measure knee height when resident sitting with bare feet flat on the floor and the knee joint at a right angle, measure from the heel on the floor to the top of the kneecap.

**Females height in cm = 84.88**  
(0.24 x age) + (1.83 x knee height in cm)

**Males height in cm = 64.19**  
(0.04 x age) + (2.02 x knee height in cm)

For example, 70 year old Mr Brown's kneew height is $54.5cm$, so his height is 171cm or 1.71m  
$64.19 - (0.04 \times 70) + (2.02 \times 54.5cm) = 171cm$
Point value

☐ Dry 2
☐ Eating difficulty 1
☐ No recent dental care (within 2 years) 1
☐ Tooth or mouth pain 2
☐ Change in food selection 1
☐ Lesions, sores or lumps in the mouth 2

TOTAL ______________________

A score of greater than two points indicates that a dental problem exists that might affect general health and wellbeing.

Completed by: ____________________  Signature: ____________________  Date: / /
ORAL HEALTH ASSESSMENT TOOL FOR DENTAL SCREENING


<table>
<thead>
<tr>
<th>Category</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline / 3 mths / 6 mths</td>
</tr>
<tr>
<td></td>
<td>(* if score 1 or 2 for any category please arrange for a dentist to assess the resident)</td>
</tr>
<tr>
<td></td>
<td>You can circle individual words as well as giving a score in each category</td>
</tr>
<tr>
<td></td>
<td>2 = unhealthy *</td>
</tr>
<tr>
<td>0 = healthy</td>
<td>1 = changes *</td>
</tr>
<tr>
<td></td>
<td>Category scores</td>
</tr>
<tr>
<td>Lips</td>
<td>smooth, pink, moist, dry, chapped, or red at corners</td>
</tr>
<tr>
<td>Tongue</td>
<td>normal, moist, roughness, pink, patchy, fissured, red, coated</td>
</tr>
<tr>
<td>Gums &amp; tissues</td>
<td>pink, moist, smooth, dry, shiny, rough, red, swollen, one ulcer/sore spot under dentures</td>
</tr>
<tr>
<td>Saliva</td>
<td>moist tissues, watery and free flowing saliva, dry, sticky tissues, little saliva present, resident thinks they have a dry mouth</td>
</tr>
<tr>
<td>Natural teeth</td>
<td>no decayed or broken teeth/roots, 1–3 decayed or broken teeth/roots or very worn down teeth</td>
</tr>
<tr>
<td>Dentures</td>
<td>no broken areas or teeth, dentures regularly worn, and named</td>
</tr>
<tr>
<td>Oral cleanliness</td>
<td>clean and no food particles or tartar in mouth or on dentures</td>
</tr>
<tr>
<td>Dental pain</td>
<td>no behavioural, verbal, or physical signs of dental pain</td>
</tr>
<tr>
<td></td>
<td>verbal &amp;/or behavioural signs of pain such as pulling at face, chewing lips, not eating, aggression</td>
</tr>
<tr>
<td></td>
<td>physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal &amp;/or behavioural signs (pulling at face, not eating, aggression)</td>
</tr>
</tbody>
</table>

Please tick this box if the resident was referred to a dentist after screening □ TOTAL SCORE ____/16

Complete Oral Hygiene Care Plan and start oral hygiene interventions for resident □

Review this resident’s oral health on: Date ____/____/____

Completed by: __________________________ Signature: __________________________ Date: ____/____/____

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ORAL HYGIENE MANAGEMENT PLAN (OHCP) (CHALMERS, 2000)

Signature
Completed by: .................................................... Date: ____/____/____ (please circle)

Dentist: public or private (please circle)
Name: ..................................................................................Phone: ...................................................

List all dental appointments: ..............................................................................................................

Date for next OHCP review:  ..............................................................................................................

Staff to help with oral hygiene care problems: □ YES □ NO

Dentures:
Upper Full/Partial/Not worn/No denture/Named (please circle)
Lower Full/Partial/Not worn/No denture/Named

Attempt denture cleaning: □ daily □ when possible
Best time to clean dentures: ...........................................................

Natural teeth:
Upper Yes/No/Roots present (please circle)
Lower Yes/No/Roots present

Attempt denture cleaning: □ daily □ when possible
Best time to clean teeth: ...........................................................

Interventions for oral hygiene care:
(please tick all that apply and circle frequency required)  (please tick all that apply)

□ is independent—no assistance needed □ forgets to do oral hygiene care
□ needs reminding/promoting/task breakdown □ won’t open mouth
□ needs supervision/checking of oral hygiene □ refuses oral hygiene care
□ needs full assistance from staff □ does not understand
□ use bridging/chaining/distraction techniques □ is aggressive/kicks/hits
□ use electric/suction toothbrush □ can’t swallow properly
□ use backward bent toothbrush for access □ can’t rinse and spit
□ use bite block □ bites toothbrush and/or staff
□ use chlorhexidine spray bottle/gel daily/weekly □ constantly grinding/chewing
□ use fluoride spray bottle/gel daily/weekly □ head faces downwards
□ use Neutrafluor 5000 toothpaste daily/weekly □ other ..........................................
□ use Oral Balance gel for dry mouth
□ other ...............................................................................

112 ASSESSMENT TOOLS
FUNCTIONAL ABILITY DOMAIN

Functional Assessment

1. Barthel Index .......................................................... 115
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Falls Assessment

3. Falls Risk Assessment Tool (FRAT) ......................... 121
4. Falls Risk Assessment and Management Form ............ 129

Continence

5. Ballarat Urinary Assessment and Management Form ...... 131
6. Ballarat Bowel Assessment and Management Plan ........ 137
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THE BARTHEL INDEX

The Barthel ADL Index: Guidelines

1. The index should be used as a record of what a resident does, not as a record of what a resident could do.
2. The main aim is to establish the degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the resident not independent.
4. A resident’s performance should be established using the best available evidence. Asking the resident, friends/relatives and carers are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the resident’s performance over the preceding 24–48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the resident supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.
8. Score range from 0–100. The higher the score, the more independent the resident is.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEEDING</strong></td>
<td></td>
</tr>
<tr>
<td>0 = unable</td>
<td></td>
</tr>
<tr>
<td>5 = needs help cutting, spreading butter, etc., requires modified diet</td>
<td></td>
</tr>
<tr>
<td><strong>BATHING</strong></td>
<td></td>
</tr>
<tr>
<td>0 = dependent</td>
<td></td>
</tr>
<tr>
<td>5 = independent (or in shower)</td>
<td></td>
</tr>
<tr>
<td><strong>GROOMING</strong></td>
<td></td>
</tr>
<tr>
<td>0 = needs help with personal care</td>
<td></td>
</tr>
<tr>
<td>5 = independent face/hair/teeth/shaving (implements provided)</td>
<td></td>
</tr>
<tr>
<td><strong>DRESSING</strong></td>
<td></td>
</tr>
<tr>
<td>0 = dependent</td>
<td></td>
</tr>
<tr>
<td>5 = needs help but can do about half unaided</td>
<td></td>
</tr>
<tr>
<td>10 = independent (including button, zips, laces, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>BOWELS</strong> (preceeding week)</td>
<td></td>
</tr>
<tr>
<td>0 = incontinent (or needs to be given enemas)</td>
<td></td>
</tr>
<tr>
<td>5 = occasional accident</td>
<td></td>
</tr>
<tr>
<td>10 = continent</td>
<td></td>
</tr>
</tbody>
</table>
The Barthel Index

116 ASSESSMENT TOOLS

BLADDER (preceeding week)
0 = incontinent or catheterized and unable to manage alone
5 = occasional accident
10 = continent

TOILET USE
0 = dependent
5 = needs some help, but can do something alone
10 = independent (on and off, dressing, wiping)

TRANSFERS (BED TO CHAIR AND BACK)
0 = unable, no sitting balance
5 = major help (one or two people, physical), can sit
10 = minor help (verbal or physical)
15 = independent

MOBILITY (ON LEVEL SURFACES)
0 = immobile or < 50 metres
5 = wheelchair independent, including corners, 50 metres
10 = walks with help of one person (verbal or physical), 50 metres
15 = independent (but may use any aid; for example, stick), 50 metres

STAIRS
0 = unable
5 = needs help (verbal, physical, carrying aid)
10 = independent

TOTAL (0–100): 

Completed by: 
Signature 
Date / /
PHYSICAL MOBILITY SCALE

Developed by the Gerontology Group of the Australian Physiotherapy Association

Supine to Side lying (*indicate left and right separately)

(0) No active participation in rolling
(1) Requires facilitation at shoulder and lower limb but actively turns head to roll
(2) Requires facilitation at shoulder or lower limb to roll
(3) Requires equipment (e.g. bedrail) to pull to side lying. Specify equipment used:
.............................................................................................................................

(4) Requires verbal prompting to roll —does not pull to roll
(5) Independent—no assistance or prompting

Supine to Sit

(0) Maximally assisted, no head control
(1) Fully assisted but controls head position
(2) Requires assistance with trunk and lower limbs or upper limbs
(3) Requires assistance with lower limbs or upper limbs only
(4) Supervision required
(5) Independent and safe

Sitting Balance

(0) Sits with total assistance, requires head support
(1) Sits with assistance, controls head position
(2) Sits using upper limbs for support
(3) Sits unsupported for at least 10 seconds
(4) Sits unsupported, turns head and trunk to look behind to left and right
(5) Sits unsupported, reaches forward to touch floor and returns to sitting position independently

Sitting to Standing

(0) Unable to weight bear
(1) Gets to standing with full assistance from therapist. Describe:
.............................................................................................................................

(2) Requires equipment (e.g. handrails) to pull to standing.
Specify equipment used: ................................................................................................................

(3) Pushes to stand, weight unevenly distributed, standby assistance required
(4) Pushes to stand, weight evenly distributed, may require frame or bar to hold onto once standing
(5) Independent, even weight bearing, hips and knees extended, does not use upper limbs

Name: 
DOB: 
Room No: 

PLACE ID LABEL HERE

place photo here

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Standing to Sitting

(0) Unable to weight bear
(1) Gets to sitting with full assistance from therapist
   Describe: ..........................................................................................................................................
(2) Can initiate flexion, requires help to complete descent, holds arms of chair, weight unevenly/evenly
distributed
(3) Poorly controlled descent, stand-by assistance required, holds arms of chair, weight evenly/unevenly
distributed
(4) Controls descent, hold arms of chair, weight evenly distributed
(5) Independent and does not use upper limbs, weight evenly distributed

Standing Balance

(0) Unable to stand without hands-on assistance
(1) Able to safely stand using aid. Specify aid used:
(2) Able to stand independently for 10 seconds, no aid
(3) Stands, turns head and trunk to look behind left or right
(4) Able to bend forwards to pick up object from floor safely
(5) Single limb balance—left:_______seconds, right:_______seconds

Transfers

(0) Non-weight bearing, hoist required. Specify:
(1) Weight bearing, hoist required. Specify:
(2) Assistance of two persons required
   Describe:
(3) Assistance of one person required
   Describe: ..........................................................................................................................................
   ............................................................................................................................ ............................
(4) Stand-by assistance/prompting required
(5) Independent

Ambulation/Mobility

(0) Bed/chair bound
(1) Wheelchair mobile
(2) Ambulant with assistance of two persons
   Describe: ..........................................................................................................................................
   ............................................................................................................................ .............................
(3) Ambulant with assistance of one person
   Describe: ..........................................................................................................................................
   ............................................................................................................................ .............................
(4) Stand-by assistance/prompting required
(5) Ambulates independently. Gait pattern: ..........................................................................................
   ............................................................................................................................ .............................
### Aids/Assistance

Specify equipment used:

- .................................................................................................................................................................
- .................................................................................................................................................................
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### Physical Mobility Scale Summary

<table>
<thead>
<tr>
<th>Date</th>
<th>Supine to sidelying Left</th>
<th>Supine to Right</th>
<th>Sitting to balance</th>
<th>Sitting to standing</th>
<th>Standing balance sitting</th>
<th>Standing balance</th>
<th>Transfers</th>
<th>Ambulation</th>
<th>Total /45</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Comments:

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Completed by: ___________________________ Signature: ___________________________ Date: __/__/
FALLS RISK ASSESSMENT TOOL (FRAT) INSTRUCTIONS

What is the Falls Risk Assessment Tool
Falls risk assessment tools have the potential to accurately quantify falls risk and provide a sound basis for decision making regarding interventions that can be effective in reducing the likelihood of falls.
In randomised trials in residential care facilities, multiple targeted intervention programs based on comprehensive risk assessment have resulted in significant reduction in falls.
Similar results have been identified in sub-acute hospital settings.

What is the FRAT?
The FRAT is
• a validated Falls Risk Assessment Tool (FRAT) to be completed by nurses in hospital and residential care facilities.
• the outcome of a two year research project, completed in 1999, by the Falls Prevention Service, Peninsula Health. The research sample was 291 patients representing all bed types in the sub-acute and residential settings of Peninsula Health.

Why the FRAT is needed
Completing the FRAT tool achieves the following.
• Provides a focus point for the collation of falls risk relevant information.
• Predicts, with reasonable accuracy, who is most likely to fall, and who is not.
• By identifying those at most risk of falls allows the targeting of resources toward those most likely to fall.
• Identification of individual fall risk factors allows the targeting of preventative strategies.

What the FRAT does
The FRAT has two functions:
A Screening tool
• By obtaining a risk score, the assessor can screen for those patients/residents who are at highest risk of falling.
and
An Assessment tool
• To identify possible risk factors contributing to the risk of falling.
• Formulate an individual management plan for targeted residents / patients as part of care planning.

Who completes the FRAT?
The FRAT is intended as a nurse administered tool, to be completed within 24 hours of admission.
The reasons are as follows:
In sub-acute and residential care settings, the nurse is most often responsible for the overall coordination of care needs, ie screening for the presence of risks, establishing the need for allied health input. Identifying and managing falls risk is an important part of this process.
The FRAT has been designed and researched with the nurse as the reader. The questions relate to observed or reported behaviours or risk factors that can be recognized by the admitting nurse soon after admission. These act as clinical indicators for the presence of falls risk, and underlying risk factors, that can assist with formulation of an action plan. It is recognized that the admitting nurse may not have all the expertise to solve all the problems and the tool is designed with this in mind to guide decision making regarding immediate actions and referrals required.
Early identification and management of falls risk needs to occur as part of the admission process to avoid delays in meeting care needs.

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Research funded by the Victorian Department of Human Services.
GUIDELINES FOR COMPLETING THE FRAT

ASSESSMENT PROCESS PARTS 1 & 2

Information required to complete Parts 1 and 2 of the FRAT can be obtained from:

- the patient or resident (if able),
- transfer information from donor facility
- clinical observations in the first 24 hours,
- initial nursing, medical or allied health assessment
- family, or other staff, familiar with the person’s care
- and/or the medical history.

It is therefore recommended that the FRAT be completed as the final part of the initial nursing assessment, with input from the medical and allied health assessment when available. Observations during patient orientation and over the initial shift or feedback from handover will assist with accuracy of completion.

PART 1: FALL RISK STATUS

Purpose:
Completing part one will provide a Fall risk score which will categorize the individuals Fall Risk Status into low, medium or high. Each level has a corresponding protocol.

How to obtain a Score

- Circle one score ONLY in each of the 4 categories in Part 1.

  If the person’s condition fluctuates you need to circle the score representing their lowest functional level.

  Determine the client’s risk classification level (risk status) by adding the 4 scores from Part 1

  Low risk  5–11
  Medium risk 12–15
  High risk  16–20

  Persons with a risk classification of 16–20 require a Fall Alert Protocol to be actioned.

- Complete the Automatic High Risk Status section.

  This section allows for clinical judgement of risk status, that would not otherwise be detected. These risks are often more acute in nature such as a sudden change in condition where the underlying causes are not yet known, the onset of illness or UTI, recent change in high risk medication etc. A tick in either box in this section will categorize the person at automatic high risk. Persons with automatic high-risk status should be reviewed regularly, at intervals deemed appropriate by the assessor, as the risk can change and settle quickly when issues are addressed.

  If ticked, circle high risk at the end of part 1 and list fall alert protocol in the action plan.

RISK CLASSIFICATION

Circle the appropriate level:   Low,    Medium    or     High

Low:  Provide standard care and follow general patient safety principles.

Medium:  Provide Standard Care but risk factors have been identified and strategies integrated in the care plan to target area of risk. See FRAT PACK, suggested strategies section for options.

High:  Commence Fall Alert Protocol. Patient has a high likelihood of a fall occurring. See section in Frat Pack-Fall Alert for details of the protocol.
PART 2: RISK FACTOR CHECKLIST & HISTORY OF FALLS

Purpose
This section includes fall risk factors that, although not found to have a high predictive value for purposes of developing the FRAT tool, are identified as major risk factors for falls in hospitals and residential care. Although Part 1 enables us to categorize an individual according to risk level, part 1 alone tells us nothing about what risk factors need targeting for management.

Instructions
Complete the risk factor checklist by placing a tick in the appropriate boxes.
Risk factors identified need targeting for management by listing in the action plan at the bottom of the page.

HISTORY AND CIRCUMSTANCES OF FALLS:
Although this section is located at the rear of the tool, it is useful to do this first before completing part 1. Information obtained by completing this section will enable accurate completion of the scored section, to establish risk status. The history of falls, particularly if occurring in the donor facility, will highlight whether the falls were associated with particular activities, problems or time of day. Information regarding strategies previously used to reduce risk can also be useful when developing an action plan.
The FRAT research indicated History of Falls as the strongest predictor that a person will fall again and is therefore weighted in the scoring. Accuracy in completing this section is therefore very important as inaccuracies can result in missing the person at high risk.

Instructions
It is recommended that this information be confirmed via a carer or family member.
Non or under-reporting by the patient / resident of falls is not uncommon and can occur for a number of reasons. This includes memory difficulties, passing off as trivial, fear that disclosure may influence staff’s perception of their ability to return home.

Explore the following and list
Ask the patient and/or family.

- Were falls a problem before entering hospital and how did they occur? detail findings under this section on the FRAT?
- Seek information from the donor facility or transfer documents re falls in that facility and what seemed to work and not work with regards to risk minimization.
- Find out the circumstances of the most recent falls. Obtain information on time; activity, environment, symptoms, was gait aid used, where available.
- If available, list previous falls on a Fall or communication sheet at the front of the patient file, where history of falls can be listed. If a fall occurs during stay add subsequent falls to this list as a quick reference re falls. Remember this does not replace the need to report the fall, with or without injury, via the incident report form and to forward onto clinical risk.

Document history of falls and strategies on any transfer / discharge summary.
Use the information to appropriate score Part 1 of the FRAT.
PART 3: ACTION PLAN

• In the left column, list problems, as identified in Part 1 and 2 of the FRAT.
• Identifies strategies to minimize the risk for each problem. (You can refer to the section “Risk Factor Checklist and Possible Interventions” in the FRAT PACK)
• >Transfer appropriate strategies to care plan.

REVIEW:
Reassessment should occur
• as part of regular team and patient review meetings
• whenever the client’s condition changes.
• if a fall has occurred since the last review.

Review involves
Questioning the team whether current status and strategies, should for any reason, be altered.
Team discussion will determine appropriate changes based on the circumstances.

Note:
Review does not involve repeating the FRAT tool. The tool is for initial assessment purposes only to obtain an initial risk profile. Managing falls risk should then become a dynamic process integrated as part of ongoing care.

Questions to ask as part of patient review:
Have any issues, observations of patient led to a need to alter current risk status and strategies as listed on the flow chart?
Are there any additional strategies that need to be considered?

Note:
Decision to remove a fall alert protocol must consider risk at all times of day and therefore be a team decision ie patient may use gait aid safely but still gets confused at night.
If falls relevant information and strategies are appropriately detailed to the care plan then reassessment can be integrated as part of general review of overall care needs.

FALL ALERT PROTOCOL
WHAT IS FALL ALERT:
Fall alert is the identification of patients/residents at high risk or falls. Patients designated by this protocol are, for various reasons, those identified as being unable to manage their own safety.

Fall alert utilizes 4 strategies:
Orange alert stickers:
Orange armbands:
Specific strategies to minimize the risk or behaviors that contribute to the risk.
Communication at each handover re alert status and strategies in place.

PURPOSE
The purpose of fall alert protocol is to:
• Alert staff on each roster who is prone to falling, and
• Ensure consistency of strategies in place to reduce the risk.

CRITERIA FOR FALL ALERT PROTOCOL
Using the Falls Risk Assessment Tool, all residents/patients identified as high risk (16–20) or Automatic High Risk should be classified as Fall Alert.

PROTOCOL

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Research funded by the Victorian Department of Human Services.
Residents scoring high risk on the FRAT have a corresponding Fall Alert protocol listed in the action plan.

Orange alert stickers are placed
- on bed head
- on the care plan
- on the alert sheet (front page of the history)

“Fall Alert” is documented on the handover sheet for the period the patient remains on Fall Alert protocol.

If agreed by the team as appropriate, the resident is to wear an orange patient arm band. This assists staff to distinguish residents who are mobile and at risk.

Notify Allied Health that resident has been classified high risk by the FRAT and is on Fall Alert Protocol (per facility protocol).

Additional strategies that may be beneficial
Select the most appropriate strategy/strategies that best meet the needs of the person and which are considered practical within the facility and transfer them to the care plan. Other strategies additional to those listed below may also be identified that are most suited to the person.

- Supervision and/or assistance for certain mobility or ADL tasks. The Occupational therapist and/or physiotherapist can give advice.
- Remove mobile equipment (ie overbed table) from areas frequently walked by the patient.
- Keep clutter around the bed clear (day and night).
- Use of bed / chair sensors, when indicated, to aid monitoring of high-risk persons with impaired cognition.
- Initiate a toileting routine including scheduled night toileting where appropriate.
- Locate person close to nurses station, if possible.
- Call button within reach at all times and ensure prompt responses to call buzzer.
- Regular supervised walking regime.
- Gait aid /mobility review.
- Individual environmental and A.D.L. assessment re additional safety precaution that may benefit.

REVIEW OF FALL ALERT PROTOCOL
Fall alert protocol can be ceased at the teams discretion.
The criteria for removing the fall Alert protocol is the agreement by the team that strategies are in place as part of routine care appear effective in minimizing falls risk.

Behaviours contributing to high risk are no longer present/or minimized.

To cease fall alert protocol
- Inform the resident and reinforce safety precautions
- Remove stickers /arm band (if used).
- Document changed status in the progress notes.
- If deemed necessary, inform the family

Note: Ceasing fall alert protocol does not mean ceasing strategies in place to minimize falls risk.
DISCHARGE PLANNING

- If a person was falling prior to admission to your facility, chances are they may fall when they leave. Referral to the appropriate community follow-up would be essential.
- O.T. home assessment prior to discharge/transfer is recommended with specific focus on what may have contributed to previous falls and to assess the need for a personal alarm if returning home at risk.
- Careful consideration should be given to what type and amount of community supports is required to keep the person safe from falls on return home.
- Provide information to the patient/resident on discharge regarding where to get help if falls continue.
- Educate the patient re safe participation in activities on return home.
FALLS RISK ASSESSMENT TOOL (FRAT)

Part 1—Fall Risk Status

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Level</th>
<th>Risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent falls</td>
<td>none in last 12 months</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>one or more between 3–12 months ago</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>one or more in last 3 months</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>one or more in last 3 months whilst inpatient/resident</td>
<td>8</td>
</tr>
<tr>
<td>Medication</td>
<td>not taking any of these</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>taking one</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>taking two</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>taking more than two</td>
<td>4</td>
</tr>
<tr>
<td>Psychological</td>
<td>does not appear to have any of these</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>appears mildly affected by one or more</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>appears moderately affected by one or more</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>appears severely affected by one or more</td>
<td>4</td>
</tr>
<tr>
<td>Cognitive status</td>
<td>m-m score 9 or 10/10 OR intact</td>
<td>1</td>
</tr>
<tr>
<td>MMSE</td>
<td>m-m score 7–8</td>
<td>2</td>
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<tr>
<td></td>
<td>m-m score 5–6</td>
<td>3</td>
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<td></td>
<td>m-m score 4 or less</td>
<td>4</td>
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</tbody>
</table>

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

Current Problems:

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

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

Important: If HIGH, commence fall alert

Part 2—Risk Factor Checklist

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

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Research funded by the Victorian Department of Human Services.
### Part 2—Risk Factor Checklist (continued)

**History of falls**  Note: For an accurate history, consult patient / family / medical records

**Falls prior to this admission** (home or donor facility) and/or during current stay

(If ticked, detail most recent below)

**Circumstances of recent falls** (past residence or current)

Information obtained from .................................................................

<table>
<thead>
<tr>
<th>Fall</th>
<th>(circle below)</th>
<th>(Where?/Comments)</th>
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</thead>
<tbody>
<tr>
<td>Last Fall:</td>
<td></td>
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<td>Previous:</td>
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<td>Previous:</td>
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<tr>
<td>Previous:</td>
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</table>

**LIST HISTORY OF FALLS ON ALERT SHEET**

### Part 3—Action Plan

(For risk factors identified in Part 1 & 2, list strategies below to manage falls risk. See tips on previous pages.)

<table>
<thead>
<tr>
<th>Problem list</th>
<th>Intervention strategies/referrals</th>
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<tbody>
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**TRANSFER CARE STRATEGIES TO CARE PLAN/FLOW CHART**

Completed by: ____________________________  Signature: ____________________________  Date: ____________

Planned Review date: ____________

**Review**

Falls Review should occur at scheduled Patient Review meetings or at intervals set by the initial assessor

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Risk Status (Y or N)</th>
<th>Revised Care Plan Signed</th>
<th>Review Date</th>
<th>Risk Status (Y or N)</th>
<th>Revised Care Plan Signed</th>
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</table>
# Falls Risk Assessment and Management Form (CERA Tool)

<table>
<thead>
<tr>
<th>Problem or issue</th>
<th>Assessment</th>
<th>Yes or No</th>
<th>Management options (tick which ones you suggest)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>• Does the person take 4 or more medications in total? <strong>Or</strong></td>
<td></td>
<td>• Allocate to high risk group</td>
</tr>
<tr>
<td></td>
<td>• Does the person take one or more tranquillisers, antidepressants or sedative/hypnotics?</td>
<td></td>
<td>• Review by GP to try to reduce medications or dosages</td>
</tr>
<tr>
<td>Acute illness</td>
<td>• Does the person have any sign of acute illness eg. Altered behaviour, confusion, pain malaise, fever, cough, urinary symptoms?</td>
<td></td>
<td>• Review by GP to ensure appropriate treatment</td>
</tr>
<tr>
<td>Mental state</td>
<td>• Is the person confused and/or disoriented and/or wandering</td>
<td></td>
<td>• Refer to GP to exclude treatable causes.</td>
</tr>
<tr>
<td></td>
<td>• CVA?</td>
<td></td>
<td>• Allocate to high risk group</td>
</tr>
<tr>
<td></td>
<td>• Parkinson’s disease?</td>
<td></td>
<td>• Review by GP to ensure optimum treatment</td>
</tr>
<tr>
<td></td>
<td>• Osteoarthritis in knees/hips?</td>
<td></td>
<td>• Refer to physiotherapist for possible treatments</td>
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<tr>
<td></td>
<td>• Dementia?</td>
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<td>• Postural hypotension?</td>
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<td>• Depression?</td>
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<tr>
<td></td>
<td>• Dizziness?</td>
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<td></td>
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<tr>
<td>Ongoing medical conditions</td>
<td>• Does the person have:</td>
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<tr>
<td></td>
<td>– CVA?</td>
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<td></td>
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<tr>
<td></td>
<td>– Parkinson’s disease?</td>
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<tr>
<td></td>
<td>– Osteoarthritis in knees/hips?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Dementia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Postural hypotension?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Depression?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– Dizziness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of previous falls</td>
<td>• Has the person had:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– one fall in past year which requires treatment or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>– more than two falls not requiring treatment in past year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor balance</td>
<td>• Is the person unsafe when asked to stand from chair, walk 3 metres, turn and return to chair independently (even with walking aid)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Allocate to high risk group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Refer to GP for assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Refer to physiotherapist for assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem or issue</td>
<td>Assessment</td>
<td>Yes or No</td>
<td>Management options (tick which ones you suggest)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Bowel or bladder problems| • Does the person have urinary or faecal incontinence, or urgency during the day or night?                                                                                                                |          | • Institute appropriate nursing care  
• Refer to GP for assessment  
• Allocate to high risk group |
| Visual problems          | • Does the person (while using their normal glasses) have problems reading headlines in the newspaper, making out figures on the TV or seeing objects alongside them? |          | • Refer to GP and ophthalmologist to exclude cataracts or other treatable disease and review glasses  
• Refer to optometrist for review of existing glasses  
• Allocate to high risk group if there is poor vision which cannot be corrected |
| Hearing problems         | • Does the person have problems hearing you with normal speech?                                                                                                                                              |          | • Refer to GP for checking of ears and hearing  
• Refer to audiologist for hearing aid assessment  
• Ensure hearing aids are working and being used correctly  
• Allocate to high risk group if there is poor hearing which cannot be corrected |
| Feet problems            | • Does the person have corns, ingrown toenails, ulcers, deformities or infection of the feet?                                                                                                                |          | • Institute appropriate nursing care  
• Refer to podiatrist for treatment  
• Allocate to high risk group if problems cannot be successfully treated |
| Footwear                 | • Does the person have unsafe footwear (slippery soles, loose fitting, inflexible soles, uneven heels etc)                                                                                                 |          | • Correct problems                                                                                 |
**BALLARAT URINARY ASSESSMENT AND MANAGEMENT FORM**

**Date of Assessment:**

Person able to give an accurate history  
- [ ] Yes  
- [ ] No

If no, specify below
- [ ] language barrier  
- [ ] memory problems  
- [ ] other cognitive problem  
- [ ] other

Other history obtained through
- [ ] family  
- [ ] staff  
- [ ] medical record

### SECTION 1 – CURRENT URINARY CONTINENCE/VOIDING STATUS

**General description of voiding pattern/continence problem**

Current frequency of voiding: ...................................................per day ...................................................per night

Has this changed from usual  
- [ ] no  
- [ ] yes—specify .................................................................

Past history of urinary problems  
- [ ] no  
- [ ] yes—specify .................................................................

Current urinary problem  
- [ ] continence problem  
- [ ] voiding problem  
- [ ] other

How long has it been a problem?  
- [ ] week(s)  
- [ ] month(s)  
- [ ] < 1 year  
- [ ] > 1 year

Comments ......................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

**Checking for related problems**

Usual bowel pattern  
- [ ] regular  
- [ ] irregular  
- [ ] more than 1/day  
- [ ] daily  
- [ ] less than daily (___x/week)

History of faecal incontinence  
- [ ] no  
- [ ] yes—specify if current  

History of constipation  
- [ ] no  
- [ ] yes—specify if current  

History of urinary tract infections  
- [ ] no  
- [ ] yes if ‘yes’— is there a current UTI?  

Comments ......................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................
<table>
<thead>
<tr>
<th>Checking the urine</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any stinging, burning, pain when voiding</td>
<td>☐ no  ☑ yes</td>
</tr>
<tr>
<td>Urine has unpleasant/strong odour</td>
<td>☐ no  ☑ yes</td>
</tr>
<tr>
<td>Visible blood/blood spots in urine</td>
<td>☐ no  ☑ yes</td>
</tr>
<tr>
<td>Recent urinalysis results date</td>
<td>☐ NAD ☑ abnormality found—specify</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specifics of voiding pattern/continence status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of voiding</td>
<td></td>
</tr>
<tr>
<td>Frequency of incontinence</td>
<td></td>
</tr>
<tr>
<td>Recognises the need to void</td>
<td>☑ yes ☐ no ☐ sometimes</td>
</tr>
<tr>
<td>Sense of urge to void is</td>
<td>☑ absent ☑ normal ☐ very strong/urgent</td>
</tr>
<tr>
<td>If couldn’t toilet immediately, would be incontinent</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Gets a warning/urge when about to be incontinent</td>
<td></td>
</tr>
<tr>
<td>Leakage happens when coughing/sneezing/on exertion</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Leakage occurs on the way to the toilet</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Usual amount of incontinence</td>
<td>☑ damp ☑ wet ☐ soaked</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observations to be made about the stream</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are small volumes (&lt;200mls) usually passed</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Is there hesitation before the stream starts</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Is stream weak or stops and starts</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Is there dribbling after stream finished</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Feels empty when stream has finished</td>
<td>☑ no ☑ yes</td>
</tr>
<tr>
<td>Has to void a few times to properly empty</td>
<td>☑ no ☑ yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Toileting issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses pan in bed OR toileting assessed elsewhere</td>
<td>☑ go to next section</td>
</tr>
<tr>
<td>Level of assistance required</td>
<td>☑ none ☑ supervision only ☑ by 1 staff ☑ by 2 staff</td>
</tr>
<tr>
<td>Height of toilet for client</td>
<td>☑ appropriate ☑ too low ☑ too high</td>
</tr>
<tr>
<td>Feet well supported when sitting</td>
<td>☑ yes ☑ no ☑ adequate privacy ☑ yes ☑ no</td>
</tr>
</tbody>
</table>

Comments......................................................................................................................................................................
.......................................................................................................................................................................................

| Frequency of voiding                              |       |
| Frequency of incontinence                         |       |
### Dietary and fluid intake

<table>
<thead>
<tr>
<th>Number of meals/day</th>
<th>............................ meals</th>
<th>............................ snacks</th>
</tr>
</thead>
</table>

Eats most of meals
- □ yes—most of servings
- □ no—comments

Dietary fibre intake
- □ adequate/normal
- □ poor—specify

Fluid intake
- □ amount per day
- □ type of fluids

Diet modified to help bowels
- □ no
- □ sometimes
- □ yes—specify modifications to diet below
  - □ extra high fibre foods & drinks (eg. prunes, PAB etc)
  - □ other—specify

Other comments

---

### Continence aids and appliances

- □ not applicable
- □ go to next question

Continence aids and appliances
- □ yes
- □ always
- □ sometimes—specify

required for urinary incontinence

Catheterisation required
- □ intermittent—frequency
- □ no
- □ yes

- □ Indwelling – next change due

Catheter type and size used

The aids used are adequate
- □ yes
- □ no – review use of aid in management plan

Other comments

---

### Skin integrity

- □ skin integrity intact
- □ go to next section

State of skin in groin/ perianal area
- □ red
- □ broken
- □ bleeding
- □ painful
- □ other

Comments

---

### Impact of the problem

Current bowel problem affects the following

- Activities of daily living
- □ no
- □ yes

- Ability to socialize
- □ no
- □ yes

- Emotional state/self-esteem
- □ no
- □ yes

Comments

---
SECTION 2 – COMPLETE A URINARY DIARY/OBSERVATION FORM

Date started   /  /  
Date completed  / /  

SECTION 3 – GENERAL CONDITION RELATED TO CONTINENCE/VOIDING PROBLEM

Medical & surgical problems that may impact on continence/voiding status

Relevant medical history

☐ None known  ☐ Neurological problem eg. CVA, M.S., Parkinson’s Disease, Spinal Condition
☐ Renal/Urinary system disease
☐ Cognitive/Psychological disorder eg. Dementia, Depression
☐ Gastroenterological disorder eg. Irritable Bowel Disease
☐ Other

Relevant surgical history

☐ None known  ☐ Bowel surgery
☐ Urological surgery eg. to prostate, bladder
☐ Uro-gynae surgery eg. prolapse repair, hysterectomy
☐ Other

Comments........................................................................................................................................................................................
........................................................................................................................................................................................................

Medicines and continence/voiding status (to be completed by RN or medical staff)

Number of different medicines prescribed  ☐ < 2 different drugs  ☐ 2–5 different drugs  ☐ > 5 different drugs

Prescribed medicines that may affect the bladder

☐ Anticholinergics  ☐ NSAID  ☐ Opiates
☐ Diuretics  ☐ Iron preparations  ☐ Verapamil/nifedipine
☐ Anti-Parkinsonian  ☐ Anti-psychotics  ☐ Tricyclic antidepressants
☐ Anti-hypertensives  ☐ Sedatives
☐ Other

Cognitive state & toileting

☐ no impairment or toileting assessed separately  ☐ go to next section

Unable to initiate the use of the toilet  ☐ sometimes  ☐ always  ☐ n/a
Shows altered behaviour when needing to void  ☐ sometimes  ☐ always  ☐ n/a
Is unaware of toilet location  ☐ sometimes  ☐ always  ☐ n/a
Unable to sequence toileting tasks independently  ☐ sometimes  ☐ always  ☐ n/a
Is uncooperative when assisted to toilet  ☐ sometimes  ☐ always  ☐ n/a
<table>
<thead>
<tr>
<th>Mobility/dexterity &amp; toileting</th>
<th>☐ no impairment or ☐ toileting assessed separately ☐ go to next section</th>
</tr>
</thead>
<tbody>
<tr>
<td>General activity level of person</td>
<td>☐ fully ambulant ☐ walks around facility/unit ☐ non-ambulant/bed fast</td>
</tr>
<tr>
<td>Activity level recently decreased</td>
<td>☐ no ☐ yes—specify ..............................................................................</td>
</tr>
<tr>
<td>Getting out of chair/bed</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Walking to the toilet</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Getting on and off toilet</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Managing clothing</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Managing toilet paper/wiping</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Changing continence aids</td>
<td>☐ needs supervision ☐ needs assistance ☐ n/a</td>
</tr>
<tr>
<td>Comments</td>
<td>......................................................................................................................................................................</td>
</tr>
</tbody>
</table>

SECTION 4 – IDENTIFYING THE PROBLEM AND DEVELOPING AN INDIVIDUALISED MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>☐ Voiding problem (separate to incontinence)</th>
<th>Causative/Related Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Urinary Incontinence</td>
<td>☐ Constipation</td>
</tr>
<tr>
<td>(Indicate type of incontinence if known)</td>
<td>☐ Urinary Tract Infection</td>
</tr>
<tr>
<td>☐ Stress Incontinence</td>
<td>☐ Reduced fluid intake</td>
</tr>
<tr>
<td>☐ Urge Incontinence</td>
<td>☐ Reduced mobility/dexterity</td>
</tr>
<tr>
<td>☐ Overflow Incontinence</td>
<td>☐ Cognitive difficulties</td>
</tr>
<tr>
<td>☐ Functional Incontinence</td>
<td>☐ Medicines</td>
</tr>
<tr>
<td>☐ Constipation</td>
<td>☐ Medical/surgical condition</td>
</tr>
<tr>
<td>☐ Faecal Incontinence</td>
<td>☐ Environment</td>
</tr>
<tr>
<td>If yes, to constipation and/or faecal incontinence consider using the assessment— bowel elimination form</td>
<td>☐ Other ..............................................................................</td>
</tr>
<tr>
<td>☐ Other</td>
<td>...................................................................................................................................</td>
</tr>
</tbody>
</table>
TREATMENT AND MANAGEMENT PLAN

☐ Increase fluid intake
☐ Improve environment to make toileting easier
☐ Strategies to improve mobility
☐ Have medicines reviewed
☐ Introduce a toileting program
☐ Timed/scheduled toileting program
☐ Prompted toileting program
☐ Bladder retraining program
☐ Pelvic floor exercise program
☐ Use of continence product/aid
☐ Referral to medical or nursing specialist

Using the 24 hour clock, indicate what times the person should be toileted (circle times)

1 2 3 4 5 6 7 8 9 10 11 12
13 14 15 16 17 18 19 20 21 22 23 24

Other comments ..................................................................................................................................................................................
.......................................................................................................................................................................................
.......................................................................................................................................................................................

Completed by: Signature Date
Ballarat Bowel Assessment and Management Form

Date of Assessment: / / 

Person able to give an accurate history □ Yes □ No
If no, specify below
□ language barrier □ memory problems □ other cognitive problem □ other
History obtained from:
□ family □ staff □ medical record □ other

SECTION 1 – THE CURRENT BOWEL PATTERN

Bowel frequency/timing
Usual bowel pattern □ regular □ irregular □ more than 1/day □ daily □ less than daily (____/week)
Usual time of day for bowel motions
Has this changed from usual □ No □ Yes
If yes, document the usual pattern ................................................................................................................................
.......................................................................................................................................................................................
Any specific toileting routine for bowels □ No □ Yes
specify ............................................................................................................................................................................
.......................................................................................................................................................................................
Characteristics of bowel motions
Usual consistency of motions (scale per Bristol Stool Form Scale) Lewis & Heaton, 1997, Scand. J. of Gastroenterology. 32(9):920-4
□ hard pellets/lumps (1) □ soft blobs with clear edges (5)
□ lumpy, hard cylinder (2) □ fluffy and unformed (6)
□ dry, cracked cylinder (3) □ watery – no solid pieces (7)
□ soft, smooth cylinder (4)
Is stool consistency variable?
□ no □ a little □ considerably
Is there a presence of any of these in the stool?
□ mucous □ blood □ undigested food
□ other ..................................................................................................................................................
............................................................................................................................. .................................
<table>
<thead>
<tr>
<th>Other bowel symptoms</th>
<th>No</th>
<th>Occasionally</th>
<th>Yes ≥ 3/4 of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems unaware of the urge to use bowels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has to use their bowels urgently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strains to open bowels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has pain during bowel emptying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has abdomen pain at times other than bowel emptying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels like there’s a blockage when emptying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses fingers/other methods to aid bowel emptying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels as though not empty, even when finished</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments/describe .......................................................................................................................................................

.......................................................................................................................................................................................

<table>
<thead>
<tr>
<th>Continence status</th>
<th>□ no bowel incontinence □ go to next section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is aware of soiling or incontinence</td>
<td>□ yes □ no</td>
</tr>
<tr>
<td>Frequency of incontinence</td>
<td>_____ per day OR _____ per week</td>
</tr>
<tr>
<td>Specify when incontinence occurs</td>
<td></td>
</tr>
</tbody>
</table>

If incontinent, stool consistency is □ hard □ soft □ loose/fluidy

Usual amount of incontinence □ whole bowel action □ partial bowel action or soiling

Other comments ............................................................................................................................................................

.......................................................................................................................................................................................

<table>
<thead>
<tr>
<th>Nature of the problem</th>
<th>□ no current problem □ go to end of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ constipation □ faecal incontinence □ diarrhoea □ other</td>
<td></td>
</tr>
<tr>
<td>How long has it been a problem</td>
<td>□ week(s) □ month(s) □ &lt;1 year □ &gt;1 year</td>
</tr>
<tr>
<td>Frequency of problem</td>
<td>□ only occasional □ comes &amp; goes but quite regularly □ constant</td>
</tr>
<tr>
<td>Comments .....................................................................................................................................................................</td>
<td></td>
</tr>
</tbody>
</table>

.......................................................................................................................................................................................

| Toileting issues □ uses pan in bed OR □ toileting assessed elsewhere □ go to next section |
|-------------------------------------------------|----------------------------------|
| Level of assistance required                    | □ none □ supervision only □ 1 staff □ 2 staff |
| Height of toilet for client                      | □ appropriate □ too low □ too high |
| Feet well supported when sitting                 | □ yes □ no                         |
| adequate privacy                                 | □ yes □ no                         |

Comments.........................................................................................................................................................................

.......................................................................................................................................................................................

Reproduced with permission from Ballarat Health Services
**Dietary and fluid intake**

**Number of meals/day**  
- [ ] [ ] [ ] meals  
- [ ] [ ] [ ] snacks  

**Eats most of meals**  
- [ ] yes—most of servings  
- [ ] no—comments  

**Dietary fibre intake**  
- [ ] adequate/normal  
- [ ] poor—specify  

**Fluid intake**  
- amount per day ...........................................  
- type of fluids ..................................................  

**Diet modified to help bowels**  
- [ ] no  
- [ ] sometimes  
- [ ] yes—specify modifications to diet below  
  - [ ] extra high fibre foods & drinks (eg. prunes, PAB etc)  
  - [ ] other—specify  

**Other comments** 

**Continence aids and appliances**  
- [ ] not applicable  
- [ ] go to next question  

**Continence aids and appliances**  
- [ ] yes  
- [ ] always  
- [ ] sometimes—specify  

**The aids used are adequate**  
- [ ] yes  
- [ ] no  
- [ ] sometimes  

**Skin integrity**  
- [ ] skin integrity intact  
- [ ] go to next section  

**State of skin in groin/perianal area**  
- [ ] red  
- [ ] broken  
- [ ] bleeding  
- [ ] painful  
- [ ] other  

**Comments**

**Impact of the problem**

**Current bowel problem affects the following**  

**Activities of daily living**  
- [ ] no  
- [ ] yes  

**Ability to socialise**  
- [ ] no  
- [ ] yes  

**Emotional state/self-esteem**  
- [ ] no  
- [ ] yes  

**Comments**

---

**SECTION 2 – COMPLETE A BOWEL ELIMINATION OBSERVATION FORM**

**Date started**  
**Date completed**

**SECTION 3 – GENERAL CONDITION RELATED TO BOWEL PROBLEM**

**Medical & surgical problems that may impact on bowel status**

**Relevant medical history**

- [ ] none known  
- [ ] neurological problem eg. CVA, MS, Parkinson’s disease, spinal condition  
- [ ] endocrine disorders eg. diabetes, hypothyroidism  
- [ ] cognitive/psychological disorder eg. dementia, depression  
- [ ] gastroenterological disorder eg. haemorrhoids, rectal prolapse, IBS  
- [ ] other
Relevant surgical history
- None known
- Bowel surgery
- Recent procedures involving bowel preparation
- Other

Use of laxatives: Not applicable

Use of laxatives
- Regular use of laxatives
  - Yes
  - No

Treatmen effective
- Yes
- No

Comments

Other medicines and bowel status—to be completed by RN Div 1s or medical staff

No. of drugs prescribed
- <2 different drugs
- 2–5 different drugs
- >5 different drugs

Prescribed medicines that may cause:
- Constipation
  - Anticholinergics
  - NSAID
  - Opiates
  - Diuretics
  - Iron preparations
  - Verapamil/nifedipine
  - Anti-Parkinsonian
  - Anti-psychotics
  - Tricyclic antidepressants
  - Other

- Diarrhoea/faecal incont.
  - Antibiotics
  - Laxatives
  - Other

Cognitive state & toileting
- No impairment or toileting assessed separately

Unable to initiate the use of the toilet
- Sometimes
- Always
- N/A

Shows altered behaviour when needing to void
- Sometimes
- Always
- N/A

Is unaware of toilet location
- Sometimes
- Always
- N/A

Unable to sequence toileting tasks independently
- Sometimes
- Always
- N/A

Is uncooperative when assisted to toilet
- Sometimes
- Always
- N/A

Mobility/dexterity & toileting
- No impairment or toileting assessed separately

General activity level of person
- Fully ambulant
- Walks around facility/unit
- Walks around room
- Non-ambulant/bed fast

Activity level recently decreased
- No
- Yes—specify

Getting out of chair/bed
- Needs supervision
- Needs assistance
- N/A

Walking to the toilet
- Needs supervision
- Needs assistance
- N/A

Getting on and off toilet
- Needs supervision
- Needs assistance
- N/A

Managing clothing
- Needs supervision
- Needs assistance
- N/A

Managing toilet paper/wiping
- Needs supervision
- Needs assistance
- N/A

Changing continence aids
- Needs supervision
- Needs assistance
- N/A

Comments
### SECTION 4 – IDENTIFYING THE PROBLEM AND DEVELOPING AN INDIVIDUALISED MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>Constipation with the main symptom(s) of:</th>
<th>Causative/Related Factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ infrequent bowel actions</td>
<td>□ high/low fibre intake</td>
</tr>
<tr>
<td>□ straining</td>
<td>□ inadequate fluid intake</td>
</tr>
<tr>
<td>□ having a feeling of blockage</td>
<td>□ reduced mobility</td>
</tr>
<tr>
<td>□ don’t feel empty after finishing</td>
<td>□ physical difficulties using toilet</td>
</tr>
<tr>
<td>□ have to help themselves empty manually</td>
<td>□ cognitive difficulties using the toilet</td>
</tr>
<tr>
<td>□ Faecal incontinence</td>
<td>□ medicines</td>
</tr>
<tr>
<td>□ Diarrhoea</td>
<td>□ neurogenic factors</td>
</tr>
<tr>
<td>□ acute diarrhoea (2–3 weeks of symptoms)</td>
<td>□ other medical/surgical condition</td>
</tr>
<tr>
<td>□ chronic diarrhoea (&gt;2–3 weeks)</td>
<td>□ other..........................</td>
</tr>
<tr>
<td>□ other ..................................................</td>
<td></td>
</tr>
</tbody>
</table>

#### Treatment & Management Plan

<table>
<thead>
<tr>
<th>□ educate person about bowel function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify........................................</td>
</tr>
<tr>
<td>□ increase fluid intake</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ increase dietary fibre intake</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ increase mobility/exercise</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ introduce a toileting program</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ reduce/modify current laxative use</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ introduce laxative therapy</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ referral to medical or nursing specialist</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
<tr>
<td>□ other ...........................................</td>
</tr>
<tr>
<td>..................................................</td>
</tr>
</tbody>
</table>
COGNITIVE AND MENTAL HEALTH
COGNITIVE AND MENTAL HEALTH DOMAIN

Behavioural Assessment

1. Behavioural Assessment Form (BAF) ................................................................. 145

2. 24 hour Behaviour Timechart ............................................................................. 147

Cognitive

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Depression

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5. Geriatric Depression Scale (GDS) ................................................................. 153

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BEHAVIOURAL ASSESSMENT FORM

Behaviour does not occur in a vacuum. Whether we can see it or not, there is always something that starts it off. Sometimes this is an event such as the delivery of a meal, sometimes it is a thought such as ‘I am missing my husband.’ The trigger to the behaviour is called the Antecedent, it is the A of the ABC.

The Behaviour itself is the B and the Consequences of the behaviour are the C. The consequences have a strong influence on whether or not the behaviour will be repeated. If the consequences are experienced as rewarding the behaviour is likely to go on or be repeated, if they are not rewarding the behaviour it is likely to stop, eventually.

Effective behaviour management begins by trying to clearly describe the behaviour, identifying the triggers and analysing the consequences to see what is keeping it going. In other words applying the ABC approach. This is assisted by the use of the Behavioural Assessment Form. There are many varieties of this, one example modified from John Bowles’ version (Bowles, 1986) is given as an example below. If the antecedents can be identified and changed the behaviour may be avoided. A simple, but actual, example of this involved a resident who repeatedly screamed ‘Murder, murder.’ When the antecedents were identified it was found that these outbursts were often preceded by a door slamming loudly. When this was changed the behaviour did not occur as frequently. Similarly if nonrewarding consequences can be substituted for rewarding consequences the behaviour will also reduce. Disruptive, dangerous and unpleasant behaviours can be managed indirectly, i.e. by looking at what starts them and what keeps them going, more humanely and with more dignity than when confronted directly, by administering drugs or restraints.
### Behavioral Assessment Form (BAF)

**Antecedents** *(What was happening before the incident)*  
<table>
<thead>
<tr>
<th>Date:</th>
<th>Observed behaviour:</th>
<th>What interaction took place afterwards?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where did it take place?:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Behaviour** *(What, exactly, was the incident)*  
<table>
<thead>
<tr>
<th>Date:</th>
<th>Observed behaviour:</th>
<th>Consequences <em>(What happened afterwards)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
<td>What interaction took place afterwards?</td>
</tr>
<tr>
<td>Where did it take place?:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consequences** *(What happened afterwards)*  
<table>
<thead>
<tr>
<th>Date:</th>
<th>Observed behaviour:</th>
<th>Consequences <em>(What happened afterwards)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
<td>What interaction took place afterwards?</td>
</tr>
<tr>
<td>Where did it take place?:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:**

The BAF should be completed every time a significant incident takes place. If the person responsible for monitoring the resident is not present during the incident they should complete the BAF by discussing the events with someone who was. Begin by filling out the middle column, i.e. clearly describe the behaviour. Then describe what happened before and then what happened afterwards.

**Section B. Describe what your actions were and what effect they had on the persons behaviour.**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CAM**  

Completed by: [ ]  
Signature: [ ]  
Date: [ / / ]

---

Reproduced with permission from Dr Richard Fleming (Hammond Care Group), based on work carried out by H.D Fredrick and revised by John Bowles.
24 HOUR BEHAVIOUR TIME CHART

Date: ..............................................................................................................................................................................

Behaviour type: ............................................................................................................................................................

Details of behaviours: ....................................................................................................................................................

Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Behaviour</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>not disruptive</td>
<td>no intervention by staff</td>
</tr>
<tr>
<td>1</td>
<td>a little disruptive</td>
<td>co-operative response to intervention, not disruptive to other residents or visitors</td>
</tr>
<tr>
<td>2</td>
<td>moderately disruptive</td>
<td>not always co-operative, but can be resolved with intervention, sometimes disruptive to other residents or visitors</td>
</tr>
<tr>
<td>3</td>
<td>very disruptive</td>
<td>sometimes requires immediate intervention, interferes with others, their belongings or visitors, asocial behaviour</td>
</tr>
<tr>
<td>4</td>
<td>extremely disruptive</td>
<td>always requires immediate intervention, wakes others at night, disruptive to others during the day, requires one or more staff attention or constant attention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>Mon Date:</th>
<th>Tues Date:</th>
<th>Wed Date:</th>
<th>Thurs Date:</th>
<th>Fri Date:</th>
<th>Sat Date:</th>
<th>Sun Date:</th>
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</thead>
<tbody>
<tr>
<td>MN-0100</td>
<td>0200</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>1700</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1800</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1900</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2000</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2100</td>
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<tr>
<td></td>
<td>2200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>2300</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>2400</td>
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<td></td>
</tr>
</tbody>
</table>

Completed by: ........................................ Signature: ........................................ Date: / /
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MINI-MENTAL STATE EXAMINATION

The Mini-Mental State Examination can be used to assess a person’s mental state. It is intended to be given quickly and easily which is useful in residents with only limited spans of attention or cooperation. It can be used over time to assess changes in status with recovery, further deterioration or treatment interventions.

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### PRELIMINARY DEPRESSION ASSESSMENT

In your opinion has the resident been depressed over the last week?

(Please circle answer)

<table>
<thead>
<tr>
<th>No</th>
<th>Mildly</th>
<th>Moderately</th>
<th>Severely</th>
</tr>
</thead>
</table>

Answer the questions by putting a tick in the appropriate box:

1. Did any of the resident’s relatives describe him/her as being depressed before they were admitted?
2. Did the resident have any problems settling in, particularly with establishing good relationships?
3. Did the resident seem to avoid people during the first 4 weeks after their admission?
4. Is the resident having any problems with the staff?
5. Is the resident grieving over the loss of opportunities, or abilities, to take part in activities they value?
6. Does the resident take an active part in activities when he/she attends them?
7. Is the resident grieving over the loss of their own home?
8. Is the resident grieving over the loss of their privacy or dignity?
9. Is the resident grieving over separation from a spouse or child?
10. Is the resident in pain?
11. Does the resident have a visit from a friend or a relative at least once a week?
12. Does the resident regularly help another resident or staff member?

If you have described the resident as being mildly, moderately or severely depressed or if you have put ticks in 3 or more of the shaded boxes in the table above, you should continue your assessment of the resident by either:

- Asking them to complete the Geriatric Depression Scale, or if they cannot do this
- Completing the Cornell Scale

Completed by: [ ] Signature: [ ] Date: [ ] / [ ] / [ ]

THE GERIATRIC DEPRESSION SCALE

The Geriatric Depression Scale (GDS) was designed to help identify depression in people who are not severely demented. It can be used with confidence when the resident has a Mini Mental Status Examination (MMSE) score of more than 14. People with an MMSE score of 14 or less will usually be having significant problems in dressing, grooming and/or toileting because of their dementia. If there is no MMSE score available then look for these problems. If these problems are present because of dementia, DO NOT administer the GDS.

Instructions

It is important that you spend a few minutes helping the resident settle down before presenting them with the questions. Please use this time to tell them that it is important to try to understand how people feel in themselves, because by doing this you might be able to help with any problems they may have.

Where possible the resident should be asked to complete the GDS by themselves. The answers should then be scored by the assessor.

If the resident is not able to complete the form because of problems with their eyesight, reading or writing, then the questions should be read out to them and the answers recorded.

Scoring

The shaded boxes in the GDS form indicate answers that should be scored as 1 point. Use this to score the answers given by the resident when they either fill in the form themselves or answer the questions verbally.

You can calculate the score by adding up the ticks in the shaded boxes. The total number of these is the score.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–10</td>
<td>normal</td>
</tr>
<tr>
<td>11–20</td>
<td>mild depression</td>
</tr>
<tr>
<td>21–30</td>
<td>moderate to severe depression</td>
</tr>
</tbody>
</table>

The abbreviated version is proposed for use to reduce problems of fatigue and lack of focus, particularly among physically or cognitively impaired residents.

Scoring for the abbreviated version:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>normal</td>
</tr>
<tr>
<td>5–9</td>
<td>mild depression</td>
</tr>
<tr>
<td>10–15</td>
<td>moderate to severe depression</td>
</tr>
</tbody>
</table>

Brink & Yesavage as cited in McDowell & Newell (1996)
Reproduced with permission from Oxford University Press.
The Geriatric Depression Scale

Note: Shaded items count as one point, score >15 indicates depression.
The fifteen items marked with an * indicate the abbreviated version of the GDS.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Are you hopeful about the future?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are you bothered by thoughts you cannot get out of your head?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Are you in good spirits most of the time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Are you afraid that something bad will happen to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you feel happy most of the time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you often feel helpless?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you often get restless and fidgety?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you prefer to stay home, rather than going out and doing new things?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Do you frequently worry about the future?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you feel you have more problems with memory than most?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you think it’s wonderful to be alive now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you often feel downhearted and blue?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Do you worry a lot about the past?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Do you find life very exciting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Is it hard for you to get started on new projects?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Do you feel full of energy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Do you feel that your situation is hopeless?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Do you think that most people are better off than you are?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Do you frequently get upset over things?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Do you frequently feel like crying?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Do you have trouble concentrating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Do you enjoy getting up in the morning?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Do you prefer to avoid social gatherings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Is it easy for you to make decisions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Is your mind as clear as it used to be?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

<table>
<thead>
<tr>
<th>Completed by</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessed by</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# THE CORNELL SCALE

Instructions: If you are not familiar with the Cornell Scale, please see the administration and scoring guidelines.

The ratings should be based on symptoms and signs occurring during the week prior to completion. No score should be given if symptoms result from physical disability or illness.

Please circle your responses

<table>
<thead>
<tr>
<th></th>
<th>Unable to rate</th>
<th>Absent</th>
<th>Mild or only happens from time to time</th>
<th>Severe</th>
</tr>
</thead>
</table>

## Mood
- Anxiety: anxious expression, ruminations, worrying
- Sadness: sad expression, sad voice, tearfulness
- Lack of reactivity to pleasant events: does not cheer up when offered pleasant activities
- Irritability: easily annoyed, short tempered

## Behavioural Disturbance
- Agitation: restlessness, handwringing, hair-pulling
- Slowness: slow movements, slow speech, slow reactions
- Multiple physical complaints: complains about physical health more than is reasonable (score 0 if gastro-intestinal symptoms only)
- Loss of interest: less involved in usual activities (score 1 or 2 only if change occurred acutely, ie in less than 1 month)

## Physical signs
- Appetite loss: eating less than usual
- Weight loss: score 2 if greater than 2.5 kg in 1 month
- Lack of energy: fatigues easily, unable to sustain activities (score only if change occurred acutely, ie in less than 1 month)

## Changes in daily/night mood and behaviours
- Changes of mood: mood changes as the day progresses with symptoms worse in morning
- Difficulty falling asleep: later than usual for this individual
- Multiple awakenings during sleep: wakes up more often than is usual for this individual
- Early morning awakening: earlier than usual for this person

## Ideational Disturbance
- Suicide: feels life is not worth living, has suicidal wishes or makes suicide attempt
- Poor self esteem: self-blame, self depreciation, feelings of failure
- Pessimism: anticipation of the worst, thinks things are always going to go wrong
- Depressing delusions: delusions of poverty, illness or loss. Cannot be convinced that they are not poor or ill, or that they have not lost something or somebody.

Total = Add all 1s + 2s in the shaded area

Completed by: [Signature] Date [ ]

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