Examining the utility of the Aged Care Funding Instrument (ACFI) as a vehicle for improving staff skills and knowledge in care planning and management of behavioural and psychological symptoms of dementia (BPSD)

SUMMARY

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The Aged Care Funding Instrument (ACFI) was introduced in 2008 as the means of allocating Australian Government subsidies to residential aged care providers (1). The ACFI was designed to improve how funding is matched with resident needs. As such, it is timely and essential to examine the potential utility of the ACFI in improving care in Residential Aged Care Facilities (RACF). This study focused on the behavioural and psychological symptoms of dementia (BPSD) relevant aspects of the ACFI (ACFI-BEH hereafter), including agitation, aggression, depression and wandering, as the management of those BPSD remains a significant challenge to many care staff in RACFs.

The five key objectives of this study were:
1. to explore the potential utility of the ACFI data in care planning;
2. to pilot an education tool that utilises the ACFI data as a component of care planning for aged care residents with BPSD (see Appendices - Aged Care Funding Instrument informed Education Tool [ACFiET]);
3. to evaluate the effect of the education tool on the care planning practice;
4. to evaluate the effect of the education tool on management of BPSD against three measures – Cohen Mansfield Agitation Inventory (CMAI), Revised Algase Wandering Scale (RAWS), and Cornell Scale for Depression in Dementia (CSDD); and
5. to investigate the construct validity of the ACFI-BEH in comparison to other validated dementia outcome measures for BPSD.

KEY FINDINGS

Care Plan Quality:
Although there was a slight improvement in care plan quality, overall care plan quality remained low, with none of the care plans fully addressing residents’ care needs associated with BPSD following the intervention. In addition, post intervention care plan quality remained low with between 31% and 65% of care plans still not addressing current behaviours. These results highlighted that the care needs of residents with
BPSD are not well assessed and documented in care plans, in particular the care needs of residents with depression/depressive symptoms.

A review of care planning policy and practice documentation highlighted some factors which may have contributed to the findings:

- 24% of care planning staff worked only night shifts, which may make it difficult for them to directly observe the daytime needs of the residents.
- Staff working patterns may be an influencing factor as a majority of staff who participated in the study and were involved in care planning worked on a part time basis.
- Although four out of five facilities had a current care planning policy that recommended a comprehensive assessment of care needs, with two utilising a person centred framework, there was limited evidence, as observed by the quality of participants’ care plans that these policies were put into practice.

**ACFI data: accessibility and credibility**
The potential utility of the ACFI in care planning was found to be hindered by two main factors, the credibility and accessibility of the ACFI data and the culture of RACFs where direct care staff were often removed from using care plans and the ACFI results in their care. The ACFI assessment scores were not available to most care staff in four out of the five RACFs and when they were available it was found that most staff did not read them.

According to ACFI guidelines RACFs are required to re-conduct ACFI assessment when there is a significant change in a resident’s condition. However, the age of the ACFI data was on average 12/15 months (pre/post tests). The presence of behaviours as reported in the ACFI-BEH was compared to the presence of behaviours in data collected by the Research Nurse. ACFI-BEH scores did not accurately reflect resident current behavioural status. This proportion of discrepancy ranged from 21.7% to 43.5% with the depression domain having the highest proportion of discrepancy at 43.5% (using pre-test data).

The validity of the ACFI-BEH measures was also only confirmed for one of the four domains, verbal behaviour. A particular concern was raised in terms of the ACFI-BEH depression domain for which the CSDD is mandatory for the assessment. A high proportion of ‘a’ - ‘unable to evaluate’ was found on CSDD questions 16 to 19 measuring ideational disturbance. This ranged from 40-48% when answered by RACF staff and the trained Research Nurse respectively.

**Conclusion:**
The utility of the ACFI in care planning appears not to be effective partly due to the lack of accessibility and credibility of the ACFI information and more notably the culture of poor care planning practice. There is an urgent need for further investigation into current care planning practices of RACFs with a specific focus on residents with BPSD. Further research is warranted to examine the construct validity of the ACFI-BEH using a larger sample and the clinical utility of the CSDD as administered by RACF staff as part of the ACFI assessment suite.