Acute Care Outcome Scales, Screeners and Clinical Action Points

You will find the Outcome Scales, Screeners and Clinical Action Points within the Acute Care Assessments. Not all will appear in the admission, review or discharge assessments.

Further information on these can be found in Workbook Unit 5 in iL&D.

An Assessment Summary page has been added to Admission and Review assessments. *This summary is optional to complete.*

To view what outputs are available in each Acute Care Assessment, see the below tables.

Outcome Scales

interRAI Outcome Scales are validated against 'gold standard' clinical assessment outcomes to ensure they are reliable, and responsive. This means they accurately measure function, provide consistent results, and detect changes in a person over time.

- These scales indicate a person's level of disability without needing to review individual assessment items.
- Outcome scales can indicate the severity of a concern, monitor progress, assess risk to health and function during hospital stays.

Table 1: Acute Care Outcome Scales

Outcome Scales			
	Admission	Review	Discharge
ADL Hierarchy Scale (ADLH)	✓	✓	✓
ADL Short Form Scale (ADLS)	✓	✓	✓
Body Mass Index (BMI)	✓	✓	
Cognitive Performance Scale (CPS)	✓	✓	✓
Communication Scale (CS)	✓	✓	✓
Pain Scale (PS)	✓	✓	✓
Pressure Ulcer Risk Scale (PURS)	✓		
Short Depression Rating Scale	✓	✓	

Table 2: Acute Care Outcome Scale details

Outcome Scales	
Outcome Scale	**Assessment items included in the Outcome Scale**
ADL Hierarchy Scale (ADLH) **(0-6)** The ADL Hierarchy scale and the ADL short scale are measures of functional performance. The ADLH scale is particularly useful in grading the level of progression of a patient's disability over long time periods. It is based on the concept of "early", "middle" and "late" loss of ADLs. For example, in many illnesses, the ability to bathe oneself is lost early in its progression (early loss ADL), whereas the ability to feed oneself (eating) is lost when a condition is far advanced (late loss ADL). The scale generates 7 levels. Higher scores indicate greater dependency. The ADL hierarchy has 7 levels: 0 = Independent 1 = Supervision required 2 = Limited impairment 3 = Extensive assistance required - 1 4 = Extensive assistance required - 2 5 = Dependent 6 = Total dependence Higher scores indicate greater dependency.	F1a1 - Personal hygiene F1b1 - Eating F1c1 - Walking F1d1 - Toilet Use
ADL Short Form Scale (ADLS) **(0-16)** The ADL Short scale provides a measure of ADL status that is more sensitive to change over time than the ADL Hierarchy Scale and is useful for comparison when a patient moves between clinical settings. It is the preferred scale for monitoring ADL performance across the hospital episode. The short ADLS scale can be calculated at every assessment period (including premorbid). The Short Form is a 16 point scale, higher scores reflect greater levels of dependency.	F1a1 - Personal hygiene F1b1 - Eating F1c1 - Walking F1d1 - Toilet Use
Body Mass Index (BMI) BMI is a major measure of geriatric nutrition. High levels represent obesity, whereas low levels represent frailty and potentially malnutrition. Because the distribution of body fat (total to visceral) varies among ethnic groups, the	J1a - Height (metres) J1b - Weight (kilograms)

Outcome Scales	
Outcome Scale	**Assessment items included in the Outcome Scale**
suggested "normal" ranges vary somewhat. In older adults, a slightly higher range (25-29.9) may be acceptable. The normal range among patients of Asian background is slightly lower. Careful interpretation is also required in individuals with limb amputation, and with loss of height associated with conditions such as severe osteoporosis. A BMI of more than 35 represents obesity, while a BMI of less than 20 represents frailty.	
Cognitive Performance Scale (CPS) **(0-6)** The Cognitive Performance Scale (CPS) describes the cognitive status of an individual. It assigns individuals to seven easily understood ranked categories. Higher scores indicate a greater degree of cognitive impairment. The CPS has 7 levels: 0 = Intact 1 = Borderline intact 2 = Mild impairment 3 = Moderate impairment 4 = Moderate/severe impairment 5 = Severe impairment 6 = Very severe impairment Scores of 2 or more are associated with a high likelihood that the patient has dementia.	C1 - Daily decision-making C2 - Short-term memory D1 - Making self understood F1b1 (admission) - Eating F1b (discharge) - Eating
Communication Scale (CS) **(0-8)** The Communication Scale is a simple method to assess a person's communication abilities. The ability to make oneself understood and understand others is not restricted to verbal communication. It doesn't specifically focus on hearing and vision but rather dysphasia and other similar syndromes. Higher levels of the scale represent poorer communication. The scale has categories 0 to 8: 0 = Intact 1 = Borderline intact 2 = Mild impairment 3 = Mild/moderate impairment 4 = Moderate impairment	D1 - Making self-understood D2 - Ability to understand others

Outcome Scales

Outcome Scale	Assessment items included in the Outcome Scale
5 = Moderate/severe impairment 6 = Severe impairment 7 = Severe/very severe impairment 8 = Very severe impairment If a person scores 6 or more on the Communication Scale, their ability to process language (this may be verbal, written or signed) is severely impaired.	
Pain Scale **(0-4)** The Pain Scale uses assessment items pain frequency and pain intensity to simply measure the person's experience of pain. The pain scale scores ranges from 0 to 4, as follows: 0 = No pain 1 = Less than daily pain 2 = Daily pain but not severe 3 = Daily severe pain 4 = Daily excruciating pain Higher values equate to higher pain experienced.	I3a1 - Pain frequency I3b1 - Pain intensity
Pressure Ulcer Risk Scale (PURS) **(0-8)** This scale is informed by items coded in the AC assessment that provide a measure of risk for development of a pressure injury. These can be used as areas to target interventions when planning care. The PURS has been validated against the Braden Scale for pressure-ulcer risk. The Pressure Ulcer Risk scale scores ranges from 0 to 8, as follows: 0 = Very low risk 1 = Low risk 2 = Low risk 3 = Moderate risk 4 = High risk 5 = High risk 6 = Very high risk 7 = Very high risk 8 = Very high risk Higher scores indicate greater risk of developing pressure injuries.	F1c1 - Walking F1f - Bed mobility H3 - Bowel continence I2 - Dyspnoea I3a1 - Pain frequency J2 - Weight loss K2 - Prior pressure ulcer

Outcome Scales

Outcome Scale	Assessment items included in the Outcome Scale
Short Depression Rating Scale (0-6) The Short Depression Scale is based on a person's self-reported depressed mood and anxiety, and the frequency and number of a person's symptoms. The person's score on the Short Depression Scale is based on three assessment items, all of which are self-reported. Each question is scored from 0 to 2 and the maximum possible score is 6. A score of zero represents no symptoms of depression are present. A higher score indicates the presence of more symptoms. The higher the score, the worse the person's mood is, from the person's perspective.	E1a - Little interest or pleasure in things you normally enjoy? E1b - Anxious, restless, or uneasy. E1c - Sad, depressed, or hopeless?

Risk Screeners

Screeners are used to assist in identification of a problem that is not easily detected with a single observation.
An elevated score may indicate a need for further assessment or referrals.

Table 3: Acute Care Diagnostic Risk Screeners

Diagnostic Risk Screeners			
	Admission	Review	Discharge
Delirium	✓	✓	✓
Dementia	✓	✓	✓
Undernutrition	✓	✓	
Depression	✓		✓

Delirium Screener for Geriatric Syndromes

Up to 20 per cent of older people who present at hospital with an acute illness also have delirium, while up to 20 per cent of people who do not have delirium when they are admitted, develop it subsequently. The Delirium Screener for Geriatric Syndromes helps you to identify if delirium is present at the time the person is assessed.

A person's score on the Delirium Screener for Geriatric Syndromes is based on their score on two assessment items. A person can score 0 (negative screen) or 1 (positive screen). If the screen is positive, the person is highly likely to have delirium (see Table 4).

Table 4. Delirium Screener

Score	Criteria
0 – Negative screen	C3 Periodic disordered thinking or awareness — mental function varies over the course of the day = 0 or 1 and C4 - Acute change in mental status from person's usual functioning = 0. No
1 – Positive screen	C3 Periodic disordered thinking or awareness — mental function varies over the course of the day = 2. Behaviour present, different form normal functioning or C4 - Acute change in mental status from person's usual functioning = 1. Yes

Dementia Screener for Geriatric Syndromes

Dementia is present in about 20 per cent of people aged 70 years and older who are admitted to an acute-care hospital. This rate increases to approximately 50 per cent among people aged 90 years and older.

The Dementia Screener for Geriatric Syndromes uses the Cognitive Performance Scale (CPS) to detect if dementia is present when the person is assessed. The CPS ranges from 0 to 6: a higher score indicates more severe cognitive decline (see Table 2).

If the person scores 2 or higher on the CPS it suggests dementia is present (the higher the score, the more certainty there is that dementia is present). Unless they have already received a dementia diagnosis, they should be referred for further evaluation.

A person can score 0 (negative screen) or 1 (positive screen) (see Table 5). If the screen is positive, it is highly likely that a dementia is present.

Table 5. Dementia Screener

Score	Criteria
0 – Negative screen	CPS is 0 or 1
1 – Positive screen	CPS is 2–6

If a person scores 2 or more on the CPS and has a positive screen on the Delirium Screener for Geriatric Syndromes, review their CPS score before their illness if possible. If this CPS score was also 2 or higher, it is likely that their high CPS score in hospital is attributable to a dementia.

Undernutrition — Risk of Adverse Outcome

Undernutrition is common in older general-medical inpatients; it may be present in as many as 50 to 60 per cent. The Undernutrition — Risk of Adverse Outcome is positive in about 25 per cent of older general-medical inpatients.

If the patient's BMI is less than 22, the patient may be undernourished.
If the answer to Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS is 'yes', the patient may be undernourished.

A person's score on Undernutrition — Risk of Adverse Outcome is based on two assessment items.
A person's Undernutrition — Risk of Adverse Outcome can be 0 or 1 (see Table 6).

Table 6. Undernutrition Screener

Score	Criteria
0 – Negative screen	BMI is at least 22 and J2 Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS = 0. No

Score	Criteria
1 – Positive screen	BMI is less than 22 or J2 Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS = 1. Yes

Depression Screener for Geriatric Syndromes

Anhedonia is the inability to feel pleasure in normally pleasurable activities, leading to a loss of interest and enjoyment in these activities.

Anhedonia is a prominent symptom of major depressive disorders in older adults.

It often leads to physical complaints, prompting individuals to seek medical care.

Mental illness, including conditions associated with anhedonia, is a common diagnosis among older adults who frequently visit the emergency department (ED).

Anhedonia, combined with impaired ability to perform activities of daily living (ADLs) and a history of ED visits, is strongly linked to repeat ED visits and inpatient hospital admissions within 28 days of discharge from the ED.

The Depression Screener for Geriatric Syndromes screens for depressed mood and anxiety based on self-reported mood and symptom frequency and provides a positive or negative screen (see Table 7). It utilises three specific assessment mood self-reported items to determine a person's score via the Short Depression Rating Scale score (see Table 2).

Older adults presenting with anhedonia may be referred to outpatient mental-health services or inpatient geriatric psychiatry for further evaluation and treatment.

Table 7. Depression Screener

Score	Criteria
0 – Negative screen	Short Depression Rating Scale = 0
1 – Positive screen	Short Depression Rating Scale is = 1 or more

The following screeners help identify the likelihood that an adverse event will occur in the future.

Table 8: Risk of Adverse Outcomes Screeners

Risk of adverse outcomes			
	Admission	**Review**	**Discharge**
ADL decline	✓		
Falls	✓		
Pressure Ulcer	✓		
Readmission	✓		

ADL Decline — Risk of Adverse Outcome

While they are in hospital, older people may experience a decline in their ability to perform ADLs. For many people, this functional decline is associated with the acute illness that brings them to hospital; some of them will not fully recover the level of function they had before their illness. For others, such as stroke patients and patients with a hip fracture, long periods of bed rest and deconditioning may cause a long-term decline in their ability to perform ADL, which will affect their ability to live independently. The risk of a person's ability to perform ADL declining is likely to increase if they are also cognitively impaired.

People who already have impaired functional ability face a greater risk that their ability to perform ADL will decline further during their hospital stay. This risk of decline can be assessed using the ADLS Scale, using the period before their illness to score them.

First, the ADL Decline - Risk of Adverse Outcome CAP calculates a person's pre-admission score on the ADLS Scale (see Table 2). Their score is a maximum of 16 points from four MDS assessment items (see Table 9).
Second, the person's score on the CPS (see Table 2) is calculated. Their score is a maximum of 6 points from four MDS assessment items

Table 9. ADL Decline Screen

Score	Criteria
0 – Negative screen	ADL Short Form (Premorbid) Scale score = ADLS score is 0, 1 or 16 CPS score is 0, 1 or 6
1 – Positive screen	ADL Short Form (Premorbid) Scale score is 2–15 or CPS score is 2–5

Falls - Risk of Adverse Outcome

Falls can result in serious injuries. In acute-care settings, older people's risks of falls outweigh other risks, such as from acute illness or delirium. The reported prevalence rate of falls among older people in hospital ranges from 2 to 17 percent. People face a greater risk of falls if they have a history of falling recently, mobility problems, cognitive impairment, or impaired vision.

A person's score on Falls - Risk of Adverse Outcome is based on their score on three assessment items and the Cognitive Performance Scale (CPS). Two items and the CPS (see Table 2) each have a possible 'falls count' score of 1, giving the person a maximum 'falls count' of 3 (see Table 10).

The third item - falls in last 90 days - is combined with the falls count to calculate Falls - Risk of Adverse Outcome (see Table 11).

Table 10. Falls Count

AC Assessment items	Description	Falls count
D4	Vision = 2, 3 or 4	1
F2	Balance = 1	1
CPS (on admission)	CPS = 2-6	1
Maximum possible falls count		**3**

If the person has experienced a fall within the last 90 days, or since their last assessment, they have a medium risk of falling. The person has a high risk of falling if they have a CPS score of 2 or more, problems with balance related to transfers, or at least moderately impaired vision.

A person's Falls - Risk of Adverse Outcome can be 0, 1 or 2 (see Table 11).

Table 11. Falls Screen

Score	Criteria
0 – Negative screen	I1 Falls in last 90 days = 0. No fall in the last 90 days and Falls count = 0
1 – Positive Screen Medium Risk	I1 Falls in last 90 days = 1. One or more falls in the last 90 days and Falls count = 0 or 1
2 – Positive Screen High Risk	I1 Falls in last 90 days is 1 or more (assessment item I1) and Falls count = 2 or 3

Pressure Ulcer (Injury) - Risk of Adverse Outcome

Older people, especially people with restricted mobility, risk developing a pressure injury while they are in hospital. Pressure ulcers can be difficult to treat, and they cause pain, discomfort, and morbidity. Therefore, it is essential to identify people who may be at risk of developing a pressure injury and treat a pressure injury if they already have one.

A person's score on Pressure Ulcer - Risk of Adverse Outcome is based on the Pressure Ulcer Risk Scale score (see Table 2). The PURS allocates scores between 0 and 8: the higher the score, the greater their risk of developing pressure injuries.

A person's Pressure Ulcer (Injury) - Risk of Adverse Outcome can be 0, 1 or 2 (see Table 12). The higher the score, the greater the risk of developing pressure injuries.

Table 12. Pressure Ulcer Screen

Score	Criterion
0 – Negative Screen	PURS is 0, 1 or 2
1 – Medium Risk	PURS is 3 or 4
2 – High Risk	PURS is 5, 6, 7 or 8

Readmission — Risk of Adverse Outcome

The risk of unplanned readmission can be screened for using the following item.

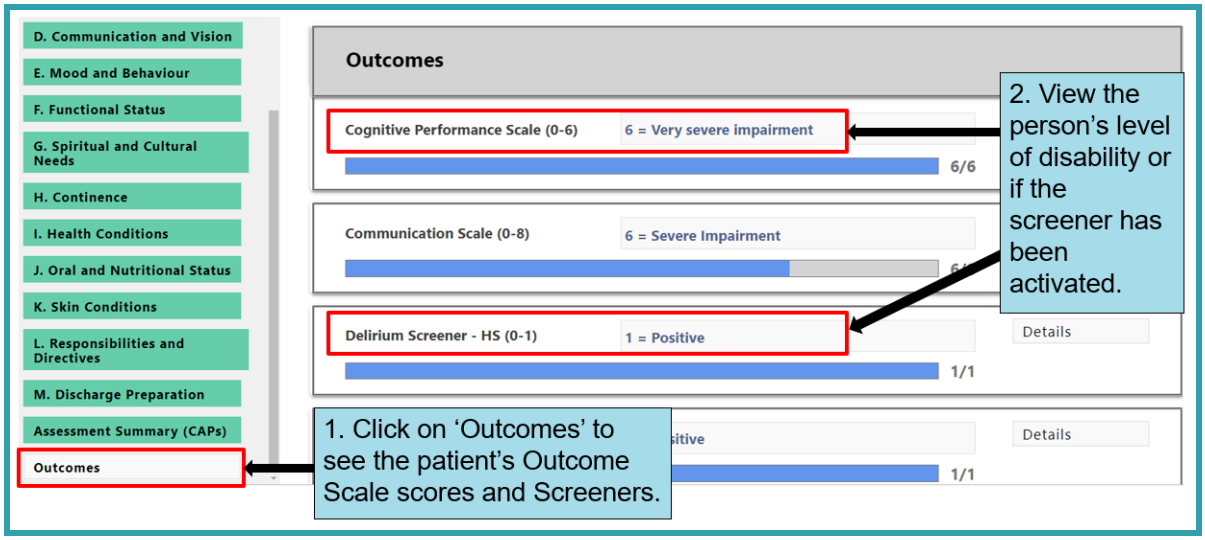
B4 Time since last hospital stay. The risk of unplanned readmission is increased if the patient had a hospital admission within the last 30 days of the current admission (see Table 13).

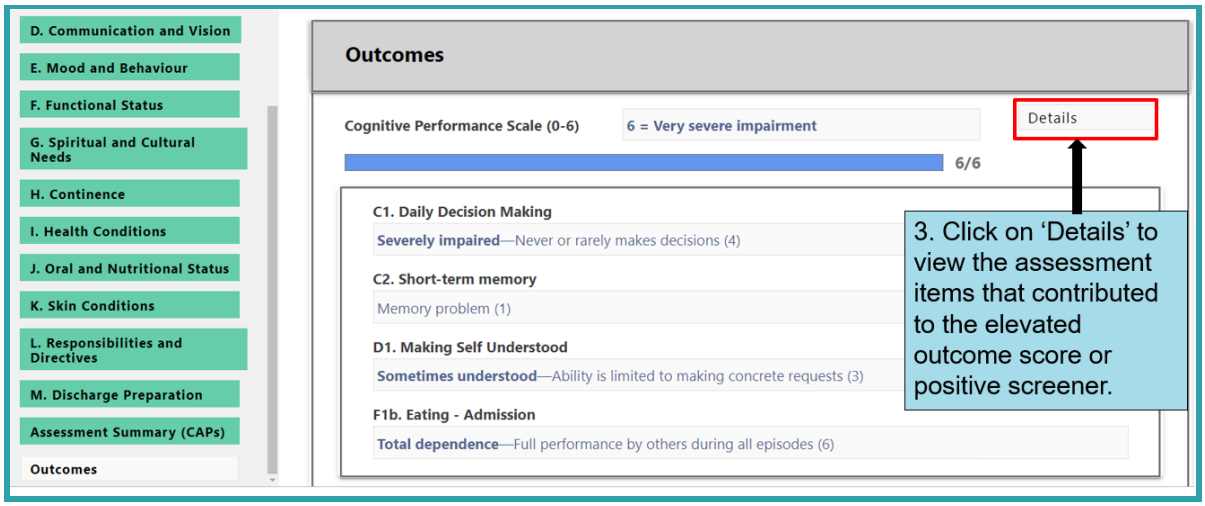
Table 13. Readmission Screen

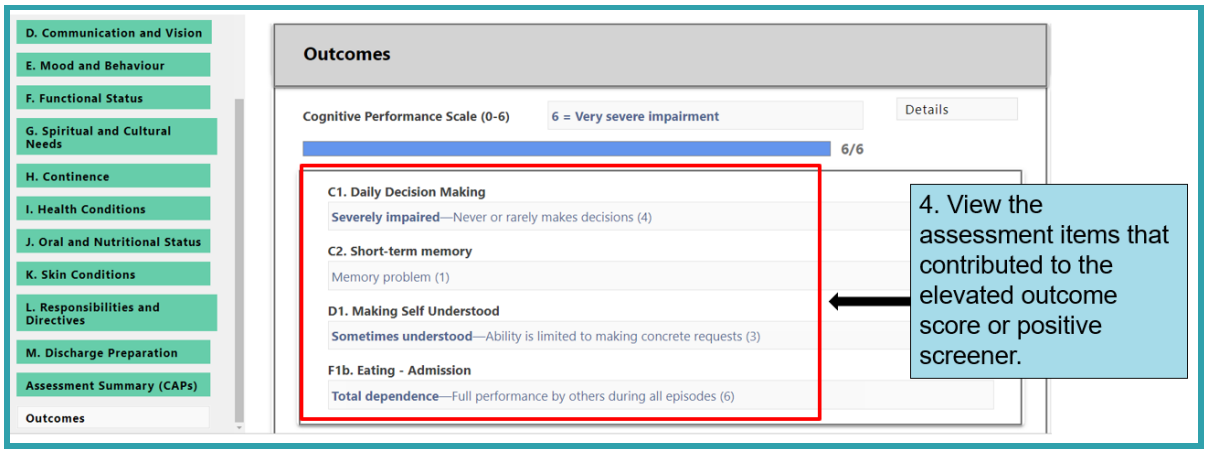
Score	Criteria
0 – Negative screen	B4 Time since last hospital stay = 0, 1, 2 or 6
1 – Positive screen	B4 Time since last hospital stay = 3, 4 or 5

To view the Outcome Scale scores and Risk Screeners in the interRAI assessment software:

- Click on ‘Outcomes’.
- View the scores (elevated Outcome Scale scores and positive risk screeners are highlighted in blue).
- View the patient’s level of disability or risk.
- Click on ‘Details’ to see the assessment items that contributed to the outcome score or screener.







Clinical Action Points

Clinical Action Points (CAPs) help identify patients who will benefit most from care interventions. While it's important to be aware of all problems, some issues cannot be prevented or treated. CAPs help focus on issues where intervention is likely to make a difference. They fall into two categories:

Prevention: The patient is at risk of an adverse event that can be prevented.
Treatment: The patient has a problem that can be effectively treated.

CAPs are identified through a process described as “triggering”. This is highlighted in bright yellow in the software. Responses to one or several items within the AC assessment are used to ‘trigger’ the CAP.

Table 14. Clinical Action Points available in the Acute Care Assessment

Clinical Action Points			
	Admission	Review	Discharge
Activities of Daily Living - Prevention	✓	✓	
Activities of Daily Living - Treatment	✓	✓	
Behaviour	✓	✓	
Delirium – Treatment	✓	✓	
Depression and Anxiety	✓	✓	
Falls	✓	✓	
Pressure Ulcer - Prevention	✓	✓	
Pressure Ulcer - Treatment	✓	✓	
Readmission	✓		
Undernutrition	✓		

Table 15. Acute Care Assessment Clinical Action Points in detail

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
ADL Prevention 	Patients in hospitals often need help with self-care, but most recover and regain independence by discharge. Conditions like stroke or hip fracture can significantly impact function, and previous functional or cognitive deficits increase the risk of further decline during hospitalisation. Mobility and ADL (Activities of Daily Living) deficits can lead to complications such as incontinence, poor communication, cognitive loss, depression, falls, postural hypotension, and pressure ulcers. It's crucial to address these issues promptly and plan appropriate discharge arrangements. Not all patients will return to their pre-admission status; some may need rehabilitation or more supervised living arrangements. Improving ADL can enhance quality of life and reduce the need for assistance. A patient's pre-hospitalisation status is a predictor of their recovery, and those with prior deficits need a restorative approach and well-planned post-hospital services to optimise recovery and prevent further decline. **Actions:** **Access to Interdisciplinary Team:** • Provide access to professionals such as physiotherapists and occupational therapists to identify aids and barriers to self-care and recommend specific interventions. **Prevention of Further Decline:** • Encourage patient independence in ADLs with aids, supervision, or assistance, aiming to reduce the level of help needed over time.	To improve function among patients who have significant newly acquired ADL limitations. To prevent decline in ADL function in vulnerable patients.	Pre-morbid ADL self-performance is impaired. OR current cognition is impaired. (Not triggered if CPS = 6.)	ADL Short Form Scale Cognitive Performance Scale

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Ensure the environment is safe and accessible (e.g., proper bed height, aids within reach, uncluttered space). • Promote early mobilisation, minimise bed rest, and encourage walking with necessary aids or supervision. • Educate and involve family members in supporting the patient's mobilisation and self-care, if safe to do so. **ADL Improvement:** • Implement early mobilisation. • Promote self-care activities. • Refer patients to relevant rehabilitation programs. **Preparation for Discharge:** • Assess the need for post-acute rehabilitation and refer appropriately, considering the potential for functional improvement, the patient's capacity to engage, and the desired discharge destination (after discussing with the patient and family). • Provide caregiver education to support ongoing maintenance or recovery at home. • Assess and arrange necessary continuing support, services, and a safe environment for the patient's return home.			
ADL Treatment 	**See above.**	Improve function among individual who have significant newly acquired ADL limitations	Cognitive function is borderline or normal (less than 3/6) AND Pre-morbid ADL deficits were 3	Cognitive Performance Scale ADL Short Form Scale

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
			points or more less than at admission	
Behaviour 	Behaviours of concern in hospital patients are often triggered by underlying medical or psychiatric issues. Factors like personality, brain damage, substance abuse, and psychiatric disorders can interact with medical problems, medications, and environmental factors to alter patient behaviour. Delirium is common in hospitalised older patients and is often linked to disturbed behaviour. It is frequently associated with dementia, which affects over 20% of general medical patients and is more common in geriatric services. Identifying signs of distress, assessing their frequency, and determining their modifiability is crucial. Documenting behavioural symptoms helps identify contributing factors. **Impact on care:** These behaviours can hinder the management of the acute medical issue that led to hospitalisation. They may lead to inappropriate interventions, such as unnecessary restraints or antipsychotic medications, and can extend hospital stays due to discharge difficulties. Behavioural disturbances can also threaten patient and staff safety and strain relationships with informal caregivers, potentially reducing their willingness to support the patient. Addressing the issue: Understanding and addressing the underlying causes of behavioural disturbances can improve the quality of life for both the patient and those around them.	Identify patients with behaviours of concern. Understand the history of these behaviours. Determine their causes, triggers, and effects. Find appropriate intervention strategies to reduce their frequency and prevent them from getting worse.	Behaviour symptoms = 1. Yes	E3 - Behaviour symptoms.

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP

	Actions:
	Further Evaluation:
	For all patients with behaviours of concern:
	• Obtain a full history, including triggers, types of behaviours, and their consequences.
	• Identify and address contributing factors, such as:
	  • Medical conditions (e.g., metabolic disturbances, sepsis, hypoxia, etc.)
	  • Cognitive or communication impairment
	  • Psychiatric or mental health conditions
	  • Poorly controlled pain
	  • Medications (prescribed and non-prescribed)
	  • Substance abuse or withdrawal
	  • Delirium & depression
	  • Unmet emotional needs (e.g., boredom, frustration)
	  • Language and cultural factors
	  • Environmental factors (e.g., noise, lighting)
	• Assess if the behaviour is dangerous to the patient or others and create an immediate action plan if necessary.
	During the Hospital Stay:
	Ensure patient safety by:
	• Addressing patient concerns and unmet needs (e.g., fear, pain, toileting)
	• Modifying the environment (e.g., reduce noise, eliminate hazards)
	• Maintaining adequate staffing levels and staff education
	• Reviewing medications
	• Referring to inpatient psychological services if needed			

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Identifying and treating underlying causes (e.g., infection, constipation) • Ensuring adequate nutrition and hydration • Implementing a behavioural management plan: • Using de-escalation techniques (non-pharmacological) • Developing care plan strategies for known situations • Cautiously using medications when necessary • Using physical restraints only as a last resort in emergencies • Documenting the patient's response to interventions **Preparation for Discharge:** • Train and educate families and caregivers in managing behaviours and effective communication techniques. • Engage community support for the patient and caregivers. • Schedule a follow-up medication review with clear guidelines for psychotropic medications. • Arrange a follow-up medical or GP review to monitor behaviours of concern.			
Delirium Treatment 	Delirium is a serious condition typically caused by acute health issues such as infections, dehydration, or drug reactions. It is linked to high mortality and morbidity, including pressure ulcers, functional decline, persistent behavioural symptoms, increased hospital stays, and premature institutionalisation. Delirium is not a normal part of aging and is often mistaken for dementia, particularly in its later stages. Unlike dementia, delirium has a rapid onset (hours to days) and typical signs include difficulty paying attention, fluctuating behaviour or cognitive function, restlessness, daytime sleepiness,	Minimise the incidence of delirium in high-risk patients. Ensure early assessment and diagnosis to provide appropriate care, reducing the severity and duration of delirium.	Delirium Opportunity for Improvement (Treatment) is likely if either of the following are present in the current assessment: C3 – Periodic disordered	C3 – Periodic disordered thinking or awareness OR C4 – Acute changes in mental status from patient's usual functioning.

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	rambling or nonsensical speech, and altered perceptions like illusions, hallucinations, or delusions. It is important to diagnose and classify the subtype of delirium to support management: • Hyperactive: Heightened arousal, restlessness, agitation, and aggression. • Hypoactive: Withdrawal, quietness, and sleepiness. • Mixed: Features of both hyperactive and hypoactive delirium. Up to 20% of older patients develop delirium during a hospital stay. Successful management requires accurate identification, diagnosis of specific causes, and prompt nursing and medical intervention. Delirium may persist for weeks or months, but many cases can be prevented, and appropriate management can lead to improved outcomes. **Actions:** **During the Hospital Stay:** • Monitor for signs of delirium every nursing shift, noting changes in behaviour, alertness, attentiveness, or judgment. • Create a supportive environment with large clocks, natural daylight, familiar care providers, optimised hearing and visual aids, minimized relocations, reduced noise, and the presence of familiar family members or caregivers. • Encourage early and frequent mobilisation, at least three times daily (e.g., sitting up for meals), and minimise the use of immobilising equipment such as catheters and restraints.		thinking or awareness = 2. Behaviour present, appears different from usual functioning OR C4 – Acute changes in mental status from patient's usual functioning = 1. Yes	

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Use non-pharmacologic approaches (e.g., sleep hygiene) to minimise psychoactive drug use. • Offer assistance with eating and drinking to ensure proper nutrition and hydration. • Monitor elimination, prevent constipation and urinary retention, and manage agitation and unsafe behaviours with non-pharmacologic measures. **Opportunity for Improvement:** • Chart delirium-associated behaviours and symptoms to track progress. • Use short-acting psychoactive agents only when necessary, starting with low doses. • Preserve or restore the normal sleep-wake cycle using natural lighting and noise management. • Consult a specialist if needed for diagnosis or management. **Preparation for Discharge:** • Consider follow-up cognitive evaluation if there's no pre-existing dementia diagnosis. • Develop an individualised care plan with the patient, family, and health care providers to avoid high-risk drugs and ensure preventive measures. Provide this plan to the patient and carer before discharge and to other clinical providers within 48 hours. • If pre-morbid cognitive status isn't likely to return, offer additional support after discharge, consider safety issues, and provide coping strategies for any frustration or behaviour problems associated with new cognitive issues.			

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
Depression and Anxiety 	Mood disorders like depression and anxiety are common in both community and hospital settings. Depression is often underdiagnosed and undertreated, and while most hospital patients with depressive symptoms do not have major depression, the issue still needs to be addressed. Untreated mood disorders can lead to high mortality, functional decline, and unnecessary suffering. In older adults, depressive symptoms may also indicate early dementia. **Actions:** **Further Evaluation:** • Assess the nature, duration, and severity of symptoms. • Check for medical conditions associated with depression, such as thyroid disease, and consider other mental health issues like bipolar disorder and psychotic depression. • Evaluate for Mild Cognitive Impairment or delirium that might mimic depression. • Consider the context of the patient's mood disturbance, including prognosis, major life events, and stressors. • Assess for complications of low mood, such as sleep disturbances, appetite and nutritional deficits, functional deterioration, and suicide risk. • Review medications and non-pharmacological substance use that might contribute to symptoms. • Investigate long-standing symptoms to rule out treatable conditions or inappropriate treatments. Refer to Behaviour CAP if there are associated behaviour disturbances.	Identify the causes and severity of mood disturbances and provide appropriate treatment.	E1 a, b and c = 1. Not in the last 24 hours but often feel that way 2. Yes, felt that way in the last 24 hours. Medium improvement potential: Total score of E1a, E1b and E1c = 1, 2 or 3 High improvement Potential: Total score of E1a, E1b and E1c = 4, 5 or 6	E1a – Little interest or pleasure in things you normally enjoy? E1b – Anxious, restless or uneasy. E1c – Sad, depressed or hopeless?

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	During the Hospital Stay: • For new symptoms, start with non-pharmacological interventions such as counselling and reassurance, and ensure appropriate follow-up. • If symptoms persist, consider pharmacological therapy and monitor response. Use benzodiazepines for anxiety judiciously. • Monitor and document treatment response and adjust as needed. • For severe symptoms that interfere with treatment or pose safety risks, start active treatment or refer to a mental health specialist. • Consult a mental health specialist if psychotic symptoms or suicidal ideation are present. **Preparation for Discharge:** • Ensure close follow-up by the primary care physician and community mental health services if symptoms are likely to persist. • Assess the wellbeing and sustainability of primary caregivers. • Educate the patient and family about the mood disorder, symptoms, medications, and compliance strategies. • Arrange ongoing review and monitoring of medications, including compliance.			
Falls 	A fall is an unintentional change in position where the patient ends up on a lower level. This can lead to significant morbidity and mortality, particularly among older adults, and can result in loss of confidence and activity restriction. Addressing falls is crucial both for patients admitted due to falls and those at high risk of falling in the hospital.	Evaluate the cause and risk of falls and implement preventive strategies. This CAP often works	Medium risk: I1 Falls = 1. One or more falls in the last 90 days, AND one of the	D4 - Vision I1 - Falls F2 - Balance

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	Actions: **At Admission:** For patients admitted due to a fall or with a recent fall: • Assess for major trauma (e.g., head trauma, fractures, spinal injury). • Consider cardiac arrhythmias, seizures, orthostatic hypotension, and hypoglycaemia if there was loss of consciousness. • Address potential complications of prolonged immobility, such as dehydration and skin breakdown. • Compare current ADL status with pre-morbid function to detect functional decline. • Conduct a functional mobility evaluation and refer to appropriate team members. **For all patients at risk of falling:** • Document history of previous falls and contributing circumstances. • Assess cognitive and memory impairment. • Evaluate balance and mobility problems; consider referrals to physical and occupational therapy. • Ensure a safe hospital environment by removing clutter, ensuring adequate lighting, and providing appropriate bed height and footwear. • Assess continence status and implement measures to manage it. • Check for orthostatic hypotension by measuring lying and standing blood pressures. • Review medications affecting cognitive, cardiovascular, and autonomic functions.	alongside others, such as those focused on ADL decline, delirium, and appropriate medication use.	other indicators is present. High risk: I1 Falls = 1. One or more falls in the last 90 days AND two or more of the other indicators are present. Other indicators: F2 Balance – difficulty or unable to move to a standing position unassisted = 1. Present. D4 Vision – ability to see in adequate light (without visual appliance) = 2. Moderate difficulty, 3. Severe difficulty or 4. No vision Cognitive Performance	Cognitive Performance Scale

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	During the Hospital Stay: • Develop and implement a targeted fall prevention plan based on individual needs. **For high-risk patients, especially with cognitive impairment or delirium:** • Ensure staff accessibility and consider special nursing arrangements. • Orient the patient to their surroundings and explain the use of the call bell. • Use falls risk alert cards and consider motion sensors, alarms, and hip protectors. • Avoid physical restraints and ensure regular toileting. • Implement hourly rounds to check on pain, call bell availability, and bathroom needs. • Promote mobility with supervision or assistance. • Monitor progress in balance, mobility, and transfers. • Ensure personal belongings and visual aids are within reach. • Regularly reassess risks and interventions, and document outcomes. • Consider medications such as Vitamin D and calcium supplements. • Educate the patient, family, carers, and staff on falls risk and prevention strategies. • Conduct an interdisciplinary falls review if a fall occurs during the hospital stay. **Discharge and Post-discharge Preparation:** • For ongoing functional deficits, consider transfer to rehabilitation or post-acute programs.		Scale score = 2 or greater	

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• If there is ongoing falls risk, arrange a home environment assessment and consider home monitoring systems. • Enrol in falls risk minimisation programs and discuss lifestyle modifications. • Coordinate with primary care physicians for ongoing evaluation and prevention. • Assess for osteopenia or osteoporosis and ensure appropriate treatments to minimise fracture risk.			
Pressure Ulcer Prevention 	Pressure injuries, or bedsores, occur when prolonged pressure cuts off blood supply to the skin and underlying tissues, commonly over bony areas. Patients with restricted mobility are especially at risk. These injuries are painful, difficult to treat, and significantly increase healthcare costs. They are common in patients in intensive care units and those on extended bed rest. **Actions:** **Further Evaluation:** • Do not rely solely on screening results; perform a full skin assessment and use clinical judgment to identify additional risk factors. • Consider factors contributing to the risk of pressure injury: mobility, activity status, nutritional status, sensory perception, age, skin moisture, body temperature, perfusion, oxygenation, general health status, medications, and underlying medical conditions. **For patients with pressure injuries:** • Identify and treat contributing factors such as diabetes, peripheral vascular disease, immobility, excess moisture, and undernutrition.	Identify patients at risk for pressure injuries and implement prevention strategies. Identify the causes of existing pressure injuries and provide effective treatment.	Medium Risk: Pressure Ulcer Risk Scale = 2, 3, or 4 High Risk: Pressure Ulcer Risk Scale = 5, 6, 7, or 8	Pressure Ulcer Risk Scale (PURS)

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Stage the pressure ulcer, record its size, location, and depth, and monitor progress using wound charts, photographs, and tracings. • Examine for signs of infection and document type of wound dressing and frequency of changes. • Assess and manage pain associated with the wound. **During the Hospital Stay:** • Perform frequent (at least 4-hourly) full skin inspections, especially in areas at risk. • Monitor and document skin status, including localized heat, delayed blanching response, oedema, and induration. • Inspect skin under and around medical devices for pressure injuries and consider using prophylactic dressings. • Use special mattresses, cushions, and pressure-relieving devices. • Reposition patients frequently (every 2 hours) to avoid sustained pressure, considering tissue tolerance, activity level, skin condition, and comfort. • Use procedures that minimize skin trauma when moving and handling patients. • Document repositioning schedules and evaluate their effectiveness. • Ensure adequate pain management, nutrition, and hydration. • Engage wound experts for complex or resistant wounds. • Document type of wound dressing and frequency of changes.			

Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	Preparation for Discharge: • Ensure follow-up by medical and nursing professionals if an ulcer is still present. • Educate the patient and family on minimizing pressure injury risk (e.g., appropriate linen, mattress, continence aids). • Ensure adequate nutrition. • Continue medical review until the injury has fully healed.			
Pressure Ulcer Treatment 	**As above.**	Identify the causes of existing pressure injuries and provide effective treatment.	K1 – Most severe pressure ulcer = 2, 3, 4 or 5	K1 – Most severe pressure ulcer
Readmission 	Hospital readmissions are common among older patients, with about one-third occurring within a month of discharge. These readmissions often involve the progression or recurrence of the initial illness, particularly in patients with heart failure and COPD. Key risk factors include a recent prior admission, long or early discharge due to economic pressures, and being discharged home rather than to an institutional setting. Poor inpatient care and discharge planning can increase readmission rates. Studies suggest that 10% to 50% of readmissions might be preventable with proper interventions. **Actions:** **Further Evaluation:**	To develop an effective discharge plan that reduces the risk of hospital readmission.	This CAP is triggered if the patient had a hospital admission within 30 days prior to the current admission. It applies to about 20% of general medical inpatients.	B4 – Time since last hospital stay

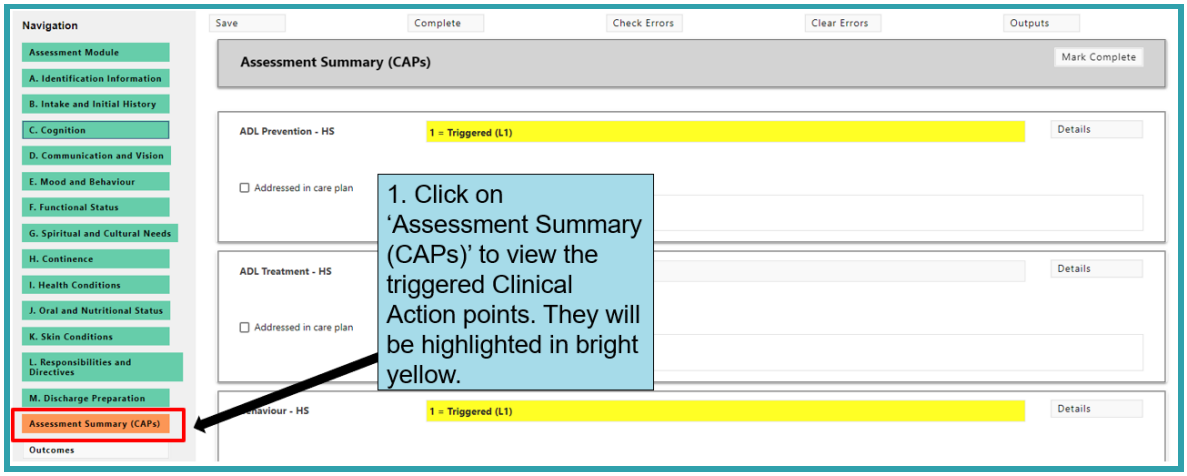
Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Review the reason for the previous hospital admission. Assess the discharge planning for that admission and consider if readmission could have been avoided: • Medical and follow-up arrangements. • Support services provided. • Nature and commitment of informal support. • Medication prescription and compliance. • Review previous interRAI assessments (e.g., home care). **During the Hospital Stay:** • Evaluate and treat illnesses, comorbidities, and conditions (e.g., depression, cognition) that may increase the risk of readmission. **Preparation for Discharge:** • Implement disease-specific protocols relevant to the patient. • Harmonise management plans for multiple comorbidities and reconcile medications. • Ensure strategies to optimise medication compliance. • Review discharge destinations to maximise independence and ensure adequate support. • Assess the adequacy of informal supports available at home. **Arrange close follow-up, such as:** • Timely primary care. • Transitional care. • Specialised care. • Outpatient or home care rehabilitation.		B4 – Time since last hospital stay = 3, 4 or 5	

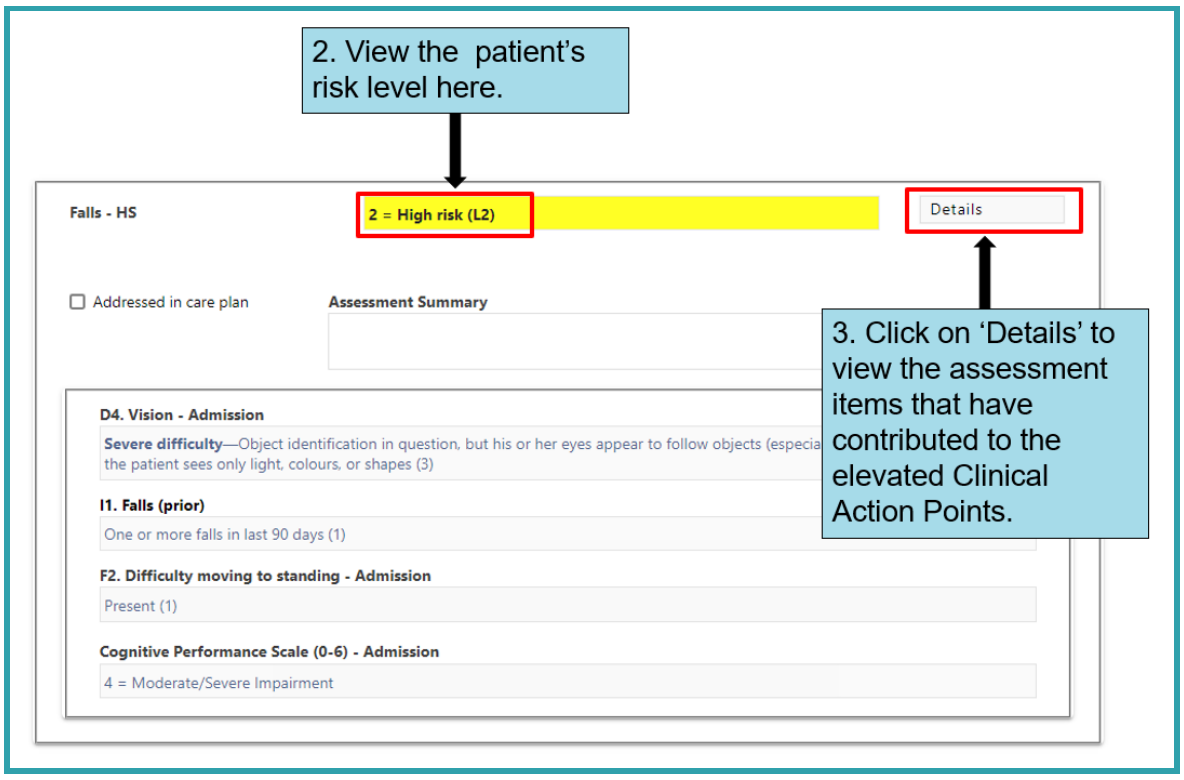
Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	• Day hospital or day centre. • Arrange supportive care to maintain independence, including community support services and home care. • Liaise carefully with the primary care physician, other service providers, and the primary informal caregiver.			
Undernutrition 	Undernutrition is common among hospital patients, particularly older adults. It may be due to long-standing issues or acute illness and often goes unnoticed. Causes include medical conditions, pain, medications, poor dentition, psychosocial factors, and decreased appetite due to aging. Undernutrition can lead to muscle wasting, impaired immune function, prolonged hospital stays, and increased mortality. **Actions:** **Further Evaluation:** • Request appropriate laboratory investigations to identify undernutrition. • Determine if weight loss is due to volume depletion and monitor necessary fluids. • Assess dietary intake, intolerances, allergies, and knowledge. • Consider underlying illnesses, dysphagia, depression, pain, and medication side effects. • Check for dentition and oral hygiene issues. • Evaluate for malabsorption and catabolic states due to chronic or acute inflammation e.g. Rheumatoid arthritis, organ failure, major infection, recent surgery or stroke. • Assess physical (e.g. hemiplegia, arthritis, apraxia, or tremor) and cognitive deficits (e.g. delirium, lack of initiation or awareness) affecting eating.	To confirm the presence of under-nutrition, evaluate its causes, and provide appropriate treatment.	BMI is less than 22 and J2 – Unintentional weight loss of 5% or more in the last 30 days, or 10% or more in last 180 days = 1. Yes.	BMI J2 - Unintentional weight loss of 5% or more in the last 30 days, or 10% or more in last 180 days.

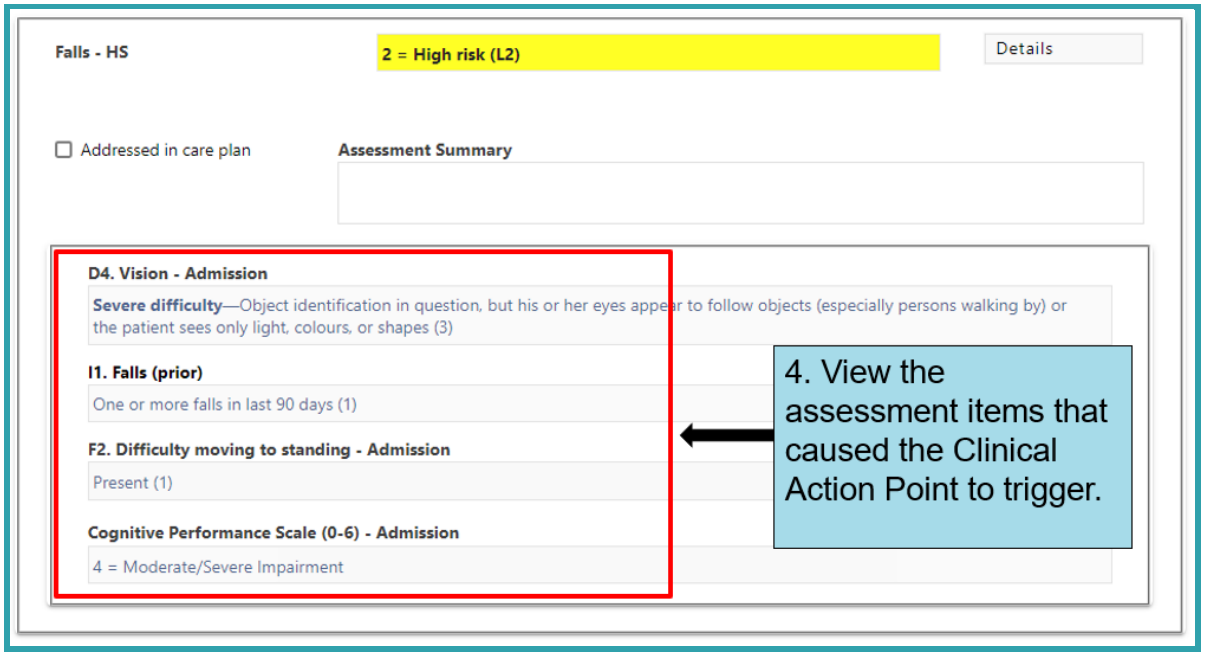
Clinical Action Point	Problem and Actions	Goals of Care	Triggers	Items that inform the CAP
	During the Hospital Stay: • Refer to a speech language therapist for dysphagia assessment. • Refer to a dietitian for a comprehensive nutritional evaluation. • Adjust diet composition and texture and monitor food intake and weight. • Ensure a suitable eating environment and menu options. • Monitor for pressure injuries and wound healing. • Provide cueing and assistance for patients with cognitive impairments. • Consult a therapist for assistive devices for physical deficits. • Review and adjust medications impacting appetite. • Document diet modifications and manage dysphagia with appropriate interventions. **Preparation for Discharge:** • Educate the patient and family on malnutrition and dietary needs. • Refer to financial, social, and nutritional support services. • Ensure follow-up with a primary care physician and dietitian. • For enteral tube feeding, provide education and referrals for ongoing management.			

To view the Clinical Action Points (CAPs) in the interRAI assessment software:

- Click on ‘Assessment Summary (CAPs)’
- View the triggered Clinical Action Points which are highlighted in bright yellow.
- View the patient’s risk level.
- Click on ‘Details’ to see the assessment items that contributed to the Clinical Action Point.







Assessment Summary

Note: The Assessment Summary page is OPTIONAL to complete.

A new Assessment Summary page has been added to the Acute Care Admission and Review Assessment. The Assessment Summary is linked to the Clinical Action Points. This page allows assessors to summarise the patient's problems and issues that will be addressed in the care plan during their hospital stay.

Steps:

- Click on 'Assessment Summary (CAPs)' to view the assessment summary page.
- Write a note about the patient's problems or issues in the appropriate 'Assessment Summary' field.
- You can add notes to both triggered and non-triggered CAPs. If no suitable CAP exists, add your note to a linked or affected CAP.
- Tick the 'Addressed in Care Plan' box.