

Tapestry

of Aged Care



Tapestry of Care

STEP-BY-STEP IMPLEMENTATION BOOKLET

PREPARED BY

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National Ageing Research Institute

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Table of Content



Tapestry of Care

Step-by-Step
Implementation Booklet

Introduction	3
Answers to some common questions	7
Implementing Tapestry	9
The Three Tools of Tapestry	11
Tapestry & the Aged Care Quality Standards	28
Appendices	30
» Transition Maps	31
» Cumulative Illness Rating Scale – Nursing Homes (CIRS-NH)	32
» Hopes Or Wishes (HOW) tool	34
» Info Sheets	35
» Translated sheets (Greek, Vietnamese)	39

The Tapestry of Care project is the culmination of many people's hard work, enthusiasm and commitment. The initial pilot project was funded and supported by the Aya and Keith Thornton Homes Fund and the evaluation of a larger scale implementation was funded by the Commonwealth Department of Health. Firstly, thank you to the staff, residents and family members that participated in the implementation and evaluation of the project. Thank you to the advisory group for their valuable input, including: Dr Steven Savvas, Prof Samuel Scherer, Ms Marie Vaughan, Prof Lynn Chenoweth, Dr Paki Rizakis and Prof Briony Dow. Thank you to the National Ageing Research Institute (NARI) and staff members involved in the evaluation, including: Dr Steven Savvas, Dr Maho Omori, Mr Jude Jayasuriya, Ms Courtney Baker, Ms Anastasia Abela and Ms Anabelle Peck and Prof Briony Dow. Finally, thank you to Dr Mark Miller for permission to adapt the CIRS-G for use in Residential Aged Care Facilities/Nursing Homes.

All Tapestry of Care materials are freely available to use for the Australian Residential Aged Care Sector



Tapestry of Care

.....
Step-by-Step
Implementation Booklet
.....

SECTION 1

.....
Introduction

What is Tapestry of Care?

Program aims

Tapestry of Care (or just **'Tapestry'**) is an evidence-based enhanced care program for residential aged care. This is a 'whole-of-person' care model based on World Health Organisation principles (see box 2: WHO). The Tapestry philosophy includes:

1. Open, honest and informative conversations with residents and families, preparing them for the journey ahead;
2. Communicating the care journey in a simple way. Tapestry helps to summarise the care approach through a visual tool;
3. Working as a team. Tapestry promotes collaboration and information sharing amongst the aged care and clinical care team;
4. Aged care is about enhancing a resident's life, not necessarily prolonging it (unless that is what the resident wants);
5. Aged care is about people, not paperwork. There are only three simple documents involved in Tapestry implementation;
6. Focus is on *'what is the matter with the resident'* and *'what matters for them'*.

A tapestry is carpet art made up of interwoven threads. We see our program as an interweaving of WHO principles on disability, person-centred and consumer centred care (see figure 1). A Tapestry can also convey complex pictures that tell a story. Our new program is an integrated story of the care and services we provide to assist each resident on their journey. As a resident's health and circumstances change, so does their care. Some of these changes are more significant than others, and may involve transitioning to better ways of being cared for. We map these transitions so that the journey ahead is easier to understand and so we can continue to support the resident with their own hopes or wishes.

Integrated person-centred care can potentially generate significant benefits to all receiving and involved in health care, improving health and clinical outcomes and improving service efficiency. This can lead to better care experiences among care recipients and better job satisfaction among care providers.

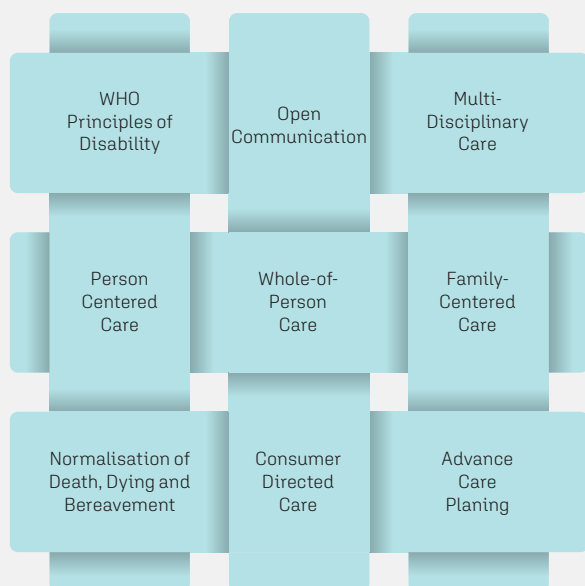
SOURCE:

Source: World Health Organisation 2016 The Framework on Integrated People-Centred Health Services (IPCHS)¹.

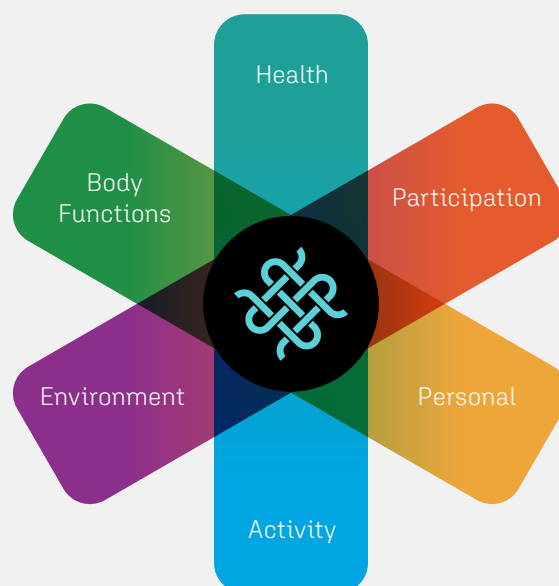
BOX 1: What is person-centred care?

According to the WHO, a person-centred health service is an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of a health systems that respond to their needs and preferences in humane and holistic ways.

¹ <https://www.who.int/servicedeliverysafety/areas/people-centred-care/framework/en/>

**FIGURE 1**

Concepts interwoven into the Tapestry Program. For more information about person-centred care, see Box 1: What is person-centred care?

**FIGURE 2**

Tapestry incorporates the International Classification of Functioning, Disability and Health (ICF) principles, developed by the World Health Organisation (WHO).

BOX 2: **The World Health Organisation (WHO)**

The WHO developed the International Classification of Functioning, Disability and Health. This classification acknowledges that disability is more than just the result of disease. A person's environment, their personal factors, activity and participation levels all interact with their health and body functions to either enable or disable them (see Figure 2). Consider for example Ms Jones who has mild COPD (ill-health) and poor eyesight (ill-health). She has no family and is a resident at a large 100+ bed aged care facility. Ms Jones wears corrective glasses but her glasses have recently been misplaced. The aged care staff have been informed but cannot find her glasses after a quick search of her room. How do different factors contribute to the disability she experiences? Ms Jones has no family to advocate how important and urgently she needs her eyeglasses (personal factors). Without her glasses, Ms Jones finds it difficult to see the visual cues that allow her to find her room quickly (body function). She lives in a large facility with many long corridors that all look the same (environment), so wrong turns and the additional walking results in some shortness of breath (disease). Ms Jones fears exacerbating her COPD so she becomes reluctant to leave her room and becomes deconditioned (further limiting her activity). She consequently limits socialising with other residents and other lifestyle activities (participation restriction). It is this interplay of factors that is increasing Ms Jones' degree of disability. And from this understanding, collaboration between medical, nursing, allied health, care staff, resident and family can be instrumental in re-enabling each resident's level of functioning, through a direct influence on the resident's disease, body functions, activities, participation, personal factors and environment.

You can read more about the International Classification of Functioning, Disability and Health at <https://www.who.int/classifications/icf/en/>

How does Tapestry work?

The concept of Tapestry is relatively straightforward (figure 3).

Tapestry involves the exploration of each residents' health and function using **Transition Maps** (see Section 4A)² and a modified version of the **Cumulative Illness Rating Scale Geriatrics** for Nursing Home residents (CIRS-NH, see Section 4B), the resident's experiences of this enhanced approach to care, and how care staff can help residents achieve their aspirations using the **Hopes Or Wishes Tool** (HOW, see Section 4C)³.

To create **Transition Maps**, we explore every aspect of the residents' health and function using WHO principles, by using medical questionnaires such as the modified **Cumulative Illness Rating Scale (CIRS-NH)**⁴, and professional perspectives from the GP, Allied Health, Nurses, and Lifestyle Services.

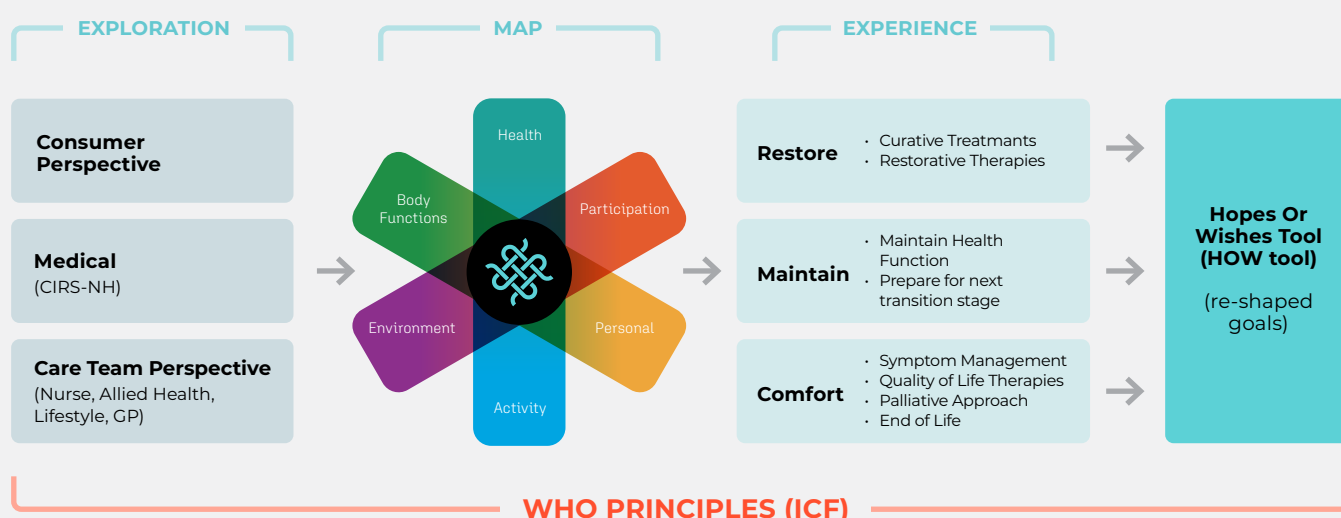
In discussion with the resident and their family, **Transition Maps** then describe the agreed level of care (Restore, Maintain, or Comfort Care) that is appropriate for the resident, and inform appropriate treatments and therapy.

Staff, therapists and doctors are then better equipped to communicate with one another and to support the resident in identifying and achieving their hopes, dreams and aspirations.

In this way, we can identify the most appropriate care services we can provide, and better engage with what is important to each resident and their goals.

The end result is an improved resident experience.

FIGURE 3



² See page 13 for more details of Transition Maps

³ See page 23 for more details of Hopes Or Wishes (HOW) tool

⁴ See page 21 for more details of CIRS-NH



Tapestry of Care

Step-by-Step
Implementation Booklet

SECTION 2

Answers to some common questions

Common Questions

What does this implementation booklet do?

This booklet provides a step-by-step guide and resources for implementing Tapestry.

How can residents and family benefit from Tapestry?

The Tapestry program aims to improve each resident's quality of care and quality of life. Tapestry is an opportunity for residents and families to openly and honestly discuss the resident's care journey ahead. Tapestry also provides a new platform for residents, families, doctors, therapists, nurses and care staff to work together towards the hopes and dreams that residents have identified as important for their quality of life.

Who should use this implementation booklet?

This manual is intended for clinical and aged care staff, including facility managers, managers of clinical practice, care managers, lifestyle staff, allied health care professionals and doctors. It can be provided to residents and families who request further information about the program than what is provided in pamphlets.

Who developed Tapestry?

Tapestry was developed by staff at Royal Freemasons and researchers at the National Ageing Research Institute. The key developers were Assoc Prof Samuel Scherer, Ms Marie Vaughan, and Dr Steven Savvas. Pilot work was funded by the Keith and Aya Thornton Trust and the program was expanded and tested with funding provided through the Dementia and Aged Care Services (DACS) Fund, Australian Government Department of Health.

Can I just use one or two element of the program?

Though the Tapestry tools are designed to work together, you can use just one or two elements of the program. If your organisation has identified a need to improve the communication about the care you provide between the care team, residents and families, then the Transition Map tool may be used. If staff require a more structured approach in helping the residents achieve their hopes and dreams, then the HOW tool may be used. If doctors, nurses and allied health practitioners wish to engage with the clinical dimension of Tapestry then the CIRS-NH may be used.

How much time does it take?

For staff with a good understanding of the medical and care needs of their residents, our experience is that, once education has been provided to staff, the Tapestry tools can be an efficient tool. What may take time is a culture change at the facility – that is, a culture change to fully embracing Tapestry in all its dimensions.

What resources do I need to invest?

Providing staff with some protected learning time when first implementing Tapestry is certainly beneficial. Our experience is that once a majority of residents are on the Tapestry program, a culture change to thinking about Tapestry is more likely. Also important is that senior management at the facility commit to the Tapestry program. This support is vital for good integration of Tapestry into day-to-day care practices of staff at all levels.

How much does Tapestry cost?

Tapestry is free to use in Australian residential aged care facilities.



Tapestry of Care

Step-by-Step
Implementation Booklet

SECTION 3

Implementing Tapestry

How do I implement Tapestry?

We recommend that a key clinical staff member leads the implementation of Tapestry, such as the most senior nurse at the facility, or an appropriate care manager.

For each resident, follow the steps on this page.

1. First **EXPLORE** the resident's medical needs with the CIRS-NH (section 4B on pg21 and appendix) and also consider the resident's health and well-being needs from their perspective (and the family's perspective when appropriate) as well as the perspectives of the multi-disciplinary aged care team (such as nurses, allied health, doctor, and lifestyle services). WHO principles on disability are a useful framework here (see box 2).
2. Next **MAP** the resident's overall goals of care by using the Transition Map tool (see section 4A on pg 13 and appendix). Make sure to incorporate the perspectives of all members of the multidisciplinary team, including the resident's doctor. Use the Transition Map in a respectful (and initially cautious) conversation with the resident and their relatives to understand their preferences and expectations about the resident's goals of care. Depending on their feedback, aim to sensitively provide an appropriate degree of open and honest information and advice to them as a summary of the combined professional opinions expressed by the multidisciplinary team.
3. Openly **COMMUNICATE** with the resident, family, staff and clinical team, aiming to arrive at a completed Transition Map for each resident that achieves mutual agreement.
4. Discuss with the resident what they want to achieve while living in aged care using the Hopes or Wishes tool (see Section 4C on pg 23 and appendix). The Transition Map can help resident's **FORMULATE** meaningful and achievable aspirations.



Tapestry of Care

Step-by-Step
Implementation Booklet

SECTION 4

The Three Tools of Tapestry



The Three Tools of Tapestry

Tapestry uses three simple tools to enhance care provision. These are the **Transition Map**, the modified **Cumulative Illness Rating Scale for Nursing Homes (CIRS-NH)** and **Hopes Or Wishes (HOW)** tool.



Transition Maps

Transition Maps describe each resident's overall goals of care



Cumulative Illness Rating Scale for Geriatric Residents (CIRS-NH)

The CIRS-NH is a review of a resident's illness and severity of these conditions



Hopes Or Wishes (HOW) tool

The HOW tool helps help translate the goals and aspirations of each resident



FIGURE 4

'What is the matter with the resident' focuses on the resident's illness and disability.

'What matters for the resident' focuses on the resident's hopes, dreams, wishes or aspirations.

A: Transition Maps

The Transition map is a user-friendly yet information rich visual tool to map, track and coordinate a resident's journey in care. Significant changes in health and circumstances may mean that there is a need to transition to better ways of being cared for. We map these transitions so that the likely journey ahead is easy to understand. Transition Maps use simple language that is usually acceptable for residents and families and can be used to inform a tailored care approach. They provide staff, residents and families with a way of describing an agreed therapeutic direction and the overall goals of care.

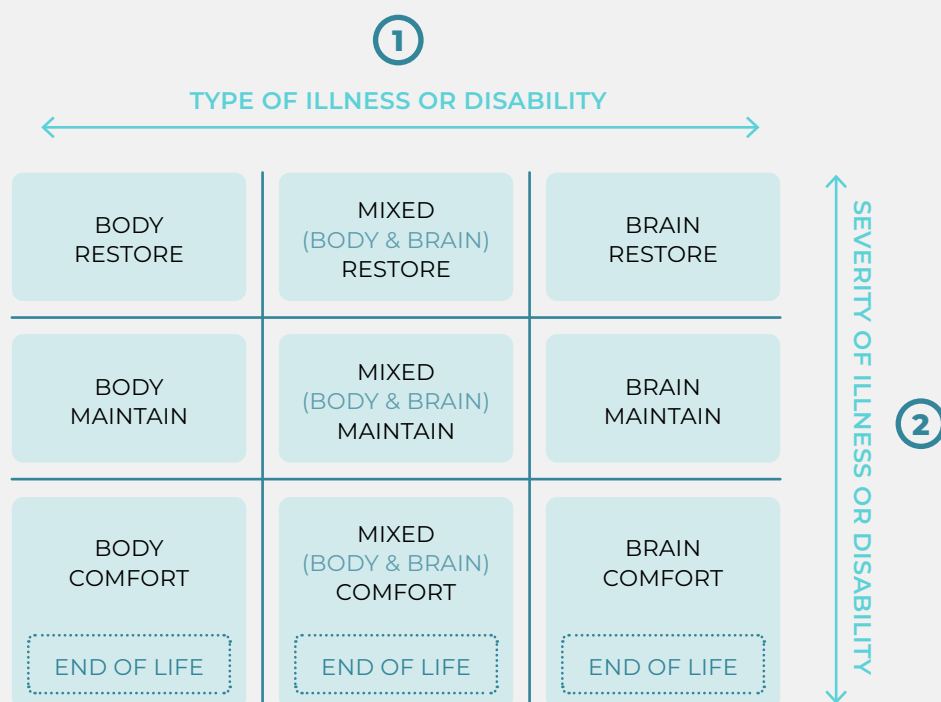
The Transition Map is a summary of the overall goals of care. For simplicity, a resident is placed in one of the 9 grid points of the map (see Figure 5 and Box 3 'Are we just labelling residents?')

BOX 3:

Are we just labelling residents?

The Transition Map does not prescribe or dictate the level of care provided. Rather the Map is used to consider, communicate, guide and track the care that is most appropriate and beneficial for the residents.

FIGURE 5: TRANSITION MAP



3

- ☐ Tick if resident has high impact of psychological factors. Still map resident above (do not map psych factors).

Psychological factors:

4

- ☐ Tick if unable to map

The Transition Map tool has four main elements (labelled 1 to 4 on Figure 5). The first two elements form a grid:

①

The type of health problem:
Body, Mixed or Brain.

Transition maps use simple terminologies understandable for residents and families (see Box 4, 'why do we need a simple language for communicating the care approach?'). For clinicians, **Body** refers to somatic illnesses and diseases, whilst **Brain** refers mainly to neurodegenerative (e.g. Alzheimer's disease) and vascular (e.g. stroke) related impairments.

②

The severity of the problem and implications for care:

Restore, Maintain or Comfort (and including End-of-Life).

These categories reflect different care approaches. A **Restore** approach seeks to rehabilitate the resident so that they can regain health or function. A **Maintain** approach acknowledges that regaining function is unlikely, so care aims to maintain and prevent further health and functional decline. There may come a time when the main aim is to provide **Comfort** through treating symptoms and providing relief. If health and function continue to decline a transition to **End of Life** care becomes appropriate. End of life refers to the expectation that death may be imminent. Care focuses on more detailed and frequent communication with the resident and family, symptom control, cultural and spiritual wishes and needs, and dignity.

③

Psychological considerations

(such as high levels of anxiety or depression).

④

Unable to Map (if it is not possible or advisable to use the map, e.g. if the family have strong feelings against using it).

BOX 4:

Why do we need a simple language for communicating the care approach?

For people that do not work in health care, understanding health and medical processes and language is difficult. This is called health literacy. Though younger family members of residents may have higher health literacy, they may not have a good understanding of the impact of disease on health, functioning and wellbeing.

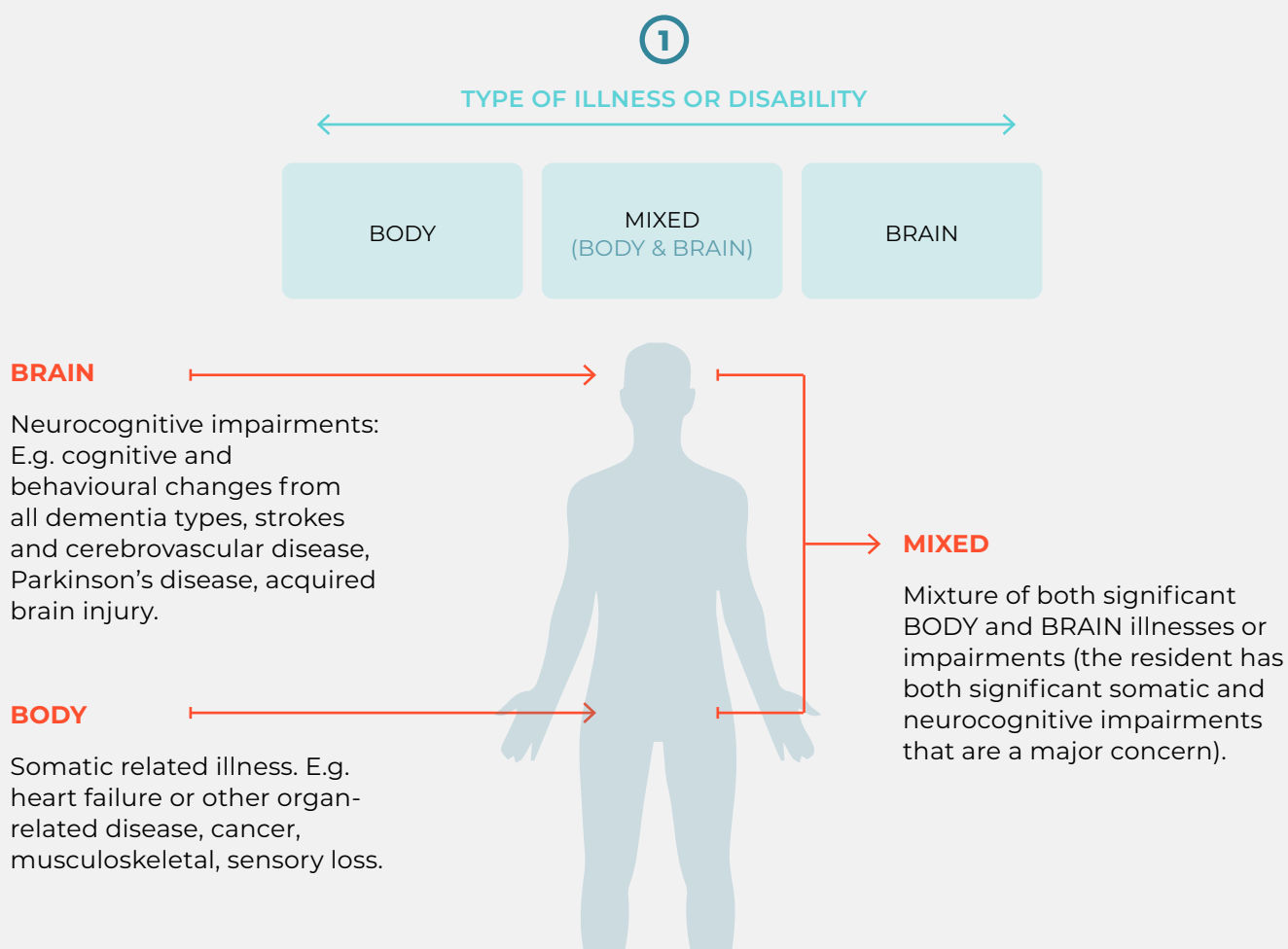
One of our roles in aged care and health care is to offer information and education to help residents and families make informed decisions about the care to be provided. This has been referred to "consumer directed care". This is one of the aims of Tapestry.

Based on your clinical judgement and in consultation with the multidisciplinary care team, mark a cross (x) in one of the boxes on the 3x3 grid where you believe the resident is regarding their overall care needs. If possible, do not mark on borders or gridlines.

To do this, the **first** question to ask is:

What type of health problems does the resident have that are of major concern?

These problems are classified as either **BODY** related, **BRAIN** related or both (**MIXED**).



Common BODY impairments (somatic related illnesses) in old age:

Organ-failure related illnesses (e.g. Heart disease chronic renal disease, chronic lung disease), Sensory changes (e.g. hearing loss, vision loss, dual sensory loss), Geriatric syndromes (e.g. falls, incontinence, frailty, sarcopenia (severe loss of muscle)), Other (Diabetes, arthritis, osteoporosis, cancer, pain).

Common BRAIN impairments (neurocognitive impairments):

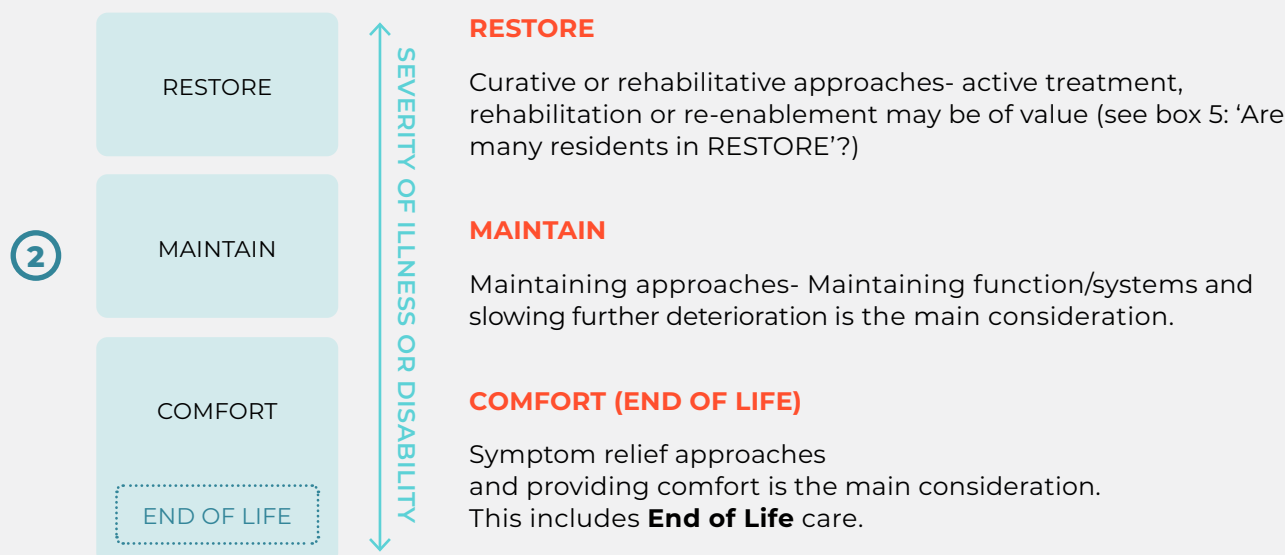
Alzheimer's Disease, vascular dementia, stroke, dementia associated with Parkinson's disease and Lewy body dementia, frontotemporal dementia, alcohol-related cognitive impairment.

Do we classify primary psychiatric disorders as BRAIN?

No. In our MAPPING we have decided to reserve the BRAIN column for neurocognitive impairments. Psychiatric disorders are highlighted in Step3 (the tick box for High impact of Psychological Factors).

The **second** question to ask is:

How severe are these health problems, and what are the implications for our approach to care?



*Here, **End of Life** is difficult to define precisely, but refers to the advent of the last stage of one's life, the imminence of death, and the need to prepare for death (See Box 5: Is comfort care different from End of Life care?)*

BOX 5:
Is Comfort Care different from End of Life Care?

The stage of Comfort can potentially last for months or even longer while health decline and disease progression remain slow. This is consistent with the Palliative Approach in Aged Care. The aim of palliative care is to achieve the best possible quality of life for the person, their family and carers. Palliative care includes end-of-life care, but also entails much more. End-of-life care is care occurring in the last part of a patient's life, typically in the last few weeks to months, depending on the underlying diagnosis and clinical course.

Are many residents in RESTORE?

Restorative care is rarely appropriate because if a resident's conditions could be cured and previous functional decline reversed they would be unlikely to need residential care. The majority of residential aged care residents have multiple chronic diseases with substantial health and functional impairments that cannot be reversed. A minority of residents may retain scope for at least some degree of improvement in health and or functioning, even if not to the degree needed to return to living in the community. The RESTORE category serves as a discussion point between staff, resident and family. Having RESTORE on the map helps residents and families frame their own hopes and beliefs in the context of their current capacity and their expectation about the journey ahead. They may have unrealistic expectations about what can be achieved in residential care, and discussions through use of the map can help to manage these expectations.

Palliative care includes end-of-life care, but also entails much more. End-of-life care is care occurring in the last part of a patient's life, typically in the last few weeks to months, depending on the underlying diagnosis and clinical course.

SOURCE: Palliative Care Australia
<https://palliativecare.org.au/what-is-palliative-care>

After placing a cross somewhere on the grid, the **next step** is to:

Tick the following boxes if appropriate.

PSYCHOLOGICAL FACTORS

3

- ☐ Tick if resident has high impact of psychological factors. Still map resident above (do not map psych factors).

Psychological factors:

Tick this box if there is a high impact of psychological factors. For example, the resident may have a chronic psychiatric illness, be highly anxious or depressed, or there may be

personality factors or other ongoing psychological factors. We need to be aware that such factors may need to be specifically acknowledge and addressed.

UNABLE TO MAP

4

- ☐ Tick if unable to map

Tick this box if you believe it is impossible or inadvisable to map the resident. There are several reasons why this may be the case. The resident and family may have strong personal, cultural or spiritual beliefs and do not wish to engage in the process of considering underlying issues involved in the MAPPING process. There may be high levels of conflict within or between the resident's family and staff. The conflict could then be exacerbated by attempts to introduce the Tapestry model. The family may perceive and take issue with the Transition map as an attempt to limit the care that the staff provide. In these scenarios it may be counterproductive to use Transition Maps.

Who helps create a Transition Map?

A senior nurse in each nursing unit leads the creation of the Transition Map as they have the clinical knowledge, as well as regular contact with the doctor, therapists, care team, resident and family. The nurse engages with the multidisciplinary team, resident and family to understand and integrate their perspectives to create the map. The Tapestry process including the Transition Map serves as the vehicle for the open discussion of the overall goals of care and for the achievement of understanding, consensus and collaboration (see box 'How to talk to families about Transition Maps?').

BOX 6:

How to talk to families about Transition Maps?

When talking with families, sensitivity, flexibility and caution may be needed.

- Family might have strong conflicting views.
- Family might not understand what Transition Maps mean or see the benefit.
- Family might want to control care in a preconceived manner.
- There might be cultural or religious sensitivities, and a reluctance to talk about the end of life.

In these scenarios, it can be beneficial to first slowly introduce Transition Map concepts. For example, show a blank Transition Map and discuss the terms in general. Suggest that the care team would like to discuss how the Transition Map may relate to the resident at a later date. Introducing a blank Transition Map and providing some brief information (see info sheet in appendix) is a good approach for preparing families to think about Tapestry concepts.

Examples for mapping residents

EXAMPLE 1:

Peter is 89 years old. He has very severe heart disease and severe osteoarthritis. Cognition and memory are quite good. He can walk only short distances with a walking aid due to shortness of breath. He needs help with personal care. Improved health is no longer realistic with his health conditions.

TYPE OF ILLNESS OR DISABILITY			SEVERITY OF ILLNESS OR DISABILITY
BODY RESTORE	MIXED (BODY & BRAIN) RESTORE	BRAIN RESTORE	
 BODY MAINTAIN	MIXED (BODY & BRAIN) MAINTAIN	BRAIN MAINTAIN	
BODY COMFORT	MIXED (BODY & BRAIN) COMFORT	BRAIN COMFORT	
END OF LIFE	END OF LIFE	END OF LIFE	

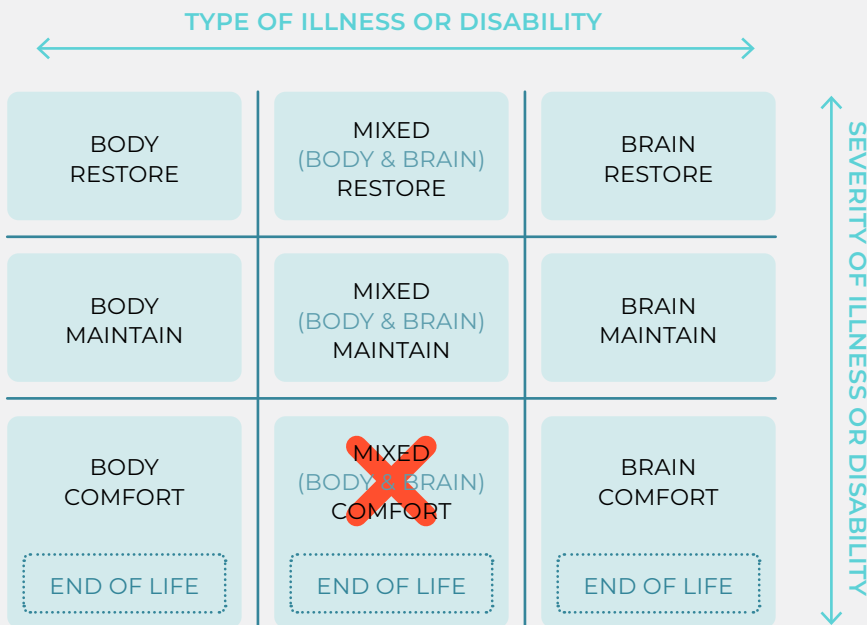
Peter is mapped in **BODY MAINTAIN**

*Peter's health conditions are all BODY related and he has no neurodegenerative BRAIN impairments. Curative approaches are no longer realistic, but maintaining his function and slowing further deterioration are still appropriate overall goals of care.



EXAMPLE 2:

Susan is 96 years old. She has advanced dementia and significant changes in personality and behaviour. Accompanying dementia is increased frailty and she no longer can stand up by herself.



Susan is mapped in **MIXED COMFORT**

*Susan has both advanced dementia (Brain) and frailty (Body). As Susan is declining in health and function despite attempts to prevent this, Comfort care is appropriate. With her dementia, she also has significant behaviour and personality changes. 'Psychological Factors' is not ticked as Susan's behaviour and personality changes are associated with her dementia.

Transition Maps – What Staff Say

Transition Maps have been perceived positively by participants in our research projects. Doctors, staff and families find that the Maps are helpful in communication and that they help lead into an open discussion aiming to establish a shared and goal-based understanding of each residents' care journey. The simple graphic provides a useful introduction to providing education about the resident's current care plan, explaining what lies ahead and planning future care as things change. Families have also reported that they feel enabled to make more informed decisions.

Transition Maps can also be useful in helping to clarify Advanced Care Planning, in which complex medical considerations may not be fully understood by residents and families. A GP who participated in our research provided an example.

"This map is a good representation of where everyone thinks the resident is heading and where the doctor thinks the patient is heading. Doctors and nurses don't always share what their approach is to a patient's care and may have arrived at a different point of view. With Tapestry we can actually discuss together where we are in the resident's trajectory."

(Nurse Manager)

"Having a visual tool, especially when speaking to family, makes the conversation smoother. Families can actually point it out by themselves and say 'this is where I think my mum is on the map'. Sometimes they are shocked when I suggest 'No. We think your mum is actually here'. Sometimes we disagree but at least we are having a discussion and can explore our points of view."

(Nurse Manager)

"Transition maps orientate you to where we are going and puts you in the same square with the staff and also with the families. One of my patients is over 100 years old, and she sleeps most of the time as you might expect at her age. I had a very long discussion with her family and we agreed on comfort measures from now on, and all staff were in agreement and so when something happens, staff know to inform the family, but are agreed to not call the hospital."

(GP)

"You get an example of family members, who say, 'She's not for resuscitation'. What they always think is, 'if my mom has a heart attack, I don't want you to use the defibrillator'. So they say 'not for resuscitation'. However if you get someone who had severe pneumonia, a chest infection, they'll say 'I want you to send her to a hospital now.' They say one thing but it actually means another, so you have to provide clear definitions. No resuscitation for them is they don't want to use defibrillators, but for loved ones with a heart attack or pneumonia, they want us to send them to a hospital. So it has a different meaning for us. So if there's a little square and say to someone, 'this is where we are now, and there is a limitation. If you want more things to be done, it'll involve this, this and this but I don't think it will achieve much.' This really helps (families understand) where we're going".

(GP)

B: Cumulative Illness Rating Scale for Geriatric Residents (CIRS-NH)

Good documentation of each resident's medical condition is an important component of 'what is the matter' with the resident. The Cumulative Illness Rating Scale for Nursing Homes (CIRS-NH) is a simple one page tool that provides a summary of the medical burden for the resident (see Box 7: How does the modified CIRS-NH version differ from the original CIRS-G?). The CIRS-NH informs and complements the Transition Map.

The CIRS-NH improves clarity, accuracy and impact of diagnoses and facilitates collaboration between nursing and medical staff. Typically on admission there will be evidence of diagnoses from a comprehensive medical assessment from a previous General Practitioner or a discharge summary from a recent acute admission that may have precipitated transition to aged care. While in residential care people may accrue new diagnoses from GPs, specialists or hospital admissions.

The CIRS-NH can be updated when there is a change in a resident's condition. It helps doctors and nurses focus on a systems based diagnosis and the subsequent impact. This also helps the nurse in their discussions with residents and families.

BOX 7:

How does the modified CIRS-NH version differ from the original CIRS-G?

The original CIRS-G was developed in the 1990s by Miller et al.¹ The tool had 14 domains and included a domain for psychiatric illness. Dementia was included in this domain.

In our version, we have separated out Dementia into its own domain. So our tool has 15 domains. There are no other differences between our version and the original.

We also thank the authors of the original version for permission to modify the CIRS-G for Australian residential aged care.

¹ Miller, Mark D., et al. "Rating chronic medical illness burden in geropsychiatric practice and research: application of the Cumulative Illness Rating Scale." *Psychiatry research* 41.3 (1992): 237-248.

Who should complete the CIRS-NH?

The doctor should complete the CIRS-NH. When the doctor has a good knowledge of the resident, we find that the CIRS-NH takes only about five minutes to complete. If the doctor is unable to fill out the CIRS-NH, a senior nurse with sufficient knowledge of the resident can instead complete the tool. In these cases, we suggest that the nurse then ask the doctor to review the CIRS-NH afterwards.

General rating strategy

- 0** - No problem
- 1** - Current **mild** problem or past significant problem
- 2** - **Moderate** disability or morbidity/requires first line therapy
- 3** - **Severe**/constant significant disability/uncontrollable chronic problems
- 4** - **Extremely severe**/immediate treatment required/and organ failure/severe impairment in function

How to use the CIRS-NH?

The CIRS-NH is designed to only rate ongoing medical conditions. Acute conditions are usually not rated unless they are expected to persist chronically.

There are 15 medical problems on the CIRS-NH, sorted broadly by organ: Heart, Vascular, Hematopoietic (blood and lymph), Respiratory, EENT, Upper GI, lower GI, Liver, Renal, Genitourinary, Musculoskeletal, Neurological, Endocrine/Metabolic, Psychiatric Illness, and Dementia. To fill out the CIRS-NH, each of these medical problems is given a score from 0 to 4.

There are two methods for scoring each of the medical problems. The first method is to score from 0 to 4 in each problem category based on the general rating strategy. Here a score of 0 indicates 'no problem', while a score of 4 indicates 'extremely severe problem or impairment/ immediate treatment is required/ end stage organ failure or severe impairment in function'.

On the back of the CIRS-NH is an alternative, more detailed scoring strategy. Each medical problem has definitions to help guide how to rate the severity of the medical problem. Our experience is that the general rating strategy is often sufficient for scoring, but the tool also includes a more detailed approach to provide more context and can be used as a reference.

Whether you use the general rating scale or the more detailed strategy, once all medical items have been scored for a resident, the CIRS-NH should be made accessible for all relevant staff.

How often should the CIRS-NH be reviewed?

The CIRS-NH should be reviewed or inspected regularly at the time of resident's overall reviews (e.g. three-monthly). It should only be redone if there has been a significant change in the resident's illness profile (e.g. significant new illness or change in existing illnesses).

C: Hopes Or Wishes tool (HOW)

Transition Maps and the CIRS-NH are tools that promote a whole-of-person approach, focusing on 'what is the matter' with the resident. The final Tapestry tool is the Hopes or Wishes tool (HOW), which focuses on 'what matters' for the resident. The HOW tool encourages residents to identify their hopes, dreams, aspirations or goals. Staff can then help assist residents formulate what is achievable and provide support.

Residents are encouraged to identify their aspirations (e.g. what they want to achieve while living in the facility). Staff can help to assist in translating these aspirations into individualised, person centred, achievable and meaningful goals. Taking health factors (e.g. severity of illness and diseases) as well as where the resident is mapped into account is important for articulating realistic goals.

How does the HOW tool work?

The HOW tool helps staff to identify and support the resident's hopes, dreams, wishes, aspirations or goals. HOW is a one-page assessment and has 3 rows and 5 columns (see Figure 6: The HOW Tool). The tool assists staff to formulate action plans and evaluate and revise any identified hopes or wishes.

How can the HOW tool be implemented?

The HOW tool should be implemented using the five steps as follows...

FIGURE 6

Hopes or Wishes (HOW) Tool

Residents Name: _____

People Involved: _____

Date of Assessment: _____

This care plan provides a summary of how we will work together to support you in achieving your hopes or wishes.

NOTE TO STAFF:

Ideally formulate 3 hopes or wishes. Focus on what the resident wants to achieve, not what is wrong.

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?				
HOPES OR WISHES (specific or general)	ACHIEVABLE GOALS	ACTIONS (be specific)	TIMEFRAME	EVALUATION at RoD (met/unmet/partialy met) & DATE
①	②	③	④	⑤

1

HOPES OR WISHES (GENERAL OR SPECIFIC)

Ask the resident what their hopes or wishes are (see also Box 8: Alternative questions that may promote a discussion about Hopes or Wishes). Residents and their family (where necessary) are central to using the HOW tool. Members of staff should guide residents and family members to identify hopes and wishes. Hopes or wishes can be general (e.g. spending less time in my room) or specific (e.g. doing some gardening).

2

ACHIEVABLE GOALS

It is important for hopes or wishes to be attainable. The health condition of the resident as well as other constraints need to be taken into consideration. Hopes or wishes that are expressed by residents and family might not seem to be achievable by the care team. If this is the case, it is important for staff to re-examine their usual practice, to re-address both their own and residents' expectations and to collaborate on formulating achievable goals.

3

ACTIONS (BE SPECIFIC)

Generate actions that will be put into place so that goals will be achieved. This could include any specific activities that the client will participate in (e.g. the resident will attend happy hour once a week on Friday) or strategies that will be put into place (e.g. a section of garden will be allocated to the resident for them to tend to). Specify the support available (e.g. the PCA will provide encouragement and escort the resident for a walk each day). Also ensure that actions are quantified (e.g. the resident will be visited by their grandchildren at 11am each Saturday).

4

TIMEFRAME

Specify a time period for goals to be achieved. An articulated timeframe will make it more likely that actions will be taken towards meeting goals. It is also important to note the date that the tool is completed to evaluate if identified goals are met within the specified time frame. If particular hopes and wishes need to be actioned on an ongoing basis, note this and be sure to note that evaluation and reassessment is also needed on an ongoing basis.

5

EVALUATION & DATE

Review progress towards meeting the resident's hopes

and wishes on a regular basis (e.g. three monthly or a half yearly). This can be done, for example, in existing regular assessments like Resident of the Day (ROD). Indicate whether hopes and wishes were 'met', 'partially met' or 'unmet'.

If hopes and wishes remain unmet, note reasons and create alternative strategies. When residents' living situations and health conditions change, their 'achievable goals' or 'actions' needed towards meeting goals may need to change. Edit the HOW tool as necessary when circumstances change, in open consultation with residents and family.

Why is setting achievable goals important?

Staff explore with residents what has value and importance to them, rather than limiting what residents may want to do based on what is currently available from lifestyle services. The HOW tool helps staff appreciate the resident perspective and inspires person-centred care. It also encourages continuous improvement across the facility.

Not all residents have tangible goals they want to achieve, but they will probably have hopes and wishes that can be shared in a safe and therapeutic environment. Some residents might not see the relevance in articulating their hopes or wishes, and some might have difficulty in expressing them. This goal setting exercise provides at minimum an opportunity for the expression of each resident's essential personal and psychological needs.

Who talks to the resident about their hopes and dreams?

We suggest that the lifestyle team are best placed to have a natural conversation with the resident about their hopes or wishes. Lifestyle staff can then communicate this information to the rest of the team to support what the resident has identified as important for them.

How to initiate a discussion with the resident (or family) about the HOW tool?

Talking with residents and families should be conversational and exploratory, rather than interrogational. The HOW tool collaborative and this may require flexibility, creativity and imagination. You might need to reframe the discussion to help the residents express their thoughts and desires. For example, when a resident has difficulty coming up with hopes or wishes, rephrase the question to 'what are your goals or aspirations?' or 'what is important for you?' (see also Box 8: Alternative questions that may promote a discussion about Hopes or Wishes.).

We aim to identify the hopes and wishes of each resident and to help translate these into achievable goals, so that the resident aged care experience is improved. Once your residents identify their hopes or wishes, you can work on individualised action plans that assist in achieving the resident's goals.

BOX 8:

Alternative questions that may promote a discussion about Hopes or Wishes.

What happens in a good day for you?

What is most important to you at this stage in your life?

How do you like to spend your day?

Is there anything that you particularly dislike in your current situation?

What are you worried about?

What do you know about your health problems and what might happen in the future?

What do you look forward to?

What matters to you? What could help with having those things?

.....

How to turn Hopes or Wishes into achievable goals?

Some residents will have specific hopes or wishes that are easy to recognise as achievable goals. For these residents, their achievable goals are the same as their hopes or wishes, so the role of the lifestyle staff is to document this on the HOW tool, to share this information with the team, and to provide appropriate support to fulfil these goals.

For other residents, they may have very broad hopes or unrealistic wishes. Residents may need a staff member's support in reframing these hopes and wishes into achievable goals. It is important that the resident and staff agree on what is achievable, and that it is lifestyle's role to guide, and not prescribe goals.

How to assist residents to identify goals?

Residents' goals should be positive and action oriented. However, residents often have broad goals or unrealistic goals such as 'wanting to go home'. The **SMART** strategy may be useful for the exploration.

Specific – Target a specific care approach or behaviour for improvement. Being specific ensures that the goal is individualised for the residents.

Measurable - How will we know when the goal is achieved? Staff should quantify or at least suggest an indicator of progress.

Achievable - What results can be realistically achieved given available resources? Collaboration and advice from other staff members might be necessary. Here any barriers and solutions can be identified.

Relevant - The goal must be of interest, and matter to the resident. Actions must be directed in some way to achieving the goal.

Time Limited - Specify when the results can be achieved, and ensure to follow up when the specified time period is over.

Some examples from using the HOW tool

Through Tapestry implementation, the HOW tool has helped staff to assist residents to achieve their hopes and wishes. Here are some examples.

EXAMPLE 1:

Mary is over 80 years old and doesn't 'feel old'. When lifestyle staff asked what she wants to do, she wanted something 'different' but didn't know what. From everyday communication with Mary, lifestyle knew that she wants to do something that stimulates her brain and she sometimes wants to get out of the facility. With these clues the lifestyle team put their ideas together and suggested if she is interested in joining University of Third Age (U3A) near the facility which she can easily access by a taxi.

"U3A has things on every day, different classes. So she can go at 10 o'clock in the morning, which worked out well. We printed out all information (about U3A) for her, from Monday to Sunday there are whole different things she could take part in, and when she got it, she was like 'Wow!' She didn't even know this existed. We are happy to call a cab if that's what she wants. . She's got a half price taxi card. It's also good for us that we know we've done something. We made a couple of phone calls, printed off the information. Mary said 'this is something different.' She's so happy." (Lifestyle Coordinator)

EXAMPLE 2:

Keith's wishes were 'to go home', 'to be independent' and 'to drive his car again'. None of which were realistically achievable. He hated living in the facility because he thought he was trapped. The lifestyle coordinator and her team discussed with Keith what could be achievable. From this discussion and using the HOW tool, Keith's doctor signed a motor registration form, which enabled him to keep his car on the premise, although he was not permitted to drive. The doctor also signed a form so that 'he can go out'. This gave him a sense of freedom and independence.

"That was a big deal. His car is still out there although he can't drive. He's very happy that he gets a taxi and go out even though most of the time he's scared of going, but I said 'this is your goal, you wanted to do it' and he said 'I just wanted to know if I could do it'. So he went out on Friday, he goes out once in blue moon, but he knows he is allowed to go out, he's not trapped. It's a big deal. He's happy to live in here now. We wouldn't have known that, we wouldn't have worked through that without Tapestry. It also makes me feel good because he is happier and I am part of that." (Lifestyle Coordinator)

Why is HOW important for people living with *dementia*?

Some families might think that their loved ones have no goals or aspirations because they have dementia. However, this may not be true. Research shows that quality of life for people living with dementia will be improved when their spiritual needs are met. Spirituality is 'all about meaning, purpose and connectedness' (Meaningful Ageing Australia, 2016) or more specifically 'the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, to the significant or sacred' (Puchalski et al. 2014: 643). The HOW tool can be used as a tool to identify what makes residents' lives meaningful through spirituality (or connectedness). For those living with dementia, this can be done in collaboration with the resident and their family members. Staff can create an environment that enables residents to meet their spiritual needs.

What should you do when a resident has no goals other than 'wanting to go home' or 'wanting to die'?

Allow time to actively listen to these residents.

'Wanting to go home'

Recognise their loss and the difficulty they may experience in accepting their transition to living in residential care. While you understand that the facility is not the home they came from, your role is to help make their time spent at the facility as home-like as possible. We can discover what 'home' means for these residents by: exploring their past life experiences, identifying their likes and dislikes in the past, having ongoing, open and personal discussions with them and their families, and involving other care staff with different expertise.

Here are some helpful prompts when talking with the resident:

- *What is it that you most miss about home?
- *What can we do to make your room or your activities more personal to you?

'Wanting to die'

This is an opportunity to discover how the person is coming to terms with the end of their life and to reassure them that you are ready and able to continue to care for and support them until that time.

Here are some helpful prompts when talking with the resident:

- *Is there anything about dying that gives you anxiety?
- *What would like to achieve before that happens?
- *Who would you like to be involved?
- *How do you wish your family, friends and carers to be involved?

Summary

Together these three simple tools can guide staff in supporting 'what matters' for the resident while also considering 'what is the matter' for the resident. The overall aim is to improve each resident's experience while living in residential aged care.



Tapestry of Care

Step-by-Step
Implementation Booklet

SECTION 5

Tapestry & the Aged Care Quality Standards

Tapestry & the Aged Care Quality Standards

Standard 1 Resident Dignity and Choice

Tapestry enhances each resident's ability to make informed choices and to express their identity and wishes. The Transition Map facilitates open and educative communication with residents and their families about the projected care journey so that they can make informed decisions about the care and services that they wish to receive. The Hopes and Wishes (HOW) tool facilitates person-centred care; encourages staff to treat each resident with dignity and respect; and supports consumers to formulate and communicate their preferences and values.

Standard 2 Ongoing Assessment and Planning with Consumers

Tapestry improves a facility's capacity to conduct effective assessment and planning in partnership with the resident. The CIRS-NH can be used to improve the clarity, accuracy and impact of diagnosis and enables better collaboration between consumers, family and multidisciplinary staff. Any changes in the resident's condition can be identified and communicated more effectively. The Transition Map is used to collaboratively plan a care approach which is updated as the resident's needs change. The resident's needs, goals and preferences are also assessed and actioned through the HOW tool on a continual basis. This informs a tailored care approach, where the resident's current and future needs, goals and preferences are identified and addressed.

Standard 3 Personal Care and Clinical Care

Tapestry is designed to improve the delivery of personal and clinical care to consumers through improving communication and collaboration between all stakeholders; facilitating person-centred care; and ensuring that care and services are in alignment with resident's needs, goals and preferences. When a resident's health changes or deteriorates towards end of life, this can be clearly identified and communicated using the Transition Map and appropriate care can be delivered based on this. The HOW tool also provides a way for consumers to express their needs, goals and preferences for care in general and as they are nearing the end of life.

Standard 4 Services and supports for daily living

Implementation of Tapestry facilitates the tailoring of services and supports for daily living to the resident's needs, goals and preferences. The Transition Map describes the appropriate level of care and enables identification of services and supports that are appropriate for the resident. The HOW tool can be used to promote the emotional, spiritual and psychological wellbeing of residents through identifying what is important to them and implementing services and supports that meet their needs.

Standard 7 Human resources

Tapestry encourages person-centred care, where staff are supported to treat residents as diverse and unique individuals with their own experiences, preferences, needs and cultures. This is especially facilitated through the HOW tool, where staff engage in conversation with residents about what has value to them. The program allows staff to work with residents in a responsive and flexible way, enabling the delivery of better quality care and improved staff satisfaction.

Standard 8 Organisational governance

Tapestry enhances the capacity for organisations to provide quality care that meets the Aged Care Quality Standards and that is in the best interests of residents. Its approach emphasises residents and families as central to the development and delivery of care and services. Residents and their families are engaged in ongoing discussions about the overall goals of care to achieve understanding and consensus about how services will be delivered to achieve the best possible resident experience.

See below link for information about the **Australian Aged Care Quality Standards**

www.agedcarequality.gov.au/providers/standards



Tapestry of Care

.....
Step-by-Step
Implementation Booklet
.....

SECTION 6

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Appendices



Transition Map Scale

Savvas S, Scherer S, and Vaughan M. 2019

Background:

Transitions occur for each resident in multiple domains (e.g. health, disability, relationships) and are not static. This form stratifies the resident into one of 9 pathways or goals of care, classified by the:

- 1. Type of illness/disability**
(Body, Brain, or Mix of both); and
- 2. Severity or stage of illness/disability**
(Restore, Maintain, or Comfort).

Transition mapping can be used to inform medical care approach, and provide staff with a greater sense of therapeutic direction and overall goals of care.

Instructions:

Based on your clinical judgement, mark a cross (x) in one of the boxes on the 3x3 map where you believe the resident is regarding the **overall** medical care they need.

Do NOT mark on the borders or gridlines.

Resident

Date

TYPE OF ILLNESS OR DISABILITY		
BODY RESTORE	MIXED (BODY & BRAIN) RESTORE	BRAIN RESTORE
BODY MAINTAIN	MIXED (BODY & BRAIN) MAINTAIN	BRAIN MAINTAIN
BODY COMFORT	MIXED (BODY & BRAIN) COMFORT	BRAIN COMFORT
END OF LIFE	END OF LIFE	END OF LIFE

SEVERITY OF ILLNESS OR DISABILITY

GENERAL MAPPING STRATEGY

Note that this scale uses simpler terminology (Body, Brain) for ease of understanding to non-health professions.

Body - Somatic related illness. e.g. musculoskeletal, sensory loss, cancer, pain, organ related diseases, diabetes.

Mixed - Mixture of both Body and Brain (Somatic and Neurocognitive) illnesses/ impairments.

Brain - Neurocognitive impairments e.g. all dementia types, cognitive changes from brain injury, Parkinson's disease, behavioural and mood changes related to dementia (BPSD).

Restore - where a rehabilitative / re-enablement approach may be of value.

Maintain - where maintaining function / systems and slowing further deterioration is the main consideration.

Comfort - where symptom relief and providing comfort is the main consideration. Includes the 'End of Life' stage.

Psychological Factors

Tick box if there is a high impact of psychological factors. e.g. highly anxious, personality factors. Then proceed to map as normal but without considering psychological factors.

- ☐ Tick if resident has high impact of psychological factors. Still map resident above (do not map psych factors). Psychological factors:

- ☐ Tick if unable to map

Cumulative Illness Rating Scale for Nursing Homes (CIRS-NH)

Modified by Savvas S, Scherer S and Vaughan M 2019, with permission from Miller, Paradis, and Reynolds 1991

Patient

Date

Rater

Instructions:

Write brief descriptions of the medical problem(s) that justified the endorsed score on the dotted line next to each item. Refer to reverse side for example rating advice and how to rate malignancies.

Minimum score for each item is 0.
Maximum score for each item is 4.

GENERAL RATING STRATEGY

- 0** No problem
- 1** Current mild problem or past significant problem
- 2** Moderate disability or morbidity/requires first line therapy
- 3** Severe/constant significant disability/uncontrollable chronic problems
- 4** Extremely severe/immediate treatment required/end organ failure/severe impairment in function

SCORE

HEART (any heart related conditions)

VASCULAR (including hypertension)

HEMATOPOIETIC (blood, blood vessels and cells, marrow, spleen, lymphatics)

RESPIRATORY (lungs, bronchi, trachea, below the larynx)

EYES, EARS, NOSE, THROAT and LARYNX (rated AFTER instrumental correction e.g. hearing aid, glasses)

UPPER GI (esophagus, stomach, duodenum)

LOWER GI (intestines, hernias)

LIVER (including biliary and pancreatic trees)

RENAL (kidneys only)

GENITOURINARY (ureters, bladder, urethra, prostate, genitals, uterus, ovaries)

MUSCULOSKELETAL/INTEGUMENT (muscles, bone, skin)

NEUROLOGICAL (brain, spinal cord and nerves. Do NOT include dementia)

ENDOCRINE/METABOLIC AND BREAST (including diabetes, thyroid, breast, systemic infections, toxicity)

PSYCHIATRIC ILLNESS (including depression, anxiety, agitation/delirium, psychosis)

NEUROCOGNITIVE (dementia and related disorders, BPSD)

RATING MALIGNANCIES

(rate in the appropriate organ category):

1. Cancer diagnosed in remote past without evidence of recurrence/ sequelae in past 10 years.
2. Cancer diagnosed in the past without evidence of recurrence/sequelae in past 5 years.
3. Required chemotherapy, radiation, hormonal therapy or surgical procedure for cancer in past 5 years.
4. Recurrent life threatening malignancy/ failed containment of primary malignancy/palliative treatment.

HEART

1. Remote MI (>5yrs ago); occasional angina.
2. CHF compensated with Rx; daily anti-angina Rx; left ventricular hypertrophy; atrial fib/ daily antiarrhythmic Rx.
3. Moderate CHF; Previous MI (<5 yrs ago); abnormal stress test; status post percutaneous coronary angioplasty; coronary artery bypass graft surgery.
4. Intractable CHF; Marked restriction to ADL secondary to cardiac status; unstable angina;

VASCULAR

1. HT controlled Rx free with restricted salt & weight.
2. HT w once daily antihypertensive Rx; 1 sympt atherosclerosis
3. HT with 2+ daily antihypertensive Rx; 2+ symptoms of atherosclerosis
4. Malignant/uncontrolled HT; atherosclerosis requires surgery.

HEMATOPOIETIC

1. Hemoglobin:10-12g/dl(female), 12-14g/dl(male); anaemia of chronic 'inflammatory' disease.
2. Hemoglobin:8-10g/dl(female),10-12g/dl(male); Previous DVT; anaemia secondary to Iron,B12Vit or folate deficiency or chronic renal failure; WBC 2000-4000/mm³.
3. Haemoglobin:<8g/dl(female),<10g/dl(male);DVT or recent DVT(<6months ago); WBC<2000/mm³
4. Any leukaemia/lymphoma.

RESPIRATORY

nb pack year =(# of cig per day x years smoking)/20

1. Recurrent episodes of acute bronchitis; current asthma treatment with prn inhalers; cig smoker 10-20 pack year
2. Instrumental diagnosis of COPD; daily prn inhalers; 2+ pneumonia episodes <5yrs ago; smoker 20-40 pack year.
3. Limited ambulation secondary to limited respiratory capacity; oral steroids for lung disease; smoker>40 pack year; acute pneumonia treated as outpatient
4. Require supplement Oxy; 1+ episode resp failure need assisted vent; any lung cancer; acute pneumonia requires hosp.

EYES, EARS, NOSE, THROAT AND LARYNX

1. Corrected vision w glasses; mild hearing loss; chronic sinusitis.
2. Diffic read newspaper w glasses; require hearing aid; chronic sinonasal complaints need Rx; Vertigo/dizziness need daily Rx.
3. Partially blind (needs escort); unable to read newsprint; impaired hearing despite hearing aid.
4. Functional blind/deaf; laryngectomy; need surgery for vertigo

UPPER GI

1. Hiatal hernia; heartburn treated with prn Rx.
2. Daily H2 blocker or antacid; gastric or duoden ulcer <5yrs ago
3. Active ulcer; guaiac positive stools; any swallowing disorder of dysphagia.
4. Gastric cancer; Hx of perforated ulcer; melena or hematochezia from Upper GI source.

LOWER GI

1. Constipation managed with prn Rx; active haemorrhoids; status post hernia repair.
2. Daily bulk lax/stool softener; diverticulosis; untreated hernia.
3. Bowel impaction in past year; daily stimulant laxative/enema.
4. Hematochezia from lower GI source; currently impacted; diverticulitis flare up; S/P bowel obstruction; bowel carcinoma.

LIVER

1. Hepatitis >5 yrs ago; cholecystectomy.
2. Cholelithiasis; mild elevated LFT (<150%norm); hepatitis <5 yrs ago; daily/ heavy alcohol use <5 yrs ago.
3. Elevated bilirubin (total>2); marked elevated LFT (>150%normal); requires supp pancreatic enzymes for digestion.
4. Biliary obstruction; any biliary tree carcinoma; cholecystitis; pancreatitis; active hepatitis;

RENAL

1. Kidney stone passage Hx<10yrs;
2. Serum Creat>1.5 but <3.0 w/o diuretic or antihypertens Rx.
3. Serum Creatinine>3.0 or serum creatinine>1.5 with diuretic, antihypertensive or bicarb therapy; current pyelonephritis.
4. Requires dialysis; renal carcinoma.

GENITOURINARY

1. Stress incontinence; hysterectomy; BPH w/o urinary symptoms
2. Abnorm pap smr;freq UTI (3+ in yr); urine incont (nonstress) in fem; BPH w hesit/freq; current UTI; urine divers procd; S/P TURP
3. Prostatic cancer in situ; vaginal bleeding; cervical carcinoma in situ; haematuria; status post urosepsis in past yr.
4. Acute urinary retention; any GU carcinoma except as above.

MUSCULOSKELETAL/INTEGUMENT

1. Prn Rx for arthritis or limited ADL from joint path; excised non-melanotic skin cancers; skin infection require antibiotic in past yr
2. Daily antiarthritic Rx or use of assistive devices or mod limited ADL; daily Rx for chronic skin cond; melanoma w/o metastasis.
3. Severely impaired ADL second to arthritis; steroids for arthritic condition; vertebral compression fractures from osteoporosis.
4. Wheelchair bound; severe joint deformity or impaired usage; osteomyelitis;any bone/muscle carcinoma;metastatic melanoma

NEUROLOGICAL

1. Headache need prn Rx w/o limited ADL; Tia phenomena Hx (I)
2. Daily Rx for chron headache; TIA or 2+ Hx of TIA; prev CVA w/o sig residual; mild severity neurodegen dis (eg Parkinson,MS,ALS)
3. S/P CVA with mild residual dysfunction; any CNS neurosurgical procedure; moderate severity neurodegenerative disease.
4. S/P CVA with residual functional hemiparesis or aphasia; severe neurodegenerative disease.

ENDOCRINE/METABOLIC AND BREAST

1. Diabetes compensated with diet; mild obesity (BMI 30-35); thyroid hormone replacement.
2. Diabetes require insulin or oral agents; fibrocystic breast disease; moderate obesity (35-45).
3. Electrolyte imbalance requires hosp; morbid obesity (BMI>45).
4. Brittle/poorly controlled diabetes; requires adrenal hormone replacement; adrenal, thyroid, breast carcinoma.

PSYCHIATRIC ILLNESS

1. Minor psych condition or Hx. Previous psych treatment w/o hosp; major depress event &/or antidepress Rx w/o hosp>10yrs ago; occasional minor tranq for episodic anxiety.
2. Major Depression <10yrs ago; any previous psych hospital; substance abuse history>10 yrs ago.
3. Current major depress or 2+ episode of major depres <10 yrs; daily antianxiety or antipsych Rx; subst abuse;
4. Current mental illness & psych inpatient or intensive outpatient care (eg severe depression, acute psychosis, severe agitation from dementia or substance abuse).

NEUROCOGNITIVE

1. MCI (mild cognitive impairment): CDR score= 0.5
2. Mild dementia: SMMSE score 20-25; CDR score= 1
3. Moderate dementia: SMMSE score 10-19; ACFI PAS-CIS/CDS score >10; CDR score= 2
4. Severe dementia: SMMSE score 0-9; ACFI PAS-CIS/CDS score >10; CDR score= 3

Hopes or Wishes Tool (HOW)

Savvas S, Scherer S, and Vaughan M. 2019

INSERT
PROVIDER LOGO
HERE

Resident's name

Date

People involved

Instructions:

This care plan provides a summary of how we will work together to support you in achieving your hopes or wishes.

Note to staff:

Ideally formulate 3 hopes or wishes. Focus on what the resident wants to achieve, not what is wrong.

What do you want to achieve by working together?

HOPES OR WISHES (specific or general)	ACHIEVABLE GOALS	>	ACTIONS (be specific)	>	TIMEFRAME	EVALUATION at RoD (met/unmet/partially met) & DATE



Customer Information – An Overview

Residential Aged Care

What is Tapestry of Care?

Tapestry of Care (or just 'Tapestry') is our new care program for Residential Services. A tapestry is carpet art, full of complex pictures that tell a story. We also see our new program as a Tapestry – an intricate story of the care and services we provide to assist each resident on their journey in aged care.

What are the benefits?

Living with care is a journey. As health and circumstances change, so should the care. Some of these changes are more significant than others, and may involve transitioning to better ways of being cared for. We map these transitions so that the journey ahead is easy to understand. We also use this information to help translate the aspirations of our residents into attainable goals.

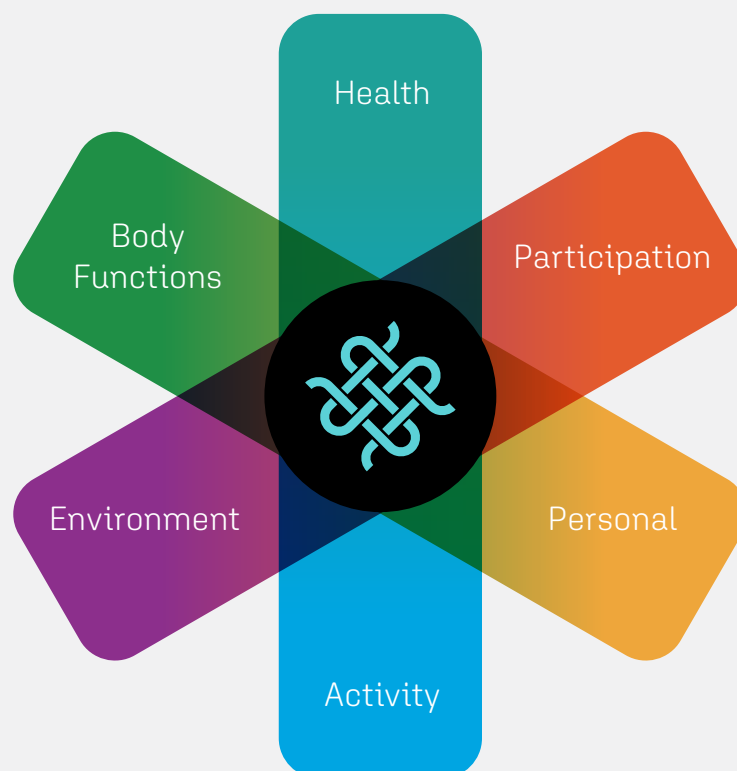
How does it work?

We can now map each resident's journey to summarise our care approach. We first explore every aspect of a resident's health and well-being using 'whole-of-person' principles developed by the World Health Organisation. We consider how Health and Body Function, Participation and Activity ability, Personal Factors, and the living Environment may impact the care of each resident. We then can summarise this on a 'Transition Map', which is our open and honest recommended pathway for care.

FIGURE 1

Figure 1

For You For Life Tapestry is a 'whole-of-person' care approach with concepts from the International Classification of Functioning, Disability and Health, developed by the World Health Organisation. This approach is a broad view of health, with biological, individual and social aspects. So our functioning capacity is defined by our health, body functions and systems, participation and activity ability, personal factors, and the environment we live in.



Our new Care Experience

We use this Exploration and Transition Map to then inform us of the most appropriate care services we can provide, and to better engage with what is important to each resident and their goals. The end result is an improved resident experience.

FIGURE 2

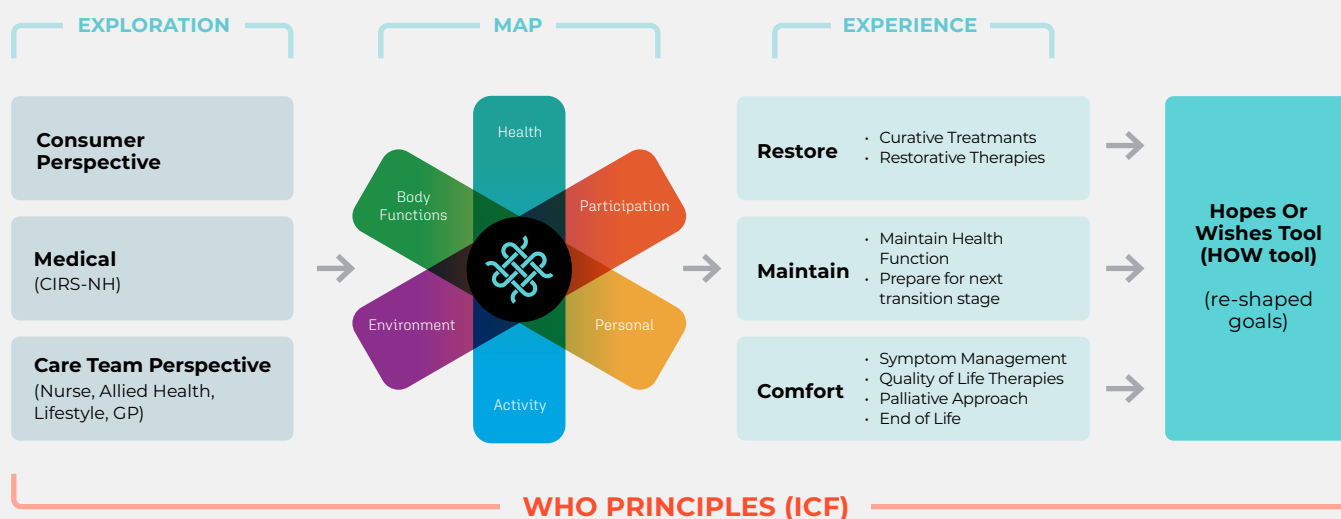


Figure 2

Our care approach involves the Exploration of the resident using Transition maps, the resident's Experience of this new care approach, and how <provider name> can help re-shape resident aspirations using the Hopes Or Wishes Tool. To create Transition Maps, we explore every aspect of the resident's health and function using medical questionnaires such as the Cumulative Illness Rating Scale (CIRS-NH), professional perspectives from the GP, Allied Health, Nurses, and Lifestyle Services, and international best practice principles developed by the World Health Organisation (WHO). Transition Maps then describe the appropriate level of care (Restore, Maintain, or Comfort Care), and inform appropriate treatment and therapy approaches, as well as Hopes of Wishes (as determined by the resident).

How can I find out more?

For general information about this program, please contact the Program Coordinator (<name>) on <phone number> or via email on <email address>.



Customer Information – Transition Maps

Residential Aged Care

Tapestry of Care (or just 'Tapestry') is our new care program for Residential Services. A tapestry is carpet art, full of complex pictures that tell a story. We also see our new program as a Tapestry – an intricate story of the care and services we provide to assist each resident on their journey in aged care.

What can the customer expect?

Living with care is a journey. As health and circumstances change, so should the care. Significant changes may involve transitioning to better ways of being cared for. We map these transitions so that the journey ahead is easy to understand. We also use this information to help translate the aspirations of our residents into attainable goals.

Transition maps provide the resident and their loved ones with an open and honest, recommended pathway for future care – highlighting how we intend to enrich their life, addressing all aspects of their well-being.

What do Transition Maps look like?

The Transition map is a user-friendly illustration. But behind the scenes sits a care model based on evidence-based health science.

The map has two parts:

- ① The type of health problem: either **Body**, **Mixed** or **Brain**.
- ② The severity of the problem and our response: either **Restore**, **Maintain** or **Comfort**.

There is also a tick box for psychological considerations (such as high levels of anxiety or depression).

TYPE OF ILLNESS OR DISABILITY			SEVERITY OF ILLNESS OR DISABILITY
BODY RESTORE	MIXED (BODY & BRAIN) RESTORE	BRAIN RESTORE	
BODY MAINTAIN	MIXED (BODY & BRAIN) MAINTAIN	BRAIN MAINTAIN	
BODY COMFORT	MIXED (BODY & BRAIN) COMFORT	BRAIN COMFORT	
END OF LIFE	END OF LIFE	END OF LIFE	

☐ Tick if patient has a high impact of psychological factors

What does Body, Brain or Mixed mean?

These terms indicate health problems that are Body related (eg osteoarthritis, sensory loss, pain, cancer, diabetes, organ related disease) or Brain / Neurocognitive related (eg dementia, brain injury, behaviours and mood changes related to dementia). Mixed is when there are both significant Body and Brain health problems.

What do Restore, Maintain, or Comfort refer to?

These categories are our different approaches or goals of care. A Restore approach seeks to rehabilitate and aims to regain function. A Maintain approach acknowledges that regaining function is unlikely, so care aims to maintain and prevent further health and functional decline. However there may come a time when the main aim is to provide Comfort, by treating symptoms to provide relief. As health declines further in Comfort care, a transition to end of life occurs. Here death may be imminent and care focuses on comfort and dignity.

Do these maps just label customers?

No. These maps are not designed to limit care. Rather, they are designed to optimise care by focusing on the best available options. They also provide an opportunity to open up other meaningful conversations, regarding each resident's health and care needs.

Who can discuss Tapestry and Transition Maps with me?

The manager of clinical practice or care manager will review and update each resident's Tapestry and Transition map every few months.

My loved one is included in this new program. What do I do with this information?

You don't need to do anything. This information helps you better understand the overall care approach for your loved ones, as well as their journey ahead. You may wish to discuss this with the care manager.

How can I find out more about this program?

For general information about this program, please contact the Program Coordinator (<name>) on <phone number> or via email on <email address>.



Κλιμακα Χαρτη Μεταβασης

Residential Aged Care | Savvas S, Scherer S, and Vaughan M. 2019

Ιστορικό:

Οι μεταβάσεις συμβαίνουν για κάθε κάτοικο σε πολλούς τομείς (π.χ. υγεία, αναπηρία, σχέσεις) και δεν είναι στατικές. Αυτή η μορφή διαστρώνει τον κάτοικο σε ένα από τα 9 μονοπάτια ή στόχους φροντίδας, ταξινομημένο από:

1. **Είδος ασθένειας / αναπηρίας**
(Σώμα, Εγκέφαλος ή Μίξη και των δύο) και
2. **Σοβαρότητα ή στάδιο ασθένειας / αναπηρίας**
(επαναφορά, διατήρηση ή άνεση).

Η χαρτογράφηση μετάβασης μπορεί να χρησιμοποιηθεί για να ενημερώσει την ιατρική περίθαλψη και να προσφέρει στο προσωπικό μεγαλύτερη αίσθηση θεραπευτικής κατεύθυνσης και γενικού στόχους φροντίδας.

Οδηγίες:

Με βάση την κλινική κρίση σας, σημειώστε ένα σταυρό (x) σε ένα από τα τετράγωνα του χάρτη 3x3 όπου πιστεύετε ότι ο κάτοικος είναι σχετικά με τη συνολική ιατρική περίθαλψη που χρειάζεται.

Μην σημειώνετε στα διαχωριστικά πλαίσια ή στις γραμμές πλέγματος.

Κατοικος

Ημερομηνια

ΕΙΔΟΣ ΑΣΘΕΝΕΙΑΣ Η ΑΝΑΠΗΡΙΑΣ

Αποκατάσταση Σώματος	Μικτή Αποκατάσταση Σώματος & Εγκεφάλου	Αποκατάσταση Εγκεφάλου
Διατήρηση Σώματος	Μικτή Διατήρηση Σώματος & Εγκεφάλου	Διατήρηση Εγκεφάλου
Ανακούφιση Σώματος	Μικτή Ανακούφιση Σώματος & Εγκεφάλου	Ανακούφιση Εγκεφάλου
Τέλος της ζωής	Τέλος της ζωής	Τέλος της ζωής

ΓΕΝΙΚΗ ΣΤΡΑΤΗΓΙΚΗ ΧΑΡΤΗ

Σημειώστε ότι αυτή η κλίμακα χρησιμοποιεί απλούστερη ορολογία (Body, Brain) για ευκολία κατανόησης σε επαγγέλματα που δεν σχετίζονται με την υγεία.

Σώμα - Σωματική ασθένεια. π.χ. μυοσκελετική, αισθητηριακή απώλεια, καρκίνο, πόνο, ασθένειες σχετιζόμενες με όργανα, διαβήτη.

Μικτή - Μείγμα τόσο σωματικών όσο και εγκεφαλικών (σωματικών και νευρογνωστικών) ασθενειών / βλαβών.

Εγκέφαλος - Νευρογνωστικές διαταραχές π.χ. όλους τους τύπους άνοιας, γνωστικές αλλαγές από εγκεφαλική βλάβη, ασθένεια του Parkinson, αλλαγές συμπεριφοράς και αλλαγές στη διάθεση που σχετίζονται με την άνοια (BPSD).

Επαναφορά - όπου μια προσέγγιση αποκατάστασης / επανεκκίνησης μπορεί να έχει αξία.

Διατήρηση - όπου η συντήρηση των λειτουργιών / συστημάτων και η επιβράδυνση της περαιτέρω υποβάθμισης είναι το κύριο μέλημα.

Άνεση - όπου η ανακούφιση των συμπτωμάτων και η παροχή άνεσης είναι το κύριο μέλημα. Περιλαμβάνει το στάδιο "Τέλος της ζωής".

Ψυχολογικοί παράγοντες

Επιλέξτε το κουτί εάν υπάρχει μεγάλη επίδραση ψυχολογικών παραγόντων. π.χ. ιδιαίτερα άγχος, παράγοντες προσωπικότητας. Στη συνέχεια προχωρήστε στη χαρτογράφηση κανονικά αλλά χωρίς να λάβετε υπόψη ψυχολογικούς παράγοντες.

- ☐ Επιλέξτε εάν ο κάτοικος έχει υψηλό αντίκτυπο ψυχολογικών παραγόντων. Ακόμα χάρτης κάτοικος παραπάνω (μην χαρτογραφείτε ψυχικούς παράγοντες).

Ψυχολογικοί παράγοντες:

- ☐ σημειώστε εδώ εάν δεν μπορείτε να επιλέξετε ένα κουτί

Φύλλο Πελάτη - Επισκόπηση

Residential Aged Care

Τί είναι το Tapestry of Care;

Tapestry of Care (ή απλά 'Tapestry') είναι το νέο μας πρόγραμμα φροντίδας για οικιακές υπηρεσίες. Μια ταπετσαρία είναι τέχνη χαλιών, γεμάτη σύνθετες εικόνες που λένε μια ιστορία. Βλέπουμε επίσης το νέο μας πρόγραμμα ως ταπετσαρία - μια περίπλοκη ιστορία της φροντίδας και των υπηρεσιών που παρέχουμε για να βοηθήσουμε κάθε κάτοικο στο ταξίδι του προς τη φροντίδα ηλικιωμένων.

Ποια είναι τα πλεονεκτήματα;

Η διαβίωση όταν υπάρχει φροντίδα είναι ένα ταξίδι. Καθώς η υγεία και οι συνθήκες αλλάζουν, θα πρέπει και η φροντίδα να είναι προσαρμοσμένη στις εκάστοτε ανάγκες. Ορισμένες από αυτές τις αλλαγές είναι πιο σημαντικές από άλλες και μπορεί να συνεπάγονται τη μετάβαση σε καλύτερους τρόπους φροντίδας. Σχεδιάζουμε αυτές τις μεταβάσεις ώστε το ταξίδι μπροστά να είναι κατανοητό. Χρησιμοποιούμε επίσης αυτές τις πληροφορίες για να μεταφέρουμε τις φιλοδοξίες των κατοίκων μας σε εφικτούς στόχους.

Πώς λειτουργεί;

Τώρα μπορούμε να χαρτογραφήσουμε το ταξίδι κάθε κατοίκου για να συνοψίσουμε την προσέγγιση φροντίδας μας. Αρχικά διερευνάμε κάθε πτυχή της υγείας και της ευημερίας ενός κατοίκου με βάση τις αρχές «ολόκληρου του ατόμου» που αναπτύσσονται από την Παγκόσμια Οργάνωση Υγείας. Θεωρούμε πώς η λειτουργία της υγείας και του σώματος, η ικανότητα συμμετοχής και δραστηριότητας, οι προσωπικοί παράγοντες και το περιβάλλον διαβίωσης μπορούν να επηρεάσουν τη φροντίδα κάθε κατοίκου. Στη συνέχεια, μπορούμε να συνοψίσουμε αυτό το θέμα σε έναν «Χάρτη μετάβασης», ο οποίος είναι ανοικτός και ειλικρινής συνιστώμενος δρόμος για τη φροντίδα..

ΕΙΚΟΝΑ 1

Εικόνα 1

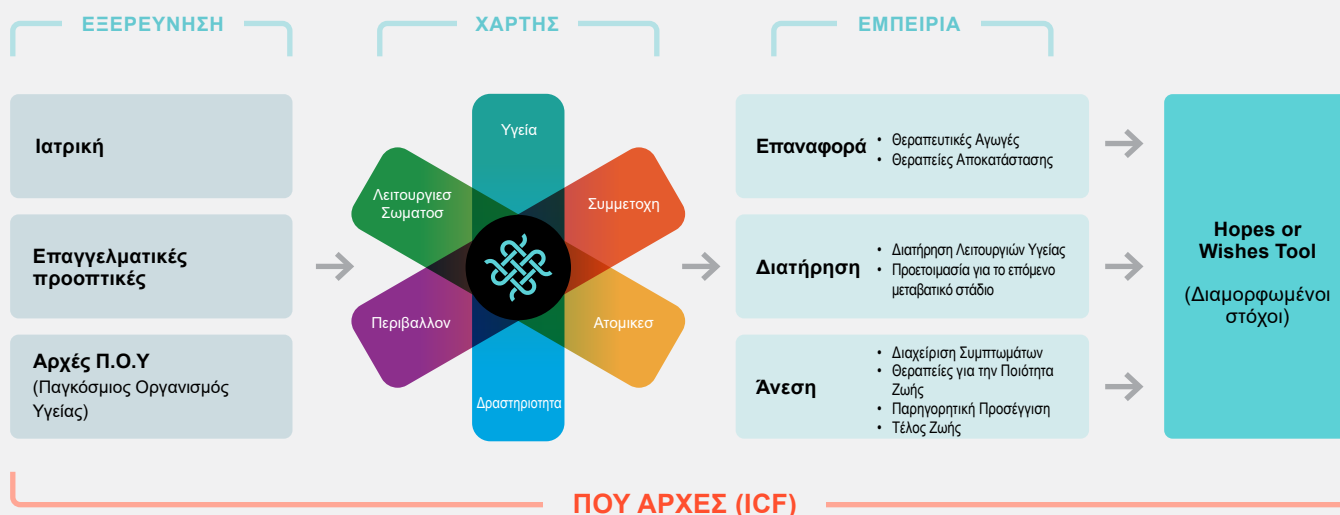
Το Tapestry είναι μια προσέγγιση περίθαλψης «όλου του ατόμου» με έννοιες από τη Διεθνή Ταξινόμηση Λειτουργίας, Αναπηρίας και Υγείας, που αναπτύχθηκε από την Παγκόσμια Οργάνωση Υγείας. Αυτή η προσέγγιση είναι μια ευρεία θεώρηση της υγείας, με βιολογικές, ατομικές και κοινωνικές πτυχές. Έτσι, η λειτουργική μας ικανότητα ορίζεται από την υγεία, τις λειτουργίες και τα συστήματα του σώματος, τη συμμετοχή και την ικανότητα των δραστηριοτήτων μας, τους προσωπικούς παράγοντες και το περιβάλλον στο οποίο ζούμε.



Η νέα μας εμπειρία φροντίδας

Χρησιμοποιούμε αυτόν τον Χάρτη Εξερεύνησης και Μετάβασης για να μας ενημερώσετε σχετικά με τις καταλληλότερες υπηρεσίες φροντίδας που μπορούμε να προσφέρουμε και να εμπλακούμε καλύτερα με το τι είναι σημαντικό για κάθε κάτοικο και τους στόχους του. Το τελικό αποτέλεσμα είναι μια βελτιωμένη εμπειρία κατοίκου.

ΣΧΗΜΑ 2



Σχήμα 2

Η προσέγγιση της περίθαλψης μας περιλαμβάνει την Εξερεύνηση του κατοίκου που χρησιμοποιεί τους Χάρτες μεταβάσεων, την Εμπειρία του κατοίκου αυτής της προσέγγισης νέας περίθαλψης και τον τρόπο με τον οποίο οι <provider name> μπορούν να βοηθήσουν στην αναδιάρθρωση των φιλοδοξιών κατοίκων χρησιμοποιώντας Σχέδια Φροντίδας Καθοδηγημένων Στόχων. Για να δημιουργήσετε Χάρτες Μετάβασης, εμείς (CIRS-NH), επαγγελματικές προοπτικές από τον Γενικό Παθολόγο, Allied Health, Nurses και Lifestyle Services και τις διεθνείς αρχές βέλτιστης πρακτικής που αναπτύχθηκαν από την Παγκόσμια Οργάνωση Υγείας Οργανισμός (ΠΟΥ). Στη συνέχεια, οι Χάρτες Μετάβασης περιγράφουν το κατάλληλο επίπεδο φροντίδας (Επαναφορά, Συντήρηση ή Άνεση) και ενημερώνουν τις κατάλληλες προσεγγίσεις θεραπείας και θεραπείας, καθώς και τα Hopes or Wishes Tool (όπως καθορίζεται από τον κάτοικο).

Πώς μπορώ να λάβω περισσότερες πληροφορίες;

Για γενικές πληροφορίες σχετικά με αυτό το πρόγραμμα, επικοινωνήστε με τον Συντονιστή Προγράμματος <name> στο <phone number> ή μέσω email στο <email address>.



Φύλλο Πελάτη - Χάρτες μετάβασης

Residential Aged Care

Tapestry of Care (ή απλά 'Tapestry') είναι το νέο μας πρόγραμμα φροντίδας για οικιακές υπηρεσίες. Μια ταπετσαρία είναι τέχνη χαλιών, γεμάτη σύνθετες εικόνες που λένε μια ιστορία. Βλέπουμε επίσης το νέο μας πρόγραμμα ως ταπετσαρία - μια περίπλοκη ιστορία της φροντίδας και των υπηρεσιών που παρέχουμε για να βοηθήσουμε κάθε κάτοικο στο ταξίδι του προς τη φροντίδα ηλικιωμένων

Τι μπορεί να περιμένει ο πελάτης;

Η διαβίωση όταν υπάρχει φροντίδα είναι ένα ταξίδι. Καθώς η υγεία και οι συνθήκες αλλάζουν, θα πρέπει και η φροντίδα να είναι προσαρμοσμένη στις εκάστοτε ανάγκες. Ορισμένες από αυτές τις αλλαγές είναι πιο σημαντικές από άλλες και μπορεί να συνεπάγονται τη μετάβαση σε καλύτερους τρόπους φροντίδας. Σχεδιάζουμε αυτές τις μεταβάσεις ώστε το ταξίδι μπροστά να είναι κατανοητό. Χρησιμοποιούμε επίσης αυτές τις πληροφορίες για να μεταφέρουμε τις φιλοδοξίες των κατοίκων μας σε εφικτούς στόχους.

Οι χάρτες μετάβασης προσφέρουν στους κατοίκους και τους αγαπημένους τους μια ανοιχτή και ειλικρινή συνιστώμενη πορεία για μελλοντική φροντίδα - υπογραμμίζοντας τον τρόπο με τον οποίο σκοπεύουμε να εμπλουτίσουμε τη ζωή τους, αντιμετωπίζοντας όλες τις πτυχές της ευημερίας τους.

Πώς μοιάζει ο Χάρτης Μετάβασης?

Ο Χάρτης Μετάβασης είναι μια φιλικός προς το χρήστη. Αλλά πίσω από τις σκηνές βρίσκεται ένα μοντέλο περίθαλψης βασισμένο σε τεκμηριωμένη επιστήμη υγείας.

Ο χάρτης χωρίζεται σε δυο μέρη:

- 1 Ο τύπος του προβλήματος υγείας: είτε **Σώματος**, **Μικτό** ή **Εγκεφάλου**.
- 2 Η σοβαρότητα του προβλήματος και η ανταπόκρισή μας: είτε **Αποκατάστασης**, **Διατήρησης** ή **Άνεση**.

Υπάρχει επίσης ένα τετραγωνίδιο για ψυχολογικές καταστάσεις (όπως υψηλά επίπεδα άγχους ή κατάθλιψης).

ΕΙΔΟΣ ΑΣΘΕΝΕΙΑΣ Η ΑΝΑΠΗΡΙΑΣ			ΣΟΒΑΡΟΤΗΤΑ ΑΣΘΕΝΕΙΑΣ Η ΑΝΑΠΗΡΙΑΣ
Αποκατάσταση Σώματος	Μικτή Αποκατάσταση Σώματος & Εγκεφάλου	Αποκατάσταση Εγκεφάλου	
Διατήρηση Σώματος	Μικτή Διατήρηση Σώματος & Εγκεφάλου	Διατήρηση Εγκεφάλου	
Ανακούφιση Σώματος	Μικτή Ανακούφιση Σώματος & Εγκεφάλου	Ανακούφιση Εγκεφάλου	
Τέλος της ζωής	Τέλος της ζωής	Τέλος της ζωής	



Επιλέξτε αν δεν είναι δυνατή η αντιστοίχιση

Τι σημαίνει Σώμα, Εγκέφαλος ή Μικτό;

Αυτοί οι όροι υποδηλώνουν προβλήματα υγείας που σχετίζονται με το **Σώμα** (π.χ. οστεοαρθρίτιδα, απώλεια αισθήσεων, πόνο, καρκίνος, διαβήτης, ασθένεια σχετιζόμενη με όργανα) ή σχετίζονται με **Εγκεφαλικά / Νευρολογικά** προβλήματα (π.χ. άνοια, εγκεφαλική βλάβη, συμπεριφορές και αλλαγές στη διάθεση που σχετίζονται με την άνοια). **Μικτό** είναι όταν υπάρχουν και τα δύο σημαντικά προβλήματα υγείας του σώματος και του εγκεφάλου.

Τι γίνεται με την Αποκατάσταση, τη Διατήρηση ή την Άνεση;

Αυτές οι κατηγορίες είναι οι διαφορετικές μας προσεγγίσεις ή οι στόχοι φροντίδας μας. Η προσέγγιση **Αποκατάσταση** αποσκοπεί στην αποκατάσταση και στοχεύει στην επαναφορά της λειτουργίας. Η προσέγγιση **“Διατήρηση”** αναγνωρίζει ότι η λειτουργία ανάκτησης είναι απίθανη, έτσι η φροντίδα έχει ως στόχο τη διατήρηση και πρόληψη περαιτέρω υγειονομικής και λειτουργικής παρακμής. Εντούτοις μπορεί να έρθει μια εποχή που ο κύριος στόχος είναι η παροχή **Άνεσης**, με τη θεραπεία των συμπτωμάτων για την παροχή ανακούφισης. Καθώς η υγεία μειώνεται περαιτέρω στην φροντίδα της Άνεσης, συμβαίνει μια μετάβαση στο τέλος της ζωής. Εδώ ο θάνατος μπορεί να είναι επικείμενη και η φροντίδα επικεντρώνεται στην άνεση και την αξιοπρέπεια.

Οι χάρτες αυτοί επισημαίνουν μόνο τους πελάτες;

Όχι. Αυτοί οι χάρτες δεν έχουν σκοπό να περιορίσουν τη φροντίδα. Αντίθετα, έχουν σχεδιαστεί για να βελτιστοποιούν τη φροντίδα εστιάζοντας στις καλύτερες διαθέσιμες επιλογές. Παρέχουν επίσης την ευκαιρία να ανοίξουν άλλες ουσιαστικές συνομιλίες σχετικά με τις ανάγκες υγείας και φροντίδας κάθε κατοίκου.

Ποιος μπορεί να συζητήσει μαζί μου το Tapestry και το Χάρτη Μετάβασης;

Ο διαχειριστής της κλινικής ή ο διαχειριστής φροντίδας θα επανεξετάζουν και θα ανανεώνουν κάθε κατοίκου το Tapestry και το Χάρτη Μετάβασης κάθε μήνα.

Το αγαπημένο μου πρόσωπο περιλαμβάνεται σε αυτό το νέο πρόγραμμα. Τι να κάνω με αυτές τις πληροφορίες;

Δεν χρειάζεται να κάνετε τίποτα. Αυτές οι πληροφορίες σας βοηθούν να κατανοήσετε καλύτερα τη γενική φροντίδα για τους αγαπημένους σας, καθώς και το ταξίδι τους μπροστά. Μπορεί να θέλετε να το συζητήσετε με τον υπεύθυνο φροντίδας.

Πώς μπορώ να μάθω περισσότερα για αυτό το πρόγραμμα?

Για γενικές πληροφορίες σχετικά με αυτό το πρόγραμμα, επικοινωνήστε με τον Συντονιστή Προγράμματος <name> στο <phone number> ή μέσω email στο <email address>



Đánh giá bản đồ chuyển đổi

Savvas S, Scherer S, and Vaughan M. 2019

Những thông tin chung::

Sự chuyển đổi là những chuyển biến xảy ra đối với người cao niên trên nhiều lĩnh vực (ví dụ như: sức khỏe, khuyết tật, các mối quan hệ) và nó diễn ra tương đối thường xuyên. Bản mẫu này phân loại người cao niên trong cư xá theo một trong 9 lộ trình cùng với mục tiêu chăm sóc dành cho họ, được xác định như sau:

- Loại bệnh lý/ khuyết tật**
(toàn thân, thần kinh hoặc kết hợp toàn thân và thần kinh)
- Mức độ nghiêm trọng và các giai đoạn của bệnh lý /khuyết tật**
(Khôi phục, Duy trì hoặc Giảm nhẹ).

Bản đồ chuyển đổi có thể được dùng để đưa ra những gợi ý nhằm áp dụng cho chăm sóc y tế, giúp cho nhân viên hiểu hơn về hướng điều trị cũng như các mục tiêu chăm sóc tổng thể.

Hướng dẫn:

Dựa trên những đánh giá lâm sàng của anh/chị về người cao niên ở cư xá, hãy đánh dấu chéo (x) vào một trong các ô trên bản đồ 3x3 mà anh/chị cho rằng họ đang cần đến việc chăm sóc y tế tổng thể.

KHÔNG đánh dấu trên các đường viền hoặc đường lưới.

Cư dân: _____

Ngày/ tháng: _____

LOẠI BỆNH

Khôi phục Toàn thân	Khôi phục Hỗn hợp (toàn thân & thần kinh)	Khôi phục Thần kinh
Duy trì Toàn thân	Duy trì Hỗn hợp (toàn thân & thần kinh)	Duy trì Thần kinh
Giảm nhẹ Toàn thân	Giảm nhẹ Hỗn hợp (toàn thân & thần kinh)	Giảm nhẹ Thần kinh
Kết thúc cuộc	Kết thúc cuộc	Kết thúc cuộc

MỨC ĐỘ NGHIÊM TRỌNG

Những giải thích chung về các thuật ngữ trong bản đồ

Lưu ý rằng bản đồ này sử dụng các thuật ngữ đơn giản như (toàn thân, thần kinh) nhằm giúp những người không chuyên về lĩnh vực y tế dễ hiểu hơn.

Toàn thân - là các loại bệnh liên quan đến cơ thể về mặt sinh học: ví dụ cơ xương khớp, mất cảm giác, ung thư, đau, các bệnh liên quan đến nội tạng, tiểu đường.

Hỗn hợp - là các loại bệnh /sự suy yếu của cả toàn thân và thần kinh (toàn thân về mặt sinh học và hệ thần kinh).

Thần kinh - Là suy giảm hệ thần kinh, ví dụ: mất trí nhớ, thay đổi nhận thức từ chấn thương não, bệnh Parkinson, thay đổi hành vi và tâm trạng liên quan đến chứng mất trí nhớ (BPSD).

Khôi phục - là phương pháp phục hồi / tái kích hoạt được áp dụng.

Duy trì - là sử dụng những phương pháp nhằm duy trì các chức năng cơ thể, để làm chậm sự xuống dốc của sức khỏe.

Giảm nhẹ - Tập trung chính tới cách xoa dịu triệu chứng, mang đến sự thoải mái thư giãn. Bao gồm giai đoạn 'Kết thúc cuộc đời'

- ☐ Đánh dấu vào ô này nếu anh/chị thấy người cao niên có những ảnh hưởng nặng về tâm lý. Vẫn đánh dấu vào bản đồ trên (không đánh dấu yếu tố tâm lý).

Yếu tố tâm lý:

- ☐ Đánh dấu vào ô này nếu không thể đánh dấu vào bản đồ

Yếu tố tâm lý

Đánh dấu vào ô này nếu bệnh nhân có tác động lớn của các yếu tố tâm lý, ví dụ như rất lo lắng, yếu tố về tính cách đặc biệt riêng. Sau đó tiến hành đánh dấu trên bản đồ như bình thường nhưng không xem xét các yếu tố tâm lý nữa.

Thông tin chung - dành cho người cao niên và thân nhân

Residential Aged Care

Chương trình For You For Life Tapestry là gì?

Chương trình 'For you and for life Tapestry' (gọi tắt là Tapestry) là chương trình chăm sóc mới của chúng tôi dành cho Dịch vụ trong cư xá. Tapestry có thể được hiểu là nghệ thuật dệt thảm, nó chứa đầy những hình ảnh phức hợp biết kể chuyện. Chúng tôi coi chương trình mới này như là một tấm thảm nghệ thuật – nghĩa là một câu chuyện chứa nhiều tầng ý nghĩa về quá trình chăm sóc và những dịch vụ mà chúng tôi cung cấp nhằm giúp đỡ quý vị trong hành trình chăm sóc người cao niên.

Chương trình này mang lại lợi ích gì?

Cuộc sống cùng với sự chăm sóc là một hành trình. Khi sức khỏe và hoàn cảnh sống thay đổi, quá trình chăm sóc sức khỏe cũng cần thích ứng với những thay đổi đó. Có những thay đổi diễn ra ở mức độ nhiều hơn so với những thay đổi khác, vì thế cần chuyển sang những hình thức chăm sóc tốt hơn. Chúng tôi lập ra bản đồ chuyển đổi này để quý vị hiểu về hành trình chăm sóc sắp tới một cách dễ dàng hơn. Chúng tôi cũng sử dụng những thông tin này để chuyển nguyện vọng của quý vị trở thành những mục tiêu khả thi.

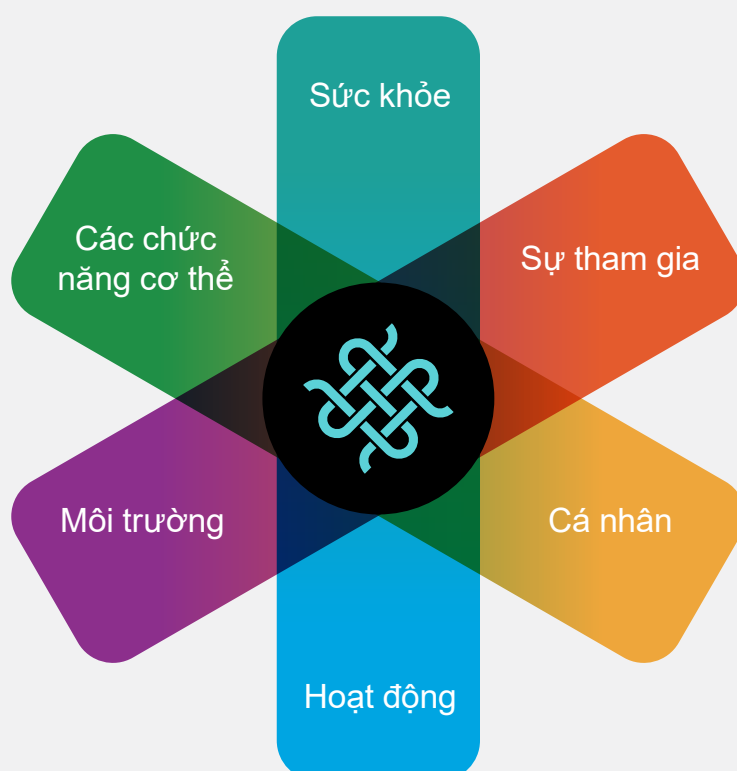
Chương trình này hoạt động như thế nào?

Hiện tại, chúng tôi lập bản đồ hành trình cho mỗi người cao niên trong cư xá để tóm tắt các phương pháp chăm sóc mà chúng tôi áp dụng. Đầu tiên, chúng tôi tìm hiểu về sức khỏe và tinh thần của họ bằng cách sử dụng nguyên tắc "toàn diện" của Tổ chức Y tế Thế giới. Qua đó, chúng tôi sẽ xem xét những yếu tố như: các chức năng cơ thể, sự tham gia và khả năng hoạt động, cá nhân, và môi trường sống ảnh hưởng như thế nào tới sự chăm sóc đối với từng người. Sau đó, chúng tôi tổng hợp những yếu tố này trên 'Bản đồ chuyển đổi', và đây sẽ là những gợi ý trung thực và cởi mở cho quá trình chăm sóc.

HÌNH 1

Hình 1

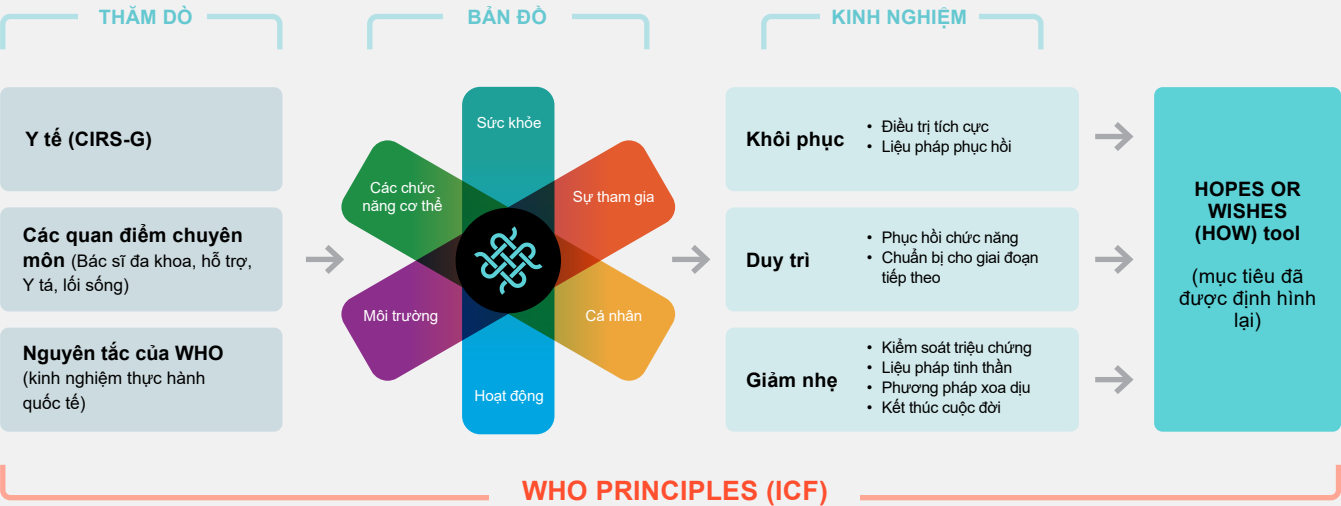
Chương trình Tapestry với phương pháp chăm sóc "toàn diện", sử dụng những khái niệm của Tổ chức Y tế thế giới như: Phân loại chức năng quốc tế, Khuyết tật và Sức khỏe. Tiếp cận này là một cách nhìn rộng hơn về sức khỏe trên các phương diện sinh học, cá nhân và xã hội. Vì vậy, năng lực hoạt động của mỗi con người chúng ta được xác định bởi các yếu tố: sức khỏe, các hệ thống và chức năng cơ thể, khả năng tham gia hoạt động, các yếu tố cá nhân cùng với môi trường mà chúng ta đang sống.



Những kinh nghiệm chăm sóc mới của chúng tôi.

Dựa trên Bản đồ Thăm dò và Chuyển đổi, chúng tôi sẽ đưa ra những dịch vụ chăm sóc phù hợp nhất, đồng thời hiểu rõ hơn những mục tiêu quan trọng mà người cao niên trong cư xá đang hướng tới. Kết quả cuối cùng là nhằm cải thiện những tình trạng hiện tại của họ.

HÌNH 2



Hình 2

Phương pháp chăm sóc của chúng tôi bao gồm Quá trình tìm hiểu người cao niên qua việc dùng Bản đồ chuyển đổi, Trải nghiệm của người cao niên về phương pháp chăm sóc mới này, và quá trình <provider name> giúp định hình lại nguyện vọng của họ khi dùng Phác đồ Chăm sóc theo Mục tiêu. Để tạo ra Bản đồ chuyển đổi, chúng tôi tìm hiểu về chức năng cơ thể và sức khỏe của người cao niên trên nhiều mặt bằng cách sử dụng bảng hỏi về y tế ví dụ như: Thang đánh giá những bệnh tích lũy (CIRS-G), các quan điểm chuyên môn từ bác sĩ đa khoa, Y tế hỗ trợ, Y tá, lối sống và những nguyên tắc thực hành quốc tế tốt nhất của Tổ chức Y tế Thế giới (WHO). Tiếp đến, Bản đồ chuyển đổi mô tả mức độ chăm sóc thích hợp (Khôi phục, Duy trì hoặc Chăm sóc giảm nhẹ) và đưa ra phương pháp điều trị và trị liệu phù hợp, cũng như các Phác đồ chăm sóc theo mục tiêu (được đề xuất bởi chính những người cao niên).

Tôi có thể tìm hiểu thêm về chương trình này bằng cách nào?

Để biết về những thông tin cơ bản của chương trình này, quý vị hãy liên hệ với điều phối viên dự án (Tiền sĩ <Coordinator name>) qua điện thoại số: <phone> hoặc bằng địa chỉ email:<email address>.



Bản đồ chuyển đổi - dành cho người cao niên và thân nhân

Residential Aged Care

Chương trình 'For you and for life Tapestry' (gọi tắt là Tapestry) là chương trình chăm sóc mới của chúng tôi dành cho dịch vụ trong cư xá. Tapestry có thể được hiểu là nghệ thuật dệt thảm, nó chứa đầy những hình ảnh phức hợp biết kể chuyện. Chúng tôi coi chương trình mới này như là một tấm thảm nghệ thuật – nghĩa là một câu chuyện chứa nhiều tầng ý nghĩa về quá trình chăm sóc và những dịch vụ mà chúng tôi cung cấp nhằm giúp đỡ quý vị trong hành trình chăm sóc người cao niên.

Chương trình này mang lại điều gì?

Cuộc sống cùng với sự chăm sóc là một hành trình. Khi sức khỏe và hoàn cảnh sống thay đổi, quá trình chăm sóc sức khỏe cũng cần thích ứng với những thay đổi đó. Có những thay đổi diễn ra ở mức độ nhiều hơn so với những thay đổi khác, vì thế cần chuyển sang những hình thức chăm sóc tốt hơn. Chúng tôi lập ra bản đồ chuyển đổi này để quý vị dễ hiểu hơn về hành trình chăm sóc sắp tới. Chúng tôi cũng sử dụng những thông tin này để chuyển các nguyện vọng của quý vị trở thành những mục tiêu khả thi. Bản đồ chuyển đổi cung cấp cho những người cao niên và thân nhân một lộ trình cởi mở và trung thực, đưa ra những gợi ý cho việc chăm sóc trước mắt - nêu bật cách mà chúng tôi dự định tiến hành để nâng cao chất lượng cuộc sống và giải quyết các vấn đề tinh thần cho người cao niên.

Bản đồ chuyển đổi được hiểu như thế nào?

Bản đồ chuyển đổi là một bản minh họa thân thiện với người dùng. Tuy nhiên, đằng sau nó là một mô hình chăm sóc dựa trên những bằng chứng khoa học về sức khỏe.

Bản đồ có hai phần:

- 1 Loại bệnh: **Toàn thân, Thần kinh, hoặc Hỗn hợp** cả thần kinh và toàn thân.
- 2 Mức độ nghiêm trọng của bệnh và cách chăm sóc: **Khôi phục, Duy trì và Giảm nhẹ**.

Ngoài ra còn có một ô đánh dấu cho những cân nhắc về mặt tâm lý (ví dụ như mức độ lo lắng hoặc trầm cảm cao).

LOẠI BỆNH			MỨC ĐỘ NGHIÊM TRỌNG
Khôi phục Toàn thân	Khôi phục Hỗn hợp (toàn thân & thần kinh)	Khôi phục Thần kinh	
Duy trì Toàn thân	Duy trì Hỗn hợp (toàn thân & thần kinh)	Duy trì Thần kinh	
Giảm nhẹ Toàn thân	Giảm nhẹ Hỗn hợp (toàn thân & thần kinh)	Giảm nhẹ Thần kinh	
Kết thúc cuộc đời	Kết thúc cuộc đời	Kết thúc cuộc đời	



Đánh dấu vào ô này nếu bệnh nhân bị tác động cao của các yếu tố tâm lý

Thuật ngữ Toàn thân, Thần kinh, và Hỗn hợp giữa toàn thân và thần kinh có nghĩa là gì?

Những thuật ngữ này chỉ ra các loại bệnh liên quan đến **Toàn thân** (ví dụ viêm xương khớp, mất cảm giác, đau, ung thư, tiểu đường, bệnh liên quan đến nội tạng) hoặc liên quan đến **Não/ Thần kinh** (ví dụ như mất trí nhớ, chấn thương não, thay đổi tâm trạng và hành vi liên quan đến chứng mất trí nhớ). **Hỗn hợp** là khi xuất hiện loại bệnh liên quan đến cả Toàn thân và Thần kinh.

Khôi phục, Duy trì và Giảm nhẹ đề cập đến điều gì?

Đây là cách phân loại về các phương pháp và mục tiêu chăm sóc khác nhau của chúng tôi. Phương pháp Khôi phục được áp dụng nhằm tìm cách phục hồi và lấy lại chức năng cho người bệnh. Phương pháp Duy trì được áp dụng khi nhận thấy việc lấy lại chức năng là không thể, bởi vậy quá trình chăm sóc ở giai đoạn này nhằm mục đích duy trì và ngăn ngừa sự giảm sút sức khỏe và các chức năng của cơ thể.

Tuy nhiên, có thể đến một thời điểm nào đó mục đích chính lại là Chăm sóc Giảm nhẹ bằng cách điều trị các triệu chứng để xoa dịu những cơn đau. Khi sức khỏe xuống dốc nhiều hơn trong giai đoạn này, sự chuyển biến cuối đời xảy ra. Ở đây, cái chết có thể sẽ đến nên quá trình chăm sóc thường chú trọng vào sự thư giãn thoải mái và thể hiện tính nhân bản.

Có phải bản đồ chuyển đổi này chỉ mô tả người cao niên trong cư xá theo hướng một chiều?

Không. Bản đồ chuyển đổi không phải được thiết kế để hạn chế sự chăm sóc. Thay vào đó, chúng được thiết kế để tối ưu hóa việc chăm sóc bằng cách tập trung vào những lựa chọn tốt nhất. Chúng còn mở ra cơ hội cho những cuộc đối thoại có ý nghĩa, liên quan đến sức khỏe của người cao niên và nhu cầu chăm sóc sức khỏe của họ.

Ai có thể thảo luận về Tapestry và Bản đồ chuyển đổi với tôi?

Người quản lý thực hành lâm sàng hoặc người quản lý công việc chăm sóc sẽ xem xét và cập nhật Tapestry và Bản đồ chuyển đổi của người cao niên trong cư xá vài tháng một lần.

Người thân của tôi cũng được bao gồm trong chương trình mới này. Tôi phải làm gì với thông tin này?

Quý vị không cần phải làm gì cả. Thông tin này giúp quý vị hiểu rõ hơn về phương pháp chăm sóc tổng thể cho những người thân yêu của quý vị, cũng như hành trình phía trước tiếp theo của họ. Nếu muốn, quý vị có thể bàn bạc điều này với người quản lý chăm sóc.

Để biết những thông tin cơ bản về chương trình này, quý vị hãy liên hệ với điều phối viên dự án (Tiến sĩ <Coordinator name>) qua điện thoại số: <phone> hoặc bằng địa chỉ email: <email address>.



Tapestry of Care

Step-by-Step
Implementation Booklet