

# **Resource Utilisation Groups – Activities of Daily Living (RUG-ADLs)**

## ***Data Collection Requirements for Maintenance Care***

**Information Package**



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### The purpose of this Information Package is to:

- provide an overview of the data collection requirements for publicly funded, admitted episodes of Maintenance Care
- support clinicians in understanding how to perform an assessment using the Resource Utilisation Group – Activities of Daily Living (RUG-ADL) tool
- support clinicians and non-clinicians with their reporting requirements to the Subacute and Non-acute Care Data Collection (SANADC).

### Who should read this package?

- Any clinician who administers or participates in the care of Maintenance Care patients.
- Relevant staff (clinical or non-clinical) who are required to enter data into the hospital patient administration system.

### Please note:

- The requirements specified in this Information Package are mandated at both State and Commonwealth levels.
- All applicable health services must report timely, complete RUG-ADL data for every instance of Maintenance Care to the SANADC.



## What is the Subacute and Non-acute Care Data Collection

### The Subacute and Non-acute Care Data Collection (SANADC) is:

- is specialised repository that collects detailed subacute and non-acute care clinical assessments for admitted subacute and non-acute programs
- mandated under the National Health Reform Agreement to provide the Independent Hospital Pricing Authority (IHPA) with a biannual data submission containing all publicly funded, admitted subacute and non-acute care activity
- essential to the classification and funding of subacute and non-acute activity using the Australian National – Subacute and Non-acute Care Patient (AN-SNAP).

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## What is Maintenance Care?

### Clinically, Maintenance Care is:

- care in which the primary clinical purpose or treatment goal is to support a patient with impairment, activity limitation or participation restriction due to a health condition
- care that does not require further complex assessment or stabilisation, following assessment or treatment
- non-acute care that is often delivered over an indefinite period.

### Administratively, Maintenance Care is:

- one of the 11 Care Types that are determined by the treating clinician to profile the predominant program of care that a patient is receiving during a single episode of care
- captured in the hospital patient administration system under the data item “Care Type”
- a key driver for data collection mandates and subsequent funding.

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## Why collect RUG-ADL data for Maintenance Care patients?

### There are two key purposes for collecting RUG-ADL data on Maintenance Care patients:

1. Formulate a clinical picture of the level of patient dependency and the resources required to care for the patient. RUG-ADL scores can also assist with discharge planning and determining patient prognosis.
2. Enable allocation of an AN-SNAP group to an episode of admitted patient care. In turn, the AN-SNAP group is used to determine the appropriate level of health service funding.

*If a RUG-ADL assessment is NOT captured for an episode of admitted Maintenance Care then the episode MAY NOT attract any Commonwealth funding.*

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## What needs to be collected for Maintenance Care episodes?

**For each episode of Maintenance Care the following data items must be collected:**

- Assessment Date
- Clinical Assessment Only Indicator
- Type of Maintenance Care
- RUG-ADL Assessment which includes:
  - RUG-ADL Bed Mobility score
  - RUG-ADL Toileting score
  - RUG-ADL Transfer score
  - RUG-ADL Eating score

The following slides will profile each of these data items in detail.

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## Assessment Date

### Definition

The date on which the patient was assessed against the RUG-ADL tool.

### Data collection guidelines

- The Assessment Date must reflect the date upon which the patient was actually assessed
- The Assessment Date must be between the Admission Date and the Discharge Date
- An Assessment must be performed within 24 hours of the patient's admission under the Maintenance Care Type.

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## Clinical Assessment Only Indicator

### Definition

An Indicator of whether an episode of admitted patient care resulted in the patient undergoing a clinical assessment (i.e. RUG-ADL clinical assessment)

There are two permitted responses to choose from for this data item:

#### Yes

- Specify the *Clinical Assessment Only Indicator* as “Yes” if the patient was assessed by a clinical team but no active Maintenance Care treatment was administered.
- Episodes where the *Clinical Assessment Only Indicator* is “Yes” are generally very short in duration (i.e. <24 hours).

#### No

- Specify the *Clinical Assessment Only Indicator* as “No” if the patient was assessed by a clinical team, a RUG-ADL was performed AND the patient proceeds to further, active Maintenance Care treatment.

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## Type of Maintenance Care

### Definition

The Type of Maintenance Care refers to the nature of the Non-acute care provided to an admitted patient during an episode of care.

There are five permitted types to choose from:

### Convalescent

- Following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period.
- Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged.
- Examples may include:
  - patient awaiting the completion of home modifications essential for discharge
  - patient awaiting the provision of specialised equipment essential for discharge
  - patient awaiting rehousing
  - patient awaiting supported accommodation such as hostel or group home bed
  - patient for whom community services are essential for discharge but are not yet available.

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## Type of Maintenance Care continued...

### Respite

- An episode where the primary reason for admission is the short term unavailability of the patient's usual care.
- Examples may include:
  - admission due to carer illness or fatigue
  - planned respite due to carer unavailability
  - short term closure of care facility
  - short term unavailability of community services

### Nursing home type

- The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

### Other

- Any other reason the patient may require a non-acute episode other than those already stated.

### Unknown

- It is not known what type of non-acute care the patient is receiving.

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## RUG-ADL Assessment

A RUG-ADL assessment is a 4-item scale measuring motor function while performing the following key activities of daily living:

- Bed mobility
- Toileting
- Transfer
- Eating

The assessment is designed to measure what the patient actually does, not what they are capable of doing.

The results of the assessment provide valuable information about a patient's functional status, the assistance they require to carry out these activities and the resources needed for patient care.

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## RUG-ADL Score: Bed Mobility

Refers to the patient's ability to move in bed after the transfer into bed has been completed. **Choose a score from:**

Score	Description	Definition
1	Independent or supervision only	Ability to readjust position in bed , and perform own pressure area relief through spontaneous movement around bed or with prompting from carer. No hands-on assistance is required. May be independent with the use of a device.
3	Limited physical assistance	Able to readjust position in bed and perform area relief with assistance of one person.
4	Other than two persons physical assist	Requires the use of a hoist or other assistive device to readjust position and provide pressure relief. Still requires the assistance of one person for task.
5	Two or more persons physical assist	Requires two or more assistants to readjust position in bed and perform pressure area relief.

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## RUG-ADL: Toileting

Refers to the patient's ability to mobilise to the toilet, adjust clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If the level of assistance differs between voiding and bowel movement record the lower performance. **Choose a score from:**

Score	Description	Definition
1	Independent or supervision only	Able to mobilise to toilet, adjust clothing, cleanse self and has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance is required. May be independent with the use of a device.
3	Limited physical assistance	Requires hands-on assistance of one person for one or more of the tasks.
4	Other than two persons physical assist	Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires assistance of one person for management of the device.
5	Two or more persons physical assist	Requires two or more assistants to perform any step of the task.

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### RUG-ADL: Transfers

Refers to the patient’s ability to transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night. **Choose a score from:**

Score	Description	Definition
1	Independent or supervision only	Able to perform all transfers independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
3	Limited physical assistance	Requires hands-on assistance of one person to perform any transfer of the day/night.
4	Other than two persons physical assist	Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.
5	Two or more persons physical assist	Requires two or more assistants to perform any transfer of the day/night.

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## RUG-ADL: Eating

Refers to the patient's ability to cut food, bring food to mouth and chew and swallow food. Does not include preparation of the meal. **Choose a score from:**

Score	Description	Definition
1	Independent or supervision only	Once a meal has been presented in the customary fashion, able to cut, chew and swallow food independently or with supervision. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself, then score 1.
2	Limited assistance	Requires hands-on assistance of one person to set-up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).
3	Extensive assistance/total dependence/tube fed	Person needs to be fed meal by assistant, or the individual does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/himself.

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## Business Rules

- RUG-ADLs must be collected for patients admitted to hospital for Maintenance Care.
- The Care Type recorded in the patient administration system must be Maintenance Care .
- A clinician is responsible for performing the RUG-ADL assessment of the patient.
- A RUG-ADL assessment should be collected within 24 hours of admission to hospital.
- The date on which a RUG-ADL assessment was performed should be between the Admission Date and Separation/Discharge Date for the Maintenance Care episode.
- For clinical purposes, clinicians can opt to capture many RUG-ADL assessments, however only the first RUG-ADL assessment needs to be reported to the SANADC.
- If a patient, during a single hospital stay, moves between Maintenance Care and other Care Types (e.g. Acute → Maintenance → Acute → Maintenance), then a complete set of RUG-ADL scores must be captured for each instance of Maintenance Care.
- The RUG-ADL assessment must be documented in the medical record.

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# Non-acute RUG-ADL Assessment Form

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- RUG-ADL assessments must be documented in the medical record.
- Health services can utilise their own medical record forms or the following resources are available:
  - Episode of care type change form that includes RUG-ADL assessments
  - Customisable medical record template

To access your resources please contact the Subacute and Non-acute Data Collection Team (see last slide for contact details).

Department of Health Western Australia		Affix Patient ID Label	
<b>EPISODE OF CARE</b> Care Type Change			
Date of Care Type Change:	<input type="checkbox"/> <b>PERSONAL USE ONLY</b> <input type="checkbox"/> Care Type Updated on PAS Card		
<p>Before changing care type 'The care to be provided must meet the applicable definitions and admission criteria as outlined on the reverse of this form. A new care type is determined and authorised by the clinician who is taking over or informing the changed care of the patient.</p> <p><b>A functional assessment is required to be completed and recorded for subacute and non-acute care to enable the episode to be grouped to the SAN-OMAT classification.</b></p> <p><b>ONLY ONE CARE TYPE CAN BE ASSIGNED PER DAY*</b></p> <p><b>Do not change care type between GEM and Rehabilitation – select only one</b></p> <p>Change of care type at statistical discharge must not be done:</p> <ul style="list-style-type: none"> <li>• On the day of formal admission or discharge*</li> <li>• For a temporary interruption/suspension due to a change in patient condition</li> <li>• For a day procedure/treatment with planned return</li> <li>• For a non-admitted care attendance e.g. emergency department, outpatients</li> <li>• For the recovery (mobilisation) period of an acute episode or prior to separation</li> <li>• For the waiting period between acute care and transfer to a subacute care facility</li> </ul> <p>* For more information/reasons please refer to the 'Admission, Readmission, Discharge &amp; Transfer Policy (MROT)' located: <a href="http://www.health.wa.gov.au/communities/clinical-services/2013/11/16">http://www.health.wa.gov.au/communities/clinical-services/2013/11/16</a></p>			
<b>FROM CARE TYPE</b>		<b>TO CARE TYPE</b>	
Consultant in Charge	Consultant in Charge	Authorising Medical Officer (current episode)	
<b>SUMMARY</b> (Current Episode of Care)		<b>Principal Diagnosis:</b>	
<b>Complications:</b>		<b>Other Conditions / Active Problems:</b>	
<b>Procedure/s:</b>			
Doctor/gp name	Signature	Date	<input type="checkbox"/> Infirm/RMO <input type="checkbox"/> Registrar <input type="checkbox"/> Consultant <input type="checkbox"/> CNS

CARE TYPE ADMISSION CRITERIA AND DEFINITIONS	
<p><b>ACUTE CARE</b></p> <p>Acute care is care in which the principal clinical intent is to do one or more of the following:</p> <ul style="list-style-type: none"> <li>• manage labour (obstetric)</li> <li>• cure illness or provide definitive treatment of injury</li> <li>• perform surgery</li> <li>• relieve symptoms of illness or injury</li> </ul>	<ul style="list-style-type: none"> <li>• reduce severity of illness or injury</li> <li>• protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions</li> <li>• perform diagnostic or therapeutic procedure</li> </ul>
<p><b>MENTAL HEALTH CARE</b> (applicable only to patients admitted to a designated mental health ward in 2015/2016)</p> <p>Mental health care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.</p> <p>Mental health care is:</p> <ul style="list-style-type: none"> <li>• delivered under the management of, or regularly informed by, a clinician with specialised expertise in mental health</li> <li>• evidenced by:           <ul style="list-style-type: none"> <li>• an individualised formal mental health assessment</li> <li>• implementation of a documented mental health plan</li> <li>• significant psychosocial components including family and carer support (where applicable)</li> </ul> </li> </ul>	
<p><b>SUBACUTE CARE</b></p> <p>Subacute care is overnight multi-day care in a specialised multidisciplinary care type of rehabilitation, palliative care, geriatric evaluation and management, or psychogeriatric care. Subacute care is:</p> <ul style="list-style-type: none"> <li>• delivered under the management of, or informed by, a clinician with specialised expertise in the subacute care type</li> <li>• evidenced by:           <ul style="list-style-type: none"> <li>• a care type change (if applicable) in the patient administration system and medical record</li> <li>• an individualised multidisciplinary management plan, which is documented in the patient's medical record</li> <li>• formal assessment of functional ability</li> <li>• monitoring of the functional assessment into the applicable information system.</li> </ul> </li> </ul>	
<p><b>Rehabilitation Care</b></p> <p>Rehabilitation care requires intensive multidisciplinary services. The primary clinical purpose of treatment goal is optimisation of the functioning of a patient with impairment, activity limitation or participation restriction due to a health condition.</p>	<p><b>Palliative Care</b></p> <p>The primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with active and advanced, life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs. Care type change must be authorised by the palliative care clinician.</p>
<p><b>Geriatric Evaluation &amp; Management Care</b></p> <p>The primary clinical purpose of treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.</p>	<p><b>Psychogeriatric Care</b></p> <p>The primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, age related organic brain impairment or a physical condition.</p>
<p><b>NON-ACUTE (MAINTENANCE) CARE</b></p> <p>Non-acute care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of an individual with a disability or severe level of functional impairment. Following assessment or treatment, the patient does not require further complex assessment or stabilisation.</p> <p>All episodes of qualified non-acute care must have a formal assessment of functional ability using the Resource Utilisation Group - Activities of Daily Living (RUG-ADL) clinical assessment tool. See below.</p>	
<p><b>RUG-ADL Clinical Assessment</b> (applicable only to patients admitted as non-acute)</p> <p>Assessment Date: _____ Time: _____ Admission for Assessment Only? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<input type="checkbox"/> Convalescent (1) <input type="checkbox"/> Respite (2) <input type="checkbox"/> Nursing Home Type (3) <input type="checkbox"/> Other (5) <input type="checkbox"/> Unknown (6)	<input type="checkbox"/> Limited physical assistance (3) <input type="checkbox"/> Limited physical assistance (3) <input type="checkbox"/> Other than two person physical assist (4) <input type="checkbox"/> Two or more person physical assist (5)
<input type="checkbox"/> Independent or supervision only (1) <input type="checkbox"/> Limited physical assistance (3) <input type="checkbox"/> Other than two person physical assist (4) <input type="checkbox"/> Two or more person physical assist (5)	<input type="checkbox"/> Independent or supervision only (1) <input type="checkbox"/> Limited physical assistance (3) <input type="checkbox"/> Other than two person physical assist (4) <input type="checkbox"/> Extensive assistance/total dependence/tube fed (4)

Patient Use (i.e. New or Non-acute)			
SUBACUTE		NON-ACUTE	
CHIEF NARRATIVE	DOB	RESIDENT	
WARD	ADDRESS	POSTCODE	
DOCTOR	TELEPHONE		
<p><b>NON-ACUTE RUG-ADL ASSESSMENT</b></p> <p>Non-acute care (also known as Maintenance Care) is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of an individual with a disability or severe level of functional impairment. Following assessment or treatment, the patient does not require further complex assessment or stabilisation.</p> <p>All episodes of qualified non-acute care must have a formal assessment of functional ability using the Resource Utilisation Group - Activities of Daily Living (RUG-ADL) clinical assessment tool. The RUG-ADL Tool measures the level of functional dependence of a patient for four activities of daily living and provides an indication of what a person actually does, rather than what they are capable of doing.</p> <p>A RUG-ADL assessment must be performed by a clinician at the beginning of the episode of care. The clinician is required to assign a score for each activity of daily living. The scores must then be summed to provide a total RUG-ADL score. This total score will inform how this episode will be classified under the Australian National Subacute and Non-acute Patient Classification.</p>			
Assessment Date:	Assessment Time:		
Type of Non-acute Care (ADD IN REVISION DATE)			
<input type="checkbox"/> Convalescent	<input type="checkbox"/> Respite	<input type="checkbox"/> Nursing Home Type	<input type="checkbox"/> Other <input type="checkbox"/> Unknown
Activity of Daily Living	Scale		Score
Bed Mobility	1 - Independent supervision only 3 - Limited physical assistance 4 - Other than two persons physical assist 5 - Two person (or more) physical assist		
Toileting	1 - Independent supervision only 3 - Limited physical assistance 4 - Other than two persons physical assist 5 - Two person (or more) physical assist		
Transfers	1 - Independent supervision only 3 - Limited physical assistance 4 - Other than two persons physical assist 5 - Two person (or more) physical assist		
Eating	1 - Independent or supervision only 2 - Limited assistance 3 - Extensive assistance/total dependence/tube fed		
Total Score			
<b>Assessor Details</b>			
Full name (surname first)	Qualification (where applicable)		
Signature	Date and time (if completed)		



### Data Entry

The RUG-ADL assessment scores must be entered into the applicable hospital patient administration system. For example, the webPAS Subacute Module.

**Maintenance RUG-ADL Assessment**

Assessment Date	<input type="text"/>	Time	<input type="text"/>
Admission for Assessment Only	<input type="text"/>		
Type of Maintenance	<input type="text"/>		
RUG-ADL Score			
Bed Mobility	<input type="text"/>	<input type="text"/>	<input type="text"/>
Toileting	<input type="text"/>	<input type="text"/>	<input type="text"/>
Transfers	<input type="text"/>	<input type="text"/>	<input type="text"/>
Eating	<input type="text"/>	<input type="text"/>	<input type="text"/>

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## Who to contact if you need help

### For assistance, please contact:

#### Subacute and Non-acute Care Data Collection Team

Purchasing and System Performance

Data Integrity Directorate

WA Department of Health

Phone: (08) 9222 0266, (08) 9222 4380

Email: [sana.data@health.wa.gov.au](mailto:sana.data@health.wa.gov.au)

Website: [www2.health.wa.gov.au](http://www2.health.wa.gov.au)

### For further information on admission criteria for Maintenance Care refer to:

Admissions, Readmissions, Discharge and Transfer Policy (2016)

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