Clinical Audit Readiness Tool

Mobility, Falls Prevention, Restorative Care & Restrictive Practices Evidence — Strengthened Aged Care Quality Standards

Facility / Service name: _____

Assessment quarter: _____ Completed by: _____

Date completed: _____ Next review date: _____

How to use this tool: Complete this checklist quarterly — not only in the weeks before an audit. For each item, mark **Y** (evidence complete and current), **P** (partial / in progress), or **N** (no evidence / not started). Any item marked P or N should be logged in the action list on the final page with an owner and a target date. This tool is a working aid and does not replace the official Aged Care Quality and Safety Commission self-assessment and pre-audit readiness resources.

1. Mobility & Falls Risk Assessment

Evidence that mobility and falls risk are assessed on admission, after any fall or functional change, and reviewed on a defined schedule.

Audit evidence item	Where the evidence lives	Status
Validated falls risk assessment completed on admission and re-administered on a set schedule (e.g. quarterly).	Falls risk assessment tool / clinical file	[ ] Y [ ] P [ ] N
Mobility and functional assessment (e.g. gait, balance, transfer ability) completed and dated.	Physiotherapy assessment notes	[ ] Y [ ] P [ ] N
Falls risk and mobility status re-assessed within 48 hours of any fall or reported decline.	Incident report cross-referenced to clinical notes	[ ] Y [ ] P [ ] N
Assessment findings are reflected in the resident's current care plan, not only in standalone clinical notes.	Care plan version history	[ ] Y [ ] P [ ] N
Environmental and equipment factors (footwear, mobility aids, room set-up) reviewed as part of the assessment.	Environmental risk checklist	[ ] Y [ ] P [ ] N

2. Restorative & Reablement Care Pathway

Evidence of a genuine, goal-directed restorative pathway following a fall, hospital admission, or functional decline — not a one-off referral.

Audit evidence item	Where the evidence lives	Status
Documented restorative/reablement pathway exists and is accessible to clinical and care staff.	Clinical governance policy folder	[ ] Y [ ] P [ ] N
Short-term, goal-directed physiotherapy plans are in place following hospital discharge, falls, or decline.	Physiotherapy treatment plans	[ ] Y [ ] P [ ] N
Restorative goals are resident-specific, measurable, and time-bound (not generic).	Goal-setting documentation	[ ] Y [ ] P [ ] N
Progress against restorative goals is reviewed and recorded at defined intervals.	Progress notes / outcome measures	[ ] Y [ ] P [ ] N

Audit evidence item	Where the evidence lives	Status
Outcomes of restorative care are communicated back to the resident, family, and broader care team.	Case conference / family meeting notes	[ ] Y [ ] P [ ] N

3. Restrictive Practices — Least Restrictive Alternative

Evidence that mobility and falls-related restrictive practices (e.g. lap belts, bed rails, sensor mats) are justified, reviewed, and supported by documented alternatives that were tried first.

Audit evidence item	Where the evidence lives	Status
Behaviour support / restrictive practice register is current for all residents with an active restrictive practice.	Restrictive practices register	[ ] Y [ ] P [ ] N
For each restrictive practice in use, less restrictive alternatives attempted are documented before authorisation.	Clinical file / consent records	[ ] Y [ ] P [ ] N
Physiotherapy or falls-prevention input is documented as part of the alternatives considered.	Physiotherapy assessment / MDT notes	[ ] Y [ ] P [ ] N
Informed consent (resident or substitute decision-maker) is current and on file.	Consent forms	[ ] Y [ ] P [ ] N
Restrictive practices are reviewed on a defined schedule with a documented rationale to continue, modify, or cease.	Review schedule / clinical notes	[ ] Y [ ] P [ ] N

4. Care Plan Integration & Documentation

Evidence that clinical findings actually change the resident's care plan, and do so within a defined timeframe.

Audit evidence item	Where the evidence lives	Status
Care plans are updated within an agreed timeframe (e.g. 5 business days) of a new clinical assessment or incident.	Care plan audit trail / version dates	[ ] Y [ ] P [ ] N
Care plans reflect resident and/or family preferences alongside clinical recommendations.	Care plan consultation notes	[ ] Y [ ] P [ ] N
Clinical notes, incident reports, and care plans are cross-referenced and internally consistent.	Random file audit sample	[ ] Y [ ] P [ ] N
Evidence of resident choice and reablement approach is documented, not assumed.	Care plan narrative / consent	[ ] Y [ ] P [ ] N

5. Workforce Capability & Training

Evidence that direct care staff — not only clinicians — are trained to recognise, record, and escalate mobility and restraint-related risk.

Audit evidence item	Where the evidence lives	Status
Care staff have completed training on safe transfers, mobility support, and falls prevention within the last 12 months.	Training records / LMS reports	[ ] Y [ ] P [ ] N
Staff can correctly document a mobility or transfer risk observation (spot-checked).	Sample documentation review	[ ] Y [ ] P [ ] N

Audit evidence item	Where the evidence lives	Status
Staff induction includes restrictive practices awareness and least-restrictive-alternative principles.	Induction checklist	[ ] Y [ ] P [ ] N
Physiotherapy provides regular case-based education or toolbox talks to care staff.	Education attendance records	[ ] Y [ ] P [ ] N

6. Governance & Continuous Improvement

Evidence that gaps identified through this tool (or incidents, complaints, and audits) are tracked through to resolution.

Audit evidence item	Where the evidence lives	Status
This audit readiness tool is completed at least quarterly, with results reported to clinical governance.	Governance meeting minutes	[ ] Y [ ] P [ ] N
Trends in falls, restrictive practice use, and restorative outcomes are analysed at facility level.	Quality/clinical indicator reports	[ ] Y [ ] P [ ] N
Identified gaps are logged with an owner and target date, and closure is verified.	Continuous improvement plan	[ ] Y [ ] P [ ] N
Findings from this tool are incorporated into the provider's broader self-assessment against the Quality Standards.	Self-assessment record	[ ] Y [ ] P [ ] N

0. Action Log — Items Marked Partial or No

Item / gap identified	Action required	Owner	Target date

Prepared as a companion resource to "Mobility Isn't a Nice-to-Have Anymore — It's Your Evidence Trail." This tool is a practical aid for internal audit preparation and does not replace the Aged Care Quality and Safety Commission's official Self-Assessment Tool or Pre-Audit Readiness Checklist, which should also be completed as part of a provider's compliance obligations under the Aged Care Act 2024.