

InterRAI Home Care (HC) ©

[CODE FOR THE LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER

1. Male 2. Female

3. BIRTHDATE

Year				Month		Day	

4. *Disregard - this item not utilized for Missouri*

5. DCN -

6. *Disregard - this item not utilized for Missouri*

7. *Disregard - this item not utilized for Missouri*

8. REASON FOR ASSESSMENT

1. Initial assessment
 2. Routine reassessment
 3. Significant change in status reassessment

9. ASSESSMENT REFERENCE DATE

Year				Month		Day

10. PERSON'S EXPRESSED GOALS OF CARE

11. POSTAL / ZIP CODE OF USUAL LIVING ARRANGEMENT

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12. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT

1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

13. MARITAL STATUS-LIVING ARRANGEMENT

- a. 01- Never married, living alone
- 02- Never married, living with someone
- 03- Divorced, living alone
- 04- Divorced, living with someone
- 05- Widowed, living alone
- 06- Widowed, living with someone
- 07- Married, living with spouse
- 08- Married, separated from spouse, living alone
- 09- Married, separated from spouse, living with someone
- 10- Unknown
- 12- Nursing Facility
- 13- RCF
- 14- Other

b. **As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new - e.g., moved in with another person, other moved in**

0. No 1. Yes

c. **Person or relative feels that the person would be better off living elsewhere**

0. No
 1. Yes, other community residence
 2. Yes, institution

14. TIME SINCE LAST HOSPITAL STAY

- Code for most recent instance in LAST 90 DAYS*
0. No hospitalization within 90 days
 1. 31 to 90 days ago
 2. 15 to 30 days ago
 3. 8 to 14 days ago
 4. In the last 7 days
 5. Now in hospital

SECTION B. INTAKE AND INITIAL HISTORY

[Note: Complete at Admission/Initial Assessment only]

1. DATE CASE OPENED (this agency)

Year				Month		Day

2. ETHNICITY AND RACE

0. No 1. Yes

ETHNICITY

a. Hispanic or Latino

RACE

b. American Indian or Alaska Native

c. Asian

d. Black or African American

e. Native Hawaiian or other Pacific Islander

f. White

g. Multi Racial

h. Unable to Determine

3. PRIMARY LANGUAGE

1. English
 2. Spanish
 3. French
 4. Other
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4. RESIDENTIAL HISTORY OVER LAST 5 YEARS

Code for all settings person lived in during 5 years prior to date case opened [Item B1]

0. No 1. Yes

a. Long-term care facility—e.g., nursing home

b. Board and care home, assisted living

c. Mental health residence—e.g., psychiatric group home

d. Psychiatric hospital or unit

e. Setting for persons with intellectual disability

SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

0. **Independent**—Decisions consistent, reasonable, and safe

1. **Modified independence**—Some difficulty in new situations only

2. **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times

3. **Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times

4. **Severely impaired**—Never or rarely makes decisions

5. **No discernable consciousness, coma** [Skip to Section G]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

0. Yes, Memory OK 1. Memory problem

a. **Short-term memory OK** -- Seems / appears to recall after 5 minutes

b. **Procedural memory OK** -- Can perform all or almost all steps in a multitask sequence without cues

c. **Situational memory OK** -- Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING/AWARENESS

[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]

0. Behavior not present

1. Behavior present, consistent with usual functioning

2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. **Easily distracted** -- e.g., episodes of difficulty paying attention; gets sidetracked

b. **Episodes of disorganized speech** -- e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought

c. **Mental function varies over the course of the day** --e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING--e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

0. No 1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)

0. Improved 2. Declined
1. No change 8. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

0. **Understood**—Expresses ideas without difficulty

1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required

2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required

3. **Sometimes understood**—Ability is limited to making concrete requests

4. **Rarely or never understood**

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able; with hearing appliance normally used)

- 0. **Understands**—Clear comprehension
- 1. **Usually understands**—Misses some part / intent of message BUT comprehends most conversation
- 2. **Often understands**—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- 3. **Sometimes understands**—Responds adequately to simple, direct communication only
- 4. **Rarely or never understands**

3. HEARING

Ability to hear (with hearing appliance normally used)

- 0. **Adequate**—No difficulty in normal conversation, social interaction, listening to TV
- 1. **Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)
- 2. **Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
- 3. **Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- 4. **No hearing**

4. VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- 0. **Adequate**—Sees fine detail, including regular print in newspapers/books
- 1. **Minimal difficulty**—Sees large print, but not regular print in newspapers/books
- 2. **Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
- 3. **Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- 4. **No vision**

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1 - 2 of last 3 days
- 3. Exhibited daily in last 3 days
- a. **Made negative statements** -- e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die"
- b. **Persistent anger with self or others** -- e.g., easily annoyed, anger at care received
- c. **Expressions, including non-verbal, of what appear to be unrealistic fears** -- e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations

- d. **Repetitive health complaints** -- e.g., persistently seeks medical attention, incessant concern with body functions
- e. **Repetitive anxious complaints / concerns (non-health related)** -- e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
- f. **Sad, pained, or worried facial expressions** -- e.g., furrowed brow, constant frowning
- g. **Crying, tearfulness**
- h. **Recurrent statements that something terrible is about to happen** -- e.g., believes he or she is about to die, have a heart attack
- i. **Withdrawal from activities of interest** -- e.g., long-standing activities, being with family / friends
- j. **Reduced social interaction**
- k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)** -- e.g., "I don't enjoy anything anymore."

2. SELF-REPORTED MOOD

- 0. Not in last 3 days
- 1. Not in last 3 days, but often feels that way
- 2. In 1-2 of last 3 days
- 3. Daily in the last 3 days
- 8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

- a. **Little interest or pleasure in things you normally enjoy?**
- b. **Anxious, restless, or uneasy?**
- c. **Sad, depressed, or hopeless?**

3. BEHAVIOR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

- 0. Not Present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

- a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
- b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
- c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
- d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings
- e. **Inappropriate public sexual behavior or public disrobing**
- f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

- 0. Never
- 1. More than 30 days ago
- 2. 8 to 30 days ago
- 3. 4 to 7 days ago
- 4. In last 3 days
- 8. Unable to determine

- a. Participation in social activities of long-standing interest
- b. Visit with a long-standing social relation or family member
- c. Other interaction with long-standing social relation or family member—e.g., telephone, e-mail
- d. Conflict or anger with family or friends
- e. Fearful of a family member or close acquaintance
- f. Neglected, abused, or mistreated

2. LONELY

Says or indicates that he/she feels lonely

- 0. No
- 1. Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO).

Decline in level of participation in social, religious, occupational or other preferred activities

IF THERE WAS A DECLINE, person distressed by this fact

- 0. No decline
- 1. Decline, not distressed
- 2. Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)

- 0. Less than 1 hour
- 1. 1-2 hours
- 2. More than 2 hours but less than 8 hours
- 3. 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS — e.g., episode of severe personal illness; death or severe illness of close family member or friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving license / car

- 0. No
- 1. Yes

SECTION G. FUNCTIONAL STATUS

1. IADL SELF PERFORMANCE and CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

- 0. **Independent**—No help, setup, or supervision
- 1. **Setup help only**
- 2. **Supervision**—Oversight/cuing
- 3. **Limited assistance**—Help on some occasions
- 4. **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
- 5. **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
- 6. **Total dependence**—Full performance by others during entire period
- 8. **Activity did not occur**—During entire period
[DO NOT USE THIS CODE IN SCORING CAPACITY]

- | | PERFORMANCE | CAPACITY |
|--|--------------------------|--------------------------|
| a. Meal preparation —How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Ordinary housework —How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Managing finances —How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Managing medications —How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Phone use —How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Stairs —How full flight of stairs is managed (12-14 stairs) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Shopping —How shopping is performed for food and household items (e.g., selecting items, paying money) -EXCLUDE TRANSPORTATION | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Transportation —How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles) | <input type="checkbox"/> | <input type="checkbox"/> |

2. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level. If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

- 0. **Independent**—No physical assistance, setup, or supervision in any episode
 - 1. **Independent, setup help only**—Article or device provided or placed within reach, no physical assistance or supervision in any episode
 - 2. **Supervision**—Oversight / cuing
 - 3. **Limited assistance**—Guided maneuvering of limbs, physical guidance without taking weight
 - 4. **Extensive assistance**—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
 - 5. **Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ helpers —OR— Weight-bearing support for more than 50% of subtasks
 - 6. **Total dependence**—Full performance by others during all episodes
 - 8. **Activity did not occur during entire period**
-
- a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
 - b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands – EXCLUDE BATHS AND SHOWERS
 - c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
 - d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
 - e. **Walking**—How walks between locations on same floor indoors
 - f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
 - g. **Transfer toilet**—How moves on and off toilet or commode
 - h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pads manages ostomy or catheter, adjusts clothes – EXCLUDE TRANSFER ON AND OFF TOILET
 - i. **Bed Mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed
 - j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total perineral nutrition)

3. LOCOMOTION / WALKING

a. Primary mode of locomotion

- 0. Walking, no assistive device
- 1. Walking, uses assistive device - e.g., cane, walker, crutch, pushing wheelchair
- 2. Wheelchair, scooter
- 3. Bedbound

b. Disregard – this item not utilized for Missouri

c. Distance walked -- Furthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)

- 0. Did not walk
- 1. Less than 15 feet (under 5 meters)
- 2. 15 - 149 feet (5 - 49 meters)
- 3. 150 - 299 feet (50 - 99 meters)
- 4. 300+ feet (100+ meters)
- 5. 1/2 mile or more (1 + kilometers)

d. Distance wheeled self -- Farthest distance wheeled self at one time in LAST 3 DAYS (includes independent use of motorized wheelchair)

- 0. Wheeled by others
- 1. Used motorized wheelchair / scooter
- 2. Wheeled self less than 15 feet (under 5 meters)
- 3. Wheeled self 15 - 149 feet (5 - 49 meters)
- 4. Wheeled self 150 - 299 feet (50 - 99 meters)
- 5. Wheeled self 300 + feet (100+ meters)
- 8. Did not use wheelchair

4. ACTIVITY LEVEL

a. Total hours of exercise or physical activity in LAST 3 DAYS—e.g., walking

- 0. None
- 1. Less than 1 hour
- 2. 1-2 hours
- 3. 3-4 hours
- 4. More than 4 hours

b. In the LAST 3 DAYS, number of days went out of the house or building in which he/she lives (no matter how short the period)

- 0. No days out
- 1. Did not go out in last 3 days, but usually goes out over a 3-day period
- 2. 1-2 days
- 3. 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

- 0. No
- 1. Yes

a. Person believes he / she is capable of improved performance in physical function

b. Care professional believes person is capable of improved performance in physical function

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

- 0. Improved
- 1. No change
- 2. Declined
- 3. Uncertain

7. DRIVING

- a. **Drove car (vehicle) in the LAST 90 DAYS**
- 0. No
 - 1. Yes
- b. **If drove in LAST 90 DAYS assessor is aware that someone has suggested that person limits OR stops driving**
- 0. No, or does not drive
 - 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

0. **Continent**—Complete control; DOES NOT USE any type of catheter or other urinary collection device
- 1. **Control with any catheter or ostomy** over last 3 days
 - 2. **Infrequently incontinent** Not incontinent over last 3 days, but does have incontinent episodes
 - 3. **Occasionally incontinent**—Less than daily
 - 4. **Frequently incontinent**—Daily, but some control present
 - 5. **Incontinent**—No control present
 - 8. **Did not occur**—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)

- 0. None
- 1. Condom catheter
- 2. Indwelling catheter
- 3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE

0. **Continent** -- Complete control; DOES NOT USE any type of ostomy device
- 1. **Complete control with ostomy** -- Control with ostomy device over last 3 days
 - 2. **Infrequently incontinent** -Not incontinent over last 3 days, but does have incontinent episodes
 - 3. **Occasionally incontinent** -- Less than daily
 - 4. **Frequently incontinent** -- Daily, but some control present
 - 5. **Incontinent** -- No control present
 - 8. **Did not occur** -- No bowel movement in the last 3 days

4. PADS, BRIEFS WORN

- 0. No
- 1. Yes

SECTION I. DISEASE DIAGNOSIS

1. DISEASE DIAGNOSES

Disease code

- 0. Not present
- 1. Primary diagnosis/diagnoses for current stay
- 2. Diagnosis present, receiving active treatment
- 3. Diagnosis present, monitored but no active treatment

MUSCULOSKELETAL

- a. Hip fracture during past 30 days (or since last assessment if less than 30 days)
- b. Other fracture over last 30 days (or since last assessment if less than 30 days)

NEUROLOGICAL

- c. Alzheimer's Disease
- d. Dementia other than Alzheimer's Disease
- e. Hemiplegia
- f. Multiple sclerosis
- g. Paraplegia
- h. Parkinson's disease
- i. Quadriplegia
- j. Stroke / CVA

CARDIAC OR PULMONARY

- k. Coronary heart disease
- l. Chronic obstructive pulmonary disease
- m. Congestive heart failure

PSYCHIATRIC

- n. Anxiety
- o. Bipolar disorder
- p. Depression
- q. Schizophrenia

INFECTION

- r. Pneumonia
- s. Urinary tract infection in last 30 days

OTHER

- t. Cancer
- u. Diabetes Mellitus

2. OTHER DISEASE DIAGNOSIS

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____

SECTION J. HEALTH CONDITIONS

1. FALLS

- 0. No fall in last 90 days
- 1. No fall in last 30 days, but fell 31-90 days ago
- 2. One fall in last 30 days
- 3. Two or more falls in last 30 days

2. RECENT FALLS

[Skip if last assessed more than 30 days ago or if this is first assessment]

- 0. No
- 1. Yes
- [blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

Code for presence in last 3 days

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1 of last 3 days
- 3. Exhibited on 2 of last 3 days
- 4. Exhibited daily in last 3 days

BALANCE

- a. Difficult or unable to move self to standing position unassisted
- b. Difficult or unable to turn self around and face the opposite direction when standing
- c. Dizziness
- d. Unsteady gait

CARDIAC OR PULMONARY

- e. Chest pain
- f. Difficulty clearing airway secretions

PSYCHIATRIC

- g. Abnormal thought process -- e.g., loosening of associations, blocking, flight of ideas, tangentially, circumstantiality
- h. Delusions -- Fixed false beliefs
- i. Hallucinations -- False sensory perceptions

NEUROLOGICAL

- j. Aphasia

GI STATUS

- k. Acid reflux -- Regurgitation of acid from stomach to throat
- l. Constipation -- No bowel movement in 3 days or difficult passage of hard stool
- m. Diarrhea
- n. Vomiting

SLEEP PROBLEMS

- o. Difficulty falling asleep or staying asleep; waking up to early; restlessness, non-restful sleep
- p. Too much sleep -- Excessive amount of sleep that interferes with person's normal functioning

OTHER

- q. Aspiration
- r. Fever
- s. GI or GU bleeding
- t. Hygiene -- Unusually poor hygiene, unkempt, disheveled
- u. Peripheral edema

4. DYSPNEA (Shortness of breath)

- 0. Absence of symptom
- 1. Absent at rest, but present when performed moderate activities
- 2. Absent at rest, but present when performed normal day-to-day activities
- 3. Present at rest

5. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

- 0. None
- 1. Minimal -- Diminished energy but completes normal day-to-day activities
- 2. Moderate -- Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
- 3. Severe -- Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
- 4. Unable to commence any normal day-to-day activities -- Due to diminished energy

6. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)

- 0. No pain
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days

b. Intensity of highest level of pain present

- 0. No pain
- 1. Mild
- 2. Moderate
- 3. Severe
- 4. Times when pain is horrible or excruciating

c. Consistency of pain

- 0. No pain
- 1. Single episode during last 3 days
- 2. Intermittent
- 3. Constant

d. Breakthrough pain -- Time in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain

- 0. No
- 1. Yes

e. Pain control—Adequacy of current therapeutic regimen to control pain (from person's point of view)

- 0. No issue of pain
- 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
- 2. Controlled adequately by therapeutic regimen
- 3. Controlled when therapeutic regimen followed, but not always followed as ordered
- 4. Therapeutic regimen followed, but pain control not adequate
- 5. No therapeutic regimen being followed for pain; pain not adequately controlled

7. INSTABILITY OF CONDITIONS

- 0. No
- 1. Yes

a. Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable (fluctuating, precarious, or deteriorating)

b. Experiencing an acute episode or a flare-up of a recurrent or chronic problem

c. End-stage disease; 6 or fewer months to live

8. SELF-REPORTED HEALTH

Ask: "In general, how would you rate your health"

- 0. Excellent
- 1. Good
- 2. Fair
- 3. Poor
- 8. Could not (would not) respond

9. TOBACCO AND ALCOHOL

a. Smokes tobacco daily

- 0. No
- 1. Not in last 3 days, but is usually a daily smoker
- 2. Yes

b. Alcohol—Highest number of drinks in any "single sitting" in last 14 days

- 0. None
- 1. 1
- 2. 2-4
- 3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HEIGHT AND WEIGHT

Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.

a. HT (in.)-

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b. WT (lb.)-

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2. NUTRITIONAL ISSUES

- 0. No
- 1. Yes

a. Weight loss of 5% or more in last 30 days, or 10% or more in last 180 days

b. Dehydrated or BUN / Cre ratio > 25 [Latter component, country specific]

c. Fluid intake less than 1,000cc per day (less than four 8oz cups / day)

d. Fluid output exceeds input

e. Physician ordered therapeutic diet, i.e. weighing, measuring, calculating and/or restricting selected nutrient components (e.g., calories, fat, sodium, and potassium)

3. MODE OF NUTRITIONAL INTAKE

- 0. Normal -- Swallows all types of foods
- 1. Modified independent -- e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- 2. Requires diet modification to swallow solid food -- e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
- 3. Requires modification to swallow liquids -- e.g., thickened liquids
- 4. Can swallow only pureed solids - AND- Thickened liquids
- 5. Combined oral and parenteral or tube feeding
- 6. Nasogastric tube feeding only
- 7. Abdominal feeding tube -- e.g., PEG tube
- 8. Parenteral feeding only -- Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- 9. Activity did not occur -- During entire period

4. DENTAL OR ORAL

0. No 1. Yes

- a. Wears a denture (removable prosthesis)
- b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
- c. Reports having dry mouth
- d. Reports difficulty chewing

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER

- 0. No pressure ulcer
- 1. Any area of persistent skin redness
- 2. Partial loss of skin layers
- 3. Deep craters in the skin
- 4. Breaks in skin exposing muscle or bone
- 5. Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER

0. No 1. Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER -- e.g., venous ulcer, arterial ulcer, mixed venousarterial ulcer, diabetic foot ulcer

0. No 1. Yes

4. MAJOR SKIN PROBLEMS -- e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds

0. No 1. Yes

5. SKIN TEARS OR CUTS -- Other than surgery

0. No 1. Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION -- e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema

0. No 1. Yes

7. FOOT PROBLEMS -- e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers

- 0. No foot problems
- 1. Foot problems, no limitation in walking
- 2. Foot problems limit walking
- 3. Foot problems prevent walking
- 4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS [Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:

- a. Name
- b. Dose—A positive number such as 0.5, 5, 150, 300. [NOTE: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]

c. Unit—Code using the following list:

gtts (Drops)	mEQ (Milli-equivalent)	Puffs
gm (Gram)	mg (Milligram)	% (Percent)
L (Liters)	ml (Milliliter)	Units
mcg (Microgram)	oz (Ounce)	OTH (Other)

d. Route of administration—Code using the following list:

PO (By mouth / oral)	REC (Rectal)	ET (Enteral Tube)
SL (Sublingual)	TOP (Topical)	TD (Transdermal)
IM (Intramuscular)	IH (Inhalation)	EYE (Eye)
IV (Intravenous)	NAS (Nasal)	OTH (Other)
Sub-Q (Subcutaneous)		

e. Freq—Code the number of times per day, week, or month the medication is administered using the following list:

Q1H (Every hour)	BID (2 times daily)	2W (2 times weekly)
Q2H (Every 2 hours)	(includes every 12 hours)	3W (3 times weekly)
Q3H (Every 3 hours)	TID (3 times daily)	4W (4 times weekly)
Q4H (Every 4 hours)	QID (4 times daily)	5W (5 times weekly)
Q6H (Every 6 hours)	5D (5 times daily)	6W (6 times weekly)
Q8H (Every 8 hours)	Q2D (Every other day)	1M (Monthly)
Daily	Q3D (Every 3 days)	2M (Twice every month)
BED (At bedtime)	Weekly	OTH (Other)

f. PRN

0. No 1. Yes

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					

[Note: Add additional lines, as necessary, for other drugs taken] [Abbreviations are Country Specific for Unit, Route, Frequency]

2. ALLERGY TO ANY DRUG

0. No known drug allergies 1. Yes

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN

- 0. Always adherent
- 1. Adherent 80% of time or more
- 2. Adherent less than 80% of time, including failure to purchase prescribed medications
- 8. No medications prescribed

4. COMPLEX DRUG REGIMEN

Are there several medications with varying dosages and schedules, or a drug regime with 9 or more medications?

- 0. No
- 1. Yes

SECTION N. TREATMENT AND PROCEDURES

1. PREVENTION

- 0. No
- 1. Yes

- a. Blood pressure measured in LAST YEAR
- b. Colonoscopy test in LAST 5 YEARS
- c. Dental exam in LAST YEAR
- d. Eye exam in LAST YEAR
- e. Hearing exam in LAST 2 YEARS
- f. Influenza vaccine in LAST YEAR
- g. Mammogram or breast exam in LAST 2 YEARS (for women)
- h. Pneumovax vaccine in LAST 5 YEARS or after age 65

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)

- 0. Not ordered AND did not occur
- 1. Ordered, not yet implemented
- 2. 1 - 2 of last 3 days
- 3. Daily in last 3 days
- 4. More than one time daily (*This code shall only be used when appropriate for K. Wound Care*)

TREATMENTS

- a. Chemotherapy
- b. Dialysis
- c. Infection control --e.g., isolation, quarantine
- d. IV Medication
- e. Oxygen therapy
- f. Radiation
- g. Suctioning

h. Tracheostomy care

i. Transfusion

j. Ventilator or respirator

k. Wound care

PROGRAMS

l. Scheduled toileting program

m. Palliative care program

n. Turning / repositioning Program

SPECIAL- ADDITIONAL TREATMENT CONSIDERATIONS

o. Other Respiratory Therapies (i.e. Nebulizer, CPAP, or Maxi Mist)

OTHER

- 0. No
- 1. Yes

p. Other non-routine preventative treatments (i.e. Ted Hose, Whirlpool Baths, Tens Unit)

q. New or unregulated Ostomy Care

3. FORMAL CARE

Days (A) and Total minutes (B) of care in last 7 days

Extent of care / treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A)	(B)		
a. Home health aides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Home nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Homemaking services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Speech-language pathology and audiology services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Psychological therapy (by any licensed mental health professional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Cardiac Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT

Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)

- a. Inpatient acute hospital with overnight stay
- b. Emergency room visit (not counting overnight hospital stay)
- c. Physician visit (or authorized assistant or practitioner)

5. PHYSICALLY RESTRAINED -- Limbs restrained, used bed rails, restrained to chair when sitting

0. No 1. Yes

6. RESTORATIVE SERVICES

[Restorative services are specialized service(s) provided by/or will be provided by trained and supervised individuals to help applicant obtain and/or maintain their optimal highest functioning potential. Restorative services require an overall plan of care developed by the specialized provider with written goals and response/progress documented.]

- 0. Not ordered
- 1. Minimum services ordered to achieve maintenance of current level of functioning
- 2. Moderate services ordered to restore higher level of functioning
- 3. Maximum services ordered to restore higher level of functioning, usually requiring professional supervision or direct services

PROGRAMS

- a. Socialization
- b. Self-transfer training
- c. Range of motion training
- d. Bowel or bladder training
- e. Patient/family teaching
- f. Person-centered or Individualized Treatment Plan

SERVICES

- g. Community integration

TRAINING

- h. Symptom mgmt. training
 - i. Daily living skills
 - j. Medication mgmt. training
 - k. Substance abuse mgmt.
- THERAPIES**
- l. Re-motivational therapy

7. MONITORING

[Please consider observation and assessment of laboratory tests, vital signs, blood glucose levels, weights and other routine monitoring procedures. Telehealth monitoring and Telemonitoring shall also be included]

- 0. Routine Monitoring (No physician's orders)
- 1. Minimal Monitoring (Periodic i.e. at least monthly, for stable physical/mental condition)
- 2. Moderate Monitoring (Periodic i.e. at least monthly, for unstable physical/mental condition as verified by a physician or licensed mental health professional)
- 3. Maximum Monitoring (Intensive monitoring, as verified by a physician or licensed mental health professional)

- a. Physical condition
- b. Mental condition

SECTION O. RESPONSIBILITY

1. LEGAL GUARDIAN

0. No 1. Yes

SECTION P. SOCIAL SUPPORTS

1. TWO KEY INFORMAL HELPERS

- a. Relationship to person Helper
1 2
 - 1. Child or child-in-law
 - 2. Spouse
 - 3. Partner / significant other
 - 4. Parent / Guardian
 - 5. Sibling
 - 6. Other relative
 - 7. Friend
 - 8. Neighbor
 - 9. No informal helper
- b. Lives with person Helper
1 2
 - 0. No
 - 1. Yes, 6 months or less
 - 2. Yes, more than 6 months
 - 8. No informal helper

AREAS OF INFORMAL HELP DURING LAST 3 DAYS

- 0. No
- 1. Yes
- 8. No informal helper

- c. IADL care Helper
1 2
- d. ADL care

2. INFORMAL HELPER STATUS

0. No 1. Yes

- a. **Informal helper(s) is unable to continue in caring activities** -- e.g., decline in health of helper makes it difficult to continue
- b. **Primary informal helper expresses feelings of distress, anger, or depression**
- c. **Family or close friends report feeling overwhelmed by person's illness**

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors

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4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY

0. No 1. Yes

SECTION Q. ENVIRONMENTAL ASSESSMENT

1. HOME ENVIRONMENT

Code for any of the following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)

0. No 1. Yes

- a. **Disrepair of the home** -- e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes
- b. **Squalid Condition** -- e.g., extremely dirty, infestation by rats or bugs
- c. **Inadequate heating or cooling** -- e.g., too hot in summer, too cold in winter
- d. **Lack of personal safety** -- e.g., fear of violence, safety problem going to mailbox or visiting neighbors, heavy traffic in street
- e. **Limited access to home or rooms in home** -- e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed

2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES

0. No 1. Yes

3. OUTSIDE ENVIRONMENT

0. No 1. Yes

- a. **Availability of emergency assistance** -- e.g., telephone, alarm response system
- b. **Accessibility to grocery store without assistance**
- c. **Availability of home delivery of groceries**

4. FINANCES

Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care; home care

0. No 1. Yes

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)

0. No 1. Yes

2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)

- 0. Improved [Skip to Section S]
- 1. No change [Skip to Section S]
- 2. Deteriorated

"CODE FOLLOWING THREE ITEMS IF DETERIORATED" IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION S."

3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION

--	--

4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION

5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION

- 0. Within last 7 days
- 1. 8 to 14 days ago
- 2. 15 to 30 days ago
- 3. 31 to 60 days ago
- 4. More than 60 days ago
- 8. No clear precipitating event

SECTION S. BACK UP PLAN

1. Enter the Back Up Plan

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

Signature (sign on above line)

Date assessment signed as complete

<input type="text"/>							
Year				Month		Day	