Which interRAI assessment to use and when to use it

Endorsed by the Health of Older People (HOP) Steering Group 14 August 2019

interRAI offers a suite of assessment instruments supporting continuity of care. Select the interRAI assessment that is most relevant for a client or resident.

1. To access long-term publicly-funded support in community or residential care, a person may be 65 years or older or close in age and interest.

2. interRAI assessments may be used for wider purposes. An interRAI assessment is appropriate and encouraged for other individuals including younger people depending on the service or model of care. This may include, for example; people who qualify for disability funding, privately funded individuals, or Accident Compensation Corporation (ACC) clients, as well as those with long term support needs for chronic health conditions (LTSCHC).

3. interRAI assessments replace any other non-specialist and non-standardised assessment tools previously used to assess long-term support services for older people living in the community.

4. An interRAI assessment provides the basis for a care plan for people living in Aged Residential Care.

Contact Assessment (CA)

5. Use a Contact Assessment (CA) for clients with non-complex needs, or those who need short-term support until a Community Health Assessment (CHA) or Home Care (HC) assessment can be completed. For example, a Contact Assessment may support discharge from hospital for clients who have not had an interRAI assessment previously.

6. Clients with non-complex needs will score less than 4 on the Urgency for Assessment outcome scale in a Contact Assessment.

7. Use a Contact Assessment over the telephone to identify whether clients require a face-to-face visit for assessment.

8. When a client scores 4 or more on the Urgency for Assessment scale in a Contact Assessment DHBs determine the timeframe for undertaking a Home Care assessment or Palliative assessment according to Ministry of Health guidelines. Clients are prioritised according to the score that signals urgency, 6 has highest priority.

9. clinical judgement should be used when making decisions about CA assessments with urgency score of 4. Options are:

   a) Provide a repeat CA at next assessment
   b) Put forward a HC at next assessment

Community Health Assessment (CHA)

10. Use a Community Health Assessment (CHA) for clients considered to have moderate clinical complexity. CHA supplements can be completed within the initial visit or must be completed as soon as possible during a subsequent visit.

    a. if the Functional Supplement is triggered it may be completed immediately. If the CHA and the triggered Functional Supplement have been completed, the DHB can chose to complete a Home Care (HC) assessment at the next assessment.

Note: A CHA with the Functional supplement is the equivalent of a HC assessment.

    b. the Mental Health supplement is used to identify individual needs and implement appropriate interventions or specialist referrals for clients with a suspected or known mental health condition. The supplement is designed to expand the assessor's understanding of the person's mental health status. It is not designed for assessing acute mental health conditions.

Home Care (HC) assessment

11. Use a Home Care assessment (HC) for clients:

    a. considered to be clinically complex or who have scored 4 or more on the Urgency for Assessment Outcome scale in a Contact Assessment

    b. who have been in hospital for less than 90 days (using the adjusted 90-day coding) who are considered to be clinically complex or have scored 4 or more on the Urgency for Assessment Outcome scale in a previous Contact Assessment

    c. who are being considered for permanent placement in residential.

Palliative Care (PC)

12. The Palliative Care (PC) assessment may be used instead of a Home Care (HC) assessment for clients with a palliative care diagnosis. Use a Palliative Care (PC) assessment when a person has a clinical prognosis of a year or less to live.

13. A Palliative Care (PC) assessment may be used instead of the Home Care (HC) assessment when considering an adult who has a palliative care diagnosis, for entry to Aged Residential Care (ARC).

Long Term Care Facilities (LTCF) assessment

14. Use a Long-Term Care Facilities assessment (LTCF) for clients who are permanently residing in an Aged Care facility.

15. People in Aged Residential Care (ARC) on respite admission are not required to undergo an assessment at this admission. This person is not a permanent resident of the facility. Their community assessments will be available for the residential facility Registered Nurses (RNs) to read and complete a care plan for the person's respite stay

A Long-Term Care Facilities (LTCF) assessment is not required in an acute hospital in-patient setting.

interRAI Methodology

A summary guide to which assessment to use and when

The following table provides guidance about which interRAI assessment tool to use for assessing older people for long term funded support services, such as homebased support services, respite care, carers support services, or for residential care.

How to use this document: Identify the circumstance of the individual who requires assessment under the, **Older person's location and profile** column. Move to

the left until you come to a ✓ and an explanation of when to use an assessment. Above that description, on the top row of the table, you will see which assessment to use. Further information is provided in the Comments column.

Explanation of symbols

< = less than > = more than ✓ this assessment applies - this assessment does not apply

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
a) 1	Community referral. Unknown profile.	✓ If the 'urgency for assessment score' is < 4 then proceed to developing a support plan. If the 'urgency for assessment score' is 4 or more then assess with HC.	✓ The CHA is useful for determining the complexity of a client. After completing CHA, proceed to care plan.	—	—	—	DHBs are likely to have different response times for an HC follow-up following an outcome score of 4 or 5 or 6 from the CA. If the urgency for assessment score is 4 or more then prioritise the client for a CHA or HC according to DHB agreed timeframes.

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
b)	Community referral. Appears Non-Complex.	If the 'urgency for assessment score' is < 4 then proceed to developing a support plan. If 4 or more escalate to CHA or HC (see 8 and 9).					A support plan describes a homebased support services response to need. A care plan is a holistic response that may or may not include home based support services. It is anticipated that DHBs will have a (publishable) timeframe for when escalated assessments will be completed. Non-complex clients may be identified from the referral with no reports or complaints of shortness of breath, no need for dressing or personal hygiene help and no signs of low mood or carer stress.

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
c)	Community referral. Some complexity known.	—	✓ After completing CHA, proceed to care plan or use Functional Health Supplement if triggered because of client's complexity.	✓ After completing HC, proceed to care plan.	—	—	
d)	Community referral. Complexity known.	—	—	✓ After completing HC, proceed to care plan.	—	✓ Only use for a client with a clinical prognosis of a year or less to live and only for those DHBs with competent palliative care assessors, otherwise use the interRAI HC assessment.	Palliative Care prognosis must be made by a medical professional.

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
e)	Community referral. Mental health issues suspected or known.	—	✓ After completing CHA, proceed to care plan or assessor should continue assessing using the CHA Mental Health Supplement, if triggered, and proceed to care plan.	—	—	—	The Mental health supplement provides understanding about a client's mental health for a general assessor.
f)	Community referral. Significant mental health issues known.	—	✓ Complete CHA and mental health supplement and proceed to care plan	✓ Home Care used to determine need for HBSS or ARC. A specialist assessment for mental health issues	—	—	DHB specific service models will differ. If under joint funding arrangements and HBSS is accessed, then interRAI assessment applies. Training to use the supplement is required to ensure the assessor has an

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
				may also be undertaken.			understanding of basic mental health issues. In instances where the DHB is accessing NASC services for long term HBSS or similar. It is not a requirement for services funded via other sources e.g. special mental health funding.
g)	Community referral. Entry to residential care is being considered.	—	—	✓ HC is required to confirm community support is no longer appropriate.	—	✓ PC is required to confirm community support is no longer appropriate.	ARC will accept a PC assessment for relevant clients when ARC entry is being considered (DHB HOP Steering group 2016)

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
h)	Respite care.	—	—	✓ If a person is in respite care and needs assessment, use HC < 90 Days Stay coding.	—	—	The ARC provider will have access to the CHA or HC assessment and associated care plan.
i)	Inpatient discharge to community. (Previously unknown to needs assessment services).	✓ Arrange support for client to get home and proceed to care plan.	✓ At scheduled date if CA 'urgency for assessment score' is > 4.	✓ For DHBs that don't use CA, a HC is appropriate using the <90 days stay coding.	—	—	Once client is assessed with CHA or HC, a CA is no longer appropriate, i.e., interRAI assessments may only be scaled up.

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j)	Inpatient discharge to community. (Previously known to needs assessment services).	✓ Use if the previous CA with urgency for assessment score is <4.	—	✓ Reassess using the <90 Days Stay coding and proceed to care plan.	—	—	
k)	Inpatient referral. Entry to residential care is being considered.	—	—	✓ HC is required to confirm community support is no longer appropriate. Use HC < 90 Days Stay coding.	—	—	All older people accessing residential care require a home care assessment or palliative care assessment prior to admission.

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
l)	Within residential care facility. Care provided by residential care nurses.	—	—	—	✓ Complete LTCF and proceed to care plan.	—	LTCF assessment to be completed by the facility's RN.
m)	Palliative care services in ARC.	—	—	—	✓ Complete LTCF and proceed to care plan.	✓ Approved pilot sites may assess and proceed with care plan.	LTCF assessment to be completed by the facility's RN.
n)	Request for re-categorisation of level of care within residential care by residential care nurses. That is, a potential change in level of care.	—	—	—	✓ Complete LTCF to substantiate change in the resident's clinical status for discussion with NASC and proceed to care plan.	—	LTCF assessment to be completed by the facility's RN.

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o)	Re-categorisation of level of care during acute inpatient stay.	—	—	—	✓ Discharge to facility then complete LTCF and proceed to care plan.	—	Use the acute care assessment where available. Alternatively, NASC endorse the inpatient team's decision but uses an administration form, not LTCF. RN will complete LTCF assessment on admission to facility. An LTCF assessment is not required in the acute setting.
p)	A person at one care level is admitted to an acute setting and returns to the **same** facility at the same level of care.				When the person returns, the provider will complete a return LTCF assessment related to change in status (i.e. the acute episode).		Person is returning to same care team and no change of level decision required by NASC.

	Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)	Use Home Care assessment (HC)	Use Long Term Care Facilities assessment (LTCF)	Use Palliative Care assessment (PC)	Comment
q)	A person from a rest home level care is admitted to acute care and returns to **same** facility but now hospital level care is recommended by inpatient team.				✓ When the person returns, the provider will complete a return LTCF assessment related to change in status (i.e. the acute episode).		Person is returning to same care team. An LTCF assessment in the acute setting is not required.
r)	A person from a rest home level care is admitted and returns to a **different** facility but now hospital level care is recommended by inpatient team.				✓ The provider will complete a routine LTCF assessment related to new admission when the person is admitted.		Person is returning to different care team. An LTCF assessment in the acute setting is not required.

Where can I get support?

Contact the interRAI Education and Support team at any time about any issues or concerns – they are there to help.

Email: interRAI@tas.health.nz
Phone: 0800 10 80 44

For more information about interRAI in general and updates for users and assessors, please visit the website: www.interrai.co.nz