Assessing people living in the community who are in hospital or respite care for fewer than 90 days

Coding Standards for interRAI: Using the Community health (CHA) assessment in hospital settings or respite care

These can be limited and patients may not be able to converse for a length of time due to medical conditions. Information should be gleaned from other sources, for example, occupational therapists or physiotherapists.

Instructions:

1. Code all sections according to the standard interRAI manual except for the changes outlined below
2. Review clients notes prior to assessment to gather as many relevant details as possible
3. Seek opinion from ward staff to provide input into the assessment for older people, especially those who have problems with conversation
4. Aim to contact family to seek 'other' reports, this may be by telephone if they are unable to be present during the assessment
5. Keep the notes section to a minimum, use only to explain or clarify ongoing issues for the older persons
6. Aim to be as accurate as possible, at times you may need to rely on your clinical judgement.

Item	Description	Coding standard	Coding guide and/or examples of where to obtain relevant information
A7	Reason for assessment	Code for current status	If this is a current client who is now in hospital code: return assessment or first if this is their first Home Care assessment
A 10	Domicile code of residence	Code for pre-admission address	
A12	Living arrangement	Code for pre-admission living arrangements	Code regardless of client's ability to return to that home
A13	Time since last hospital stay	Code 5 presently in hospital for those in secondary care (Hospital)	Respite care even at hospital level care or in a private hospital is not coded as a hospital stay
B4	Residential History	Code for pre-admission status	Code regardless of ability to return home
F4	Length of time alone	Code for pre-admission status	Conversation with client or ask family

Item	Description	Coding standard	Coding guide and/or examples of where to obtain relevant information
F5	Major life stressors in last 90 days	Code 1	Note the intent of the item includes life events that have a major impact. Code 1 applies even if client is not unhappy to be in hospital and having their situation looked at or resolved.
G1a-c and G1 e-h	IADL self-performance and capacity	Meal preparation, ordinary housework, managing finance, phone use, stairs, shopping and transportation	Code 8 for performance if it did not occur otherwise code what actually occurred. Capacity requires speculation/clinical judgement, if occupational therapy trial not completed some reference to cognitive abilities
G1d	IADL	Managing medications performance and capacity	Performance is likely to be coded 6 unless the ward is supporting medication compliance by supervising clients taking their own medications. Speculation with reference to competency or cognitive ability
M3	Medications	Do not code if in hospital, leave blank	The medications will be recorded on the discharge note by the inpatient ward staff.
M2	Adherence to medications	Record home performance if known	Code 0 unless self-administering-medications
N4	Formal care	Leave coding a-d blank	Actual times for physiotherapy, occupational therapy, psychological and speech language therapy. In notes section record dietician and social worker if significant
N2ba	Number of emergency room visits with an overnight stay	Coding to include this current admission and any others in last 90 days	Conversation with client/family or clinical notes
N2c	Physician visits	Code for community period within 90 days look-back period	Do not include physician visits while in hospital
P2-3	Informal Support services	Code situation prior to admission	Ask client or obtain family/caregiver report
P4	Hours of informal care	Code 0 for P3 unless look-back period includes the pre-admission time	Note what was provided preadmission