TAS
Kahui tuitui tangata

interRAI™
Better Assessment, Better Care, Better Outcomes

interRAI Contact Assessment (CA)

National Standards

October 2018

Contents

New Zealand interRAI National Standards

These National Standards have been developed for interRAI assessors when using the interRAI Contact assessment in New Zealand.

This document is a companion to the interRAI Contact Assessment Form and User Manual v9.2.

Each section within the National interRAI Software System has note fields that should be used for the additional information you may need for care planning. These standards will help you use the notes fields in the most effective and consistent way.

Reliable and consistent coding and notes are the backbone of interRAI. Your assessments provide information to, help plan care for residents, and contribute to aggregated data for facility, regional and national planning.

interRAI assessments travel with the person along their journey of care allowing information to be available to the next reader.

For help coding your assessments, refer to your interRAI Contact assessment manual and the interRAI website at www.interRAI.co.nz/help

For information on how to select the correct interRAI assessment for your client, read these documents:

- *Which assessment to use and when to use it* from www.interrai.co.nz/help/getting-assessments-right
- interRAI NZ Governance Board agreements for use of the interRAI assessment from www.interrai.co.nz/about/board/board-key-documents

Main items of note from these documents:

- If the Contact assessment is completed and then the person's complexity increases and a Home Care, Community Health Assessment or Long-Term care facilities assessment is completed it is not appropriate to revert back to a Contact assessment.
- A Contact assessment is used for home and community people with non-complex needs. Clients who score 4 or more on the Assessment Urgency Algorithm (AUA) scale must be followed up with a Home Care assessment.
- The clinical response time for follow up assessment for adults who have a Contact assessment AUA score of 6, 5, or 4 is prioritised, with a score of 6 being more urgent than a score of 5 or 4.

General Standards

Use the following general standards for your notes sections, software access and record management.

Standards for Assessment Notes

1. Your notes are a clinical document that may be accessed by other health professionals involved in the person's care.
2. When the coding and notes have auto populated from the previous assessment consider if they are still relevant to the person's current situation. Alter or delete notes to reflect the new assessment look back period.
3. If coding indicates an area of concern for the person, consider clarifying with a note.
4. Notes should add information to the question coding and/or capture relevant information outside the look-back assessment period, to inform care planning. For example, the person has remained in bed for the last three days unwell, but usually goes out daily.
5. Identify the most appropriate notes section for the information to be written to avoid duplication of comments.
6. Notes should not repeat the coding definitions.
7. Where information is provided by sources other than the person, identify the source.
8. When recording discrepancies in the information provided, note the conflicting points of view.
9. Abbreviations: write the word in full with the abbreviation in brackets, then freely use the abbreviation throughout the assessment, for example, Mental Health (MH).
10. Use brief sentences. You may use a bullet point style of writing.
11. You are not required to use the person's name with each new sentence or comment.
12. The notes support the minimum data set (MDS) coding and should not be printed or distributed separately.

Standards for software access and record management

1. If viewing a record that is not part of your usual role or outside your organisation, document the reason for accessing the person's clinical record in the continuation/progress notes, to clarify if the record is audited for privacy or security reasons.

2. An assessment must be marked as complete within three working days after the assessment has been undertaken (unless the assessor is in initial interRAI assessment training.

3. Once marked as complete, an assessment is unable to be reopened. Follow the instructions in the fact sheet Correcting a Marked as complete Assessment on the interRAI New Zealand website at www.interrai.co.nz/help/coding-help/completing-interrai-assessments

4. Discontinuing a draft assessment: for criteria and process see the interRAI New Zealand website at www.interrai.co.nz/help/coding-help/completing-interrai-assessments. Remember to add a note in the note icon Form Status when an assessment has been discontinued.

5. Assessments must be completed on the National interRAI Software System on an electronic device at the point of assessment, that is, no paper transcribing.

6. Check in/check out function: The assessment record must be checked in to the software production site (from green site back to blue) from your mobile device within three working days.

7. If assessment item C6 = '0-No' please ensure section **D6** is coded prior to section E completion and the assessment is marked as complete. This will ensure the Assessment Urgency Score is not displayed as '-1'.

Telephone assessment protocol

- Older people with significant hearing difficulties, visual, speech, language or cognitive difficulties such as dementia, or who have English as a second language should be assessed face to face. These issues are usually identified on the original referral for services letter. If not, the assessor should stop the call and make home visit arrangements.

- Contact Assessments should only be undertaken in instances where a full Home Care assessment is available should the Contact Assessment results indicate that this is required.

- Contact assessments should only be completed by trained interRAI assessors who meet the *Criteria for Training and Workforce Requirements* as listed in the Ministry of Health's interRAI National DHB Project Implementation Plan (2008-2012).

- Good practice as well as expectations of the Health and Disability Consumer rights requires that people must be clearly advised that an assessment or reassessment is planned. Ideally this is arranged with the older adult by letter or alternatively, by a phone call to confirm an appointment time for a different occasion.

- At the beginning of the telephone call, the assessor would advise the person of the purpose of the call, outline what they can expect will happen during the call, and inform them they can seek a review of the assessment findings if they wish.

- The assessor should ask the person for the name and contact details of a family or whānau member that the assessor could also contact to discuss the assessment if required or if desired by the older adult.

- The assessment phone call should be conducted like a conversation and be finished within 20-30 minutes.

- It is reasonable for the assessor to ask some clarifying questions to elicit the required information, however, the New Zealand interRAI Methodology group has yet to confirm additional questions required for the New Zealand context. It is anticipated that no more than three to five questions will be required.

- Sounding the person out about potential service planning arrangements or preferences is reasonable provided this is completed within the 30-minute time frame and does not pre-empt the analysis of the assessment results.

National Standards for Community Client Overview

Section	Sub-heading	Required information	Considerations
Record Status	Active		Select the appropriate sub-heading for your person.
	Inactive		
	Inactive deceased		
Date of birth	Personal details	The following fields are mandatory: • Marital Status • Interpreter Required • Primary and Secondary Language including sub-items: reads, writes, speaks, and understands.	The remaining fields in this section are optional.
Identifiers	GP, CSC Linked file	Record if these are mandatory items in your DHB.	

Section	Sub-heading	Required information	Considerations
Allergies		Check any information auto-populated from the NHI search against your organisation's clinical records, and update here as appropriate with details of the allergic reaction. If allergic reaction is not known, write Reaction Unknown. Use the tick boxes provided for categorization, for example, if allergic to nuts, tick the Food category. If no known allergies write 'Nil Known'.	This captures all types of allergies including medication and food allergies.
Diagnoses	Code	Do not use code look up. Leave this field blank. This is not required in New Zealand.	
	Description	Full name of diagnosis required.	This field populates any reports selected.
	Date diagnosed	Enter if known or tick Unknown.	
	Rank	Choose Primary Diagnosis for anything that: • Is present and active at the time of assessment • Affects the person's status, and • Requires treatment/symptom management or consideration in daily care. A Secondary Diagnosis is an active diagnosis that has minimal effect on a person's daily function, for example Hypertension. Add all diagnoses individually.	

Section	Sub-heading	Required information	Considerations
	Status	Select Active.	
	Status date	Enter date if known or tick Unknown. If the status date is not known, tick box Unknown.	
	Present on admission		Tick this box only if the diagnosis is active and impacting on a person's functional ability or requires medication oversight.
	Use in MDS	Tick the Use in MDS box to populate Section D6.	
	Comment	Information entered here does not populate to reports or any section of the MDS.	

Section	Sub-heading	Required information	Considerations
Advance directives		Tick the relevant boxes in the *Advance Directives Details* screen Enduring Power of Attorney (EPOA) – statement must include: • Type of EPOA: Property or Personal Care and Welfare. • Name and contact of the EPOA for Property and Personal Care and Welfare. • Has it been sighted by the assessor? • Is the EPOA activated? • Where is the activation form held? • If no EPOA, state No EPOA. *Advance Care Plan* • Must be a written document. • Has it been sighted by the assessor? • Is it on the person's file? • If no Advance Care plan, state No Advance Care Plan. *Treatment restrictions* • Has the person identified any treatment restrictions? For example, No Blood Products. If no restrictions, state No Treatment Restrictions.	For further information visit www.health.govt.nz/publication/advance-care-planning-guide-new-zealand-health-care-workforce

Section	Sub-heading	Required information	Considerations
Providers		The provider is the person responsible for completing the current assessment. Delete previous provider. Or follow your organizational guidelines if Provider is used to case manage. Note: If an Enrolled Nurse is completing all or part of the assessment, insert supervising Registered Nurse's name as provider as well.	
Primary contact	Primary contact	Add the person that the person wishes to be contacted first in any event as the Primary Contact.	This is the place you may want to add any other significant health provider's contact details as it will print out on the Client Information report, for example, a GP.
	Secondary contact	Add a secondary contact when the primary contact lives in the same house.	This is for use in the event of a civil emergency.
	Comments		Record additional information regarding the Primary contact, for example, 'call daughter, Sue for appointments, as Mrs. X is unable to hear telephone conversations'.
Service address		Enter the address where the person will receive services. When adding/changing addresses – leave the Move in Date blank. Check the domicile code and postal code reflect the service address.	
Mailing address			If mail is to be sent, other than to the person assessed, for instance the EPOA, record this person's name and address here.

Section	Sub-heading	Required information	Considerations
Worker safety concerns		List specific, significant behavior or environmental issues that may impact on visiting personnel's safety, for example 'large dog on premises'. Write Nil Known if no specific significant concerns.	
Client safety concerns		List specific, significant factors that may impact on a person's safety, for example, high falls risk. Write Nil Known if no specific and significant concerns.	
Infection precautions		Add specific infection precautions as advised by medical team, for example, note if a person is immunosuppressed. 'Standard Precautions if no specific precautions advised.	
Additional information			Record relevant information, for example, Receiving Palliative Care, otherwise leave blank.
Confidentiality			Use for important messages for staff in relation to privacy matters that may impact on the sharing of information of the person, for example, who they have requested not to share information with. This information is printed on the Client Information sheet.
Recent Vital Signs and Weight			This module can be found under the History and Physical tab of the Common Tasks menu.

Section	Sub-heading	Required information	Considerations
Active and Recent Wounds			This module can be found under the History and Physical tab of the Common Tasks menu.
Recent Falls Tracking		Optional	This module can be found under the Risk Management and Safety tab.
Active and Recent Infections Tracking			This module can be found under the Risk Management and Safety tab of the Common Tasks menu.

National Standards for interRAI Contact Assessment (MDS Tab)

Item Code	Required information	Considerations
Section A – Common Demographic Information		
A4b	Ensure this item is coded.	
A4c	Add ACC Claim number, if care is paid for by ACC.	
A6		Note if the person is still driving and any associated restrictions.
A7	If the person identifies as Māori, comment on Iwi affiliation if known. If not known document Not Known. Note ethnicity if Other is chosen. Record the person's expressed cultural needs and considerations. Record Nil if none identified.	
A11	Record who referred and the reason for the referral. Record Routine Reassessment if applicable.	
Section B – Intake and Initial History		
B1	Add notes, writing names in full and designation, to include who was involved and what documents you referred to for this assessment.	Document who gave consent for item if it is not the assessed person Note who may be approached to provide additional information.

Item Code	Required information	Considerations
B4	If the Contact assessment is face to face in the person's home add a note to identify specific environmental issues for the person. This can be from direct observation or from family information. For example: Presence or absence of smoke alarms and who changes the batteries, or use of a fire guard if using an open fire.	
Section C – Preliminary Screener		
C1	Describe the area of major concern in daily decision-making difficulties if this item is coded '1'.	Associated safety issues, for example, forgetting to lock the door Financial vulnerability, for example, indiscriminate use of money/being taken advantage of. 3-word test result or other measure recorded: MOCA Score X/30.
C2	If the person is not independent, specify the sub-tasks / type of support that has been required to complete the task under the following headings: BATHING PERSONAL HYGIENE DRESSING LOWER BODY MOBILITY	Note if the time taken to complete tasks independently impacts on the rest of their daily routine. Note whether the caregiver needs to get up in the night.
C3	Note if recovery time after an activity impacts on ADLs and IADLs.	Shortness of breath that is expected (see Borg's perceived exertion scale) at the end of moderate exercise is excluded. Source: Borg G.A. Psychophysical bases of perceived exertion. Medicine and Science in Sports and Exercise. 1982; 14:377-381.

Item Code	Required information	Considerations
C4	This is the person's self-report.	Always ask the question as written in the manual and write the person's response in quotation marks.
C5		Instability of condition – comment on the unstable condition / acute episode / recurrence.
Section D – Clinical Evaluation		
D1	If coding '2' – note what is the difference from usual functioning?	
D2	Note any difficulties or considerations when communicating with the person, for example: requires hearing aids to use the telephone.	Record any visual impairment or concerns and any visual aids used. Comment on type and use of glasses such as routine use, bi-focal.
D3	This is the person's response.	Always ask the question as written in the manual and write the person's response in quotation marks.
D4	If the person is not independent, specify the sub-tasks / type of support that is required to complete the task under the following headings: • MEAL PREPARATION • ORDINARY HOUSEWORK • MANAGING MEDICATION • STAIRS	Note whether the person requires help in any of the IADL areas and who helps them. Record the type of medication management used such as blister pack, dosset box.
D6	The overview diagnosis section must have the Use in MDS box ticked for the diagnoses to populate **D6**. Ensure that there is at least one diagnosis is coded as the Primary Diagnoses/ Diagnoses for Current Referral as per the item definition.	ICD codes are not used in interRAI assessments in New Zealand. Do not search for ICD code.

Item Code	Required information	Considerations
D7	If coded '1', add a note recording: • where the fall occurred • how many falls • any injuries • Was the GP informed	
D8	If this is not a usual health concern for the person, record pertinent details to advise the GP.	If the health condition is being managed through medication the item should be coded at least '1'.
D9	Name site/s of pain and record any variations in pain outside of the look back period and any known reasons.	
D11	Add any Dietician or Speech Language therapist input. Describe the food or liquid modification required. Note whether supplements are being used.	Opportunity for weight and height measurements to be recorded at Vital Signs and Monitoring on the Client Overview screen.
D12		If **D12** =code '2' add a description in line with New Zealand Pressure Injury guidelines document, for example: i. Unstageable pressure injury: depth unknown ii. Suspected deep tissue injury: depth unknown
D13	If coding a major skin problem clarify with a note if it is due to a burn, lesion or healing surgical wound.	
D14	If coded '1' add a note to describe the traumatic injury.	
D15	Name any special cares or equipment required for **D15a-d**, for example**,** type of pressure care mattress.	
D16	State reason/s for hospital admission/s.	

Item Code	Required information	Considerations
D17	State reason/s for emergency department admission/s.	Attendance at a private medical clinic, even when attended urgently, does not count for emergency department admission in this item.
D18	If coded '1' document the nature of the surgery the person has had in the last 90 days.	
D19	When coding the presence of informal helpers, record the breakdown of areas of informal support provided over the last week.	
D20	Record the ability of caregiver(s) to provide ongoing informal support. Consider the current situation and future needs.	If no informal carers D20a must not be coded.
Section E – Summary		
E1a-c	Record the action to be taken for each algorithm score that requires a follow up assessment or referral to other services. Record any reason for no further action.	
E4		Add a note if the client requires short term services (60 days or less), for example a person recovering from a Total Hip Joint Replacement, and are expected to gain full independence post rehabilitation. It may also be coded '1' if the client will require services in the short term before being assessed with the Home Care assessment.
E5		Refer to your DHB stated timeframes to code this item.
E8		Code for how the referral was received by your service.