TAS
Kahui tuitui tangata

interRAI™
Better Assessment, Better Care, Better Outcomes

interRAI Long Term Care Facilities (LTCF) Assessment

National Standards

October 2018

Contents

New Zealand interRAI National Standards

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

This document is a companion to the interRAI LTCF Assessment Form and User Manual v9.1.

Each section within the interRAI software 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 LTCF manual and the interRAI website at www.interRAI.co.nz/help

General Standards

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 3 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 complete within 3 working days after the assessment has been undertaken (unless the assessor is in initial interRAI assessment training).
3. Once marked complete, an assessment is unable to be reopened. Follow the instructions in the fact sheet *Correcting a marked complete assessment* on the interRAI New Zealand website at www.interRAI.co.nz/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/completing-interrai-assessments. Remember to add a note in the note icon Form Status when an assessment has been discontinued.
5. interRAI assessments must be completed on the National 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.

National Standards for LTCF Resident Overview

Section	Sub-heading	Required information	Considerations
ADT	Admit to room	Always admit the resident to a bed before completing the MDS. To admit a resident to a bed in your facility, go to **ADT** tab – see Chapter 5 *Admission, Discharge and Transfer*.	Always check the top right hand Resident field for the file's current status, for example, active or inactive. Check if in correct room if this is not the first assessment.
Date of birth	Personal details	The following fields are mandatory: • Likes to be called • Marital status • Interpreter required • Primary and secondary language, including sub-items: reads, writes, speaks, understands.	The remaining fields in this section are optional.
Primary ID	NHI, GP, CSC	Delete all details from here that have populated from the Home Care assessment except the NHI.	Note that the Linked File filed cannot be deleted from the software system.

Section	Sub-heading	Required information	Considerations
Allergies		Check any information auto-populated from the NHI search against your facility'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.	This captures all types of allergies including medication and food allergies.
Diet		Record special dietary needs / therapeutic diets, supplements or fluid requirements. If not on a special diet enter Regular Diet.	
Primary 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 the resident overview screen and any reports selected.
	Date diagnosed	Enter if known or tick **Unknown.**	

Section	Sub-heading	Required information	Considerations
	Rank	*Primary* A Primary diagnosis is anything that: • Is present and active at the time of assessment • Affects the resident's status, and • Requires treatment/symptom management or consideration in daily care. Add all primary diagnoses individually.	
	Status	Select **Active** to auto-populate into MDS.	
	Status date	Enter date if known. If the status date is not known, tick box **Unknown.**	
	Present on admission	Tick this box if present and active.	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 if the diagnosis is not included in Section I1.	Review the Coding Cardiac Diseases flowchart on www.interRAI.co.nz/help when entering this group of diagnoses.
	Comment	Information entered here does not populate to reports or any section of the MDS.	

Advance directives		Tick the relevant boxes in the ***Advance Directives Details*** screen. *Enduring Power of Attorney* (EPOA) – statement must include: • Type of EPOA, for example, Property or Personal Care and Welfare. • Name and contact of the EPOA for Property and Personal Care and Welfare. • Is it on file? • Is the EPOA activated • Is the activation form on file? • If no EPOA, state No EPOA. Resuscitation status • Record the current resuscitation status • Is the resuscitation status on file? • Treatment Restrictions • Has the person identified any treatment restrictions? For example: No Blood Products. • If no restrictions, state No Treatment Restrictions. *Advance Care Plan* Must be a written document. Has it been sighted by the assessor? Is it on the resident's file? If no Advance Care plan, state No Advance Care Plan.	For further information: http://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. Note: If an Enrolled Nurse is completing all or part of the assessment, insert supervising Registered Nurse's name as provider.	
Primary contact	Primary contact	Add the person that the resident 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 Resident Face Sheet report, for example, a Psychiatric Nurse.
	Comments		Record additional information regarding the Primary contact, for example, 'do not call during the night'.
Worker safety concerns		List resident specific, significant behaviour that may impact on care staff safety. Write Nil Known if no specific significant concerns.	
Resident safety concerns		List resident specific, significant factors that may impact on resident's safety, for example, high falls risk. Write Nil Known if no specific and significant concerns.	

Section	Sub-heading	Required information	Considerations
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.	
End of life instructions		Record special end of life requests / religious or cultural practice to be actioned upon death. If no specific requirements, record resident's response, for example, 'decision to be made at time of death by my family', or state that this information is kept on the facility management system record.	Record funeral director if known.
Additional information		Record relevant information, otherwise leave blank, for example, 'receiving palliative care'.	
Confidentiality			Use for important messages for staff in relation to privacy matters that may impact on the sharing of information of your resident, for example, who the resident has requested not to share information with. This information is printed on the Face Sheet.
Photo			

Section	Sub-heading	Required information	Considerations
Recent Vital Signs and Weight	Height	Required	Date of height must be in last 12 months to ensure an accurate BMI measurement. Can use Ulna Length Conversion Scale (refer to Workbook – Appendix 1).
	Weight	Required	Date of weight must be in the last 30 days. Use only whole number for weights (no decimal) and round up to the nearest Kg.
	Other vital signs	Optional	This module can also be found under the **History and Physical** tab of the Common Tasks menu.
Active and recent wounds			Located on left hand side of screen, use bar to scroll down. A separate self-directed learning module is available from www.interrai.co.nz.
Recent falls tracking			This module can also be found under the **Risk Management and Safety** tab of the Common Tasks menu.
Active and recent infections tracking			This module can also be found under the **Risk Management and Safety** tab of the Common Tasks menu.

National Standards for interRAI LTCF assessments (MDS/Assessment Tab)

Item code	Required information	Considerations
Section A – Identification information		
A1		This is an opportunity to add any information the resident feels is important to share about them and their social history, that is, their personal identity.
A5b	Add ACC claim number, if care is funded by ACC.	
A5c	If not known code No and add a comment to clarify between No and Unknown.	Refer to www.interRAI.co.nz/help for definition of war veteran and war pension.
A8	Add notes, writing names in full and designation, to include who was involved and what documents you referred to for this assessment.	A resident can only have one first LTCF assessment. Refer to LTCF User Manual v9.1 for all other assessment code options.
A9	Assessment reference date – the last day of the three-day assessment period or 'look back' period. Must be at least three days after the admit date.	Document who gave consent for item if it is not the assessed person.
A10a	Write exactly what resident says in the text box not the note.	If unable to communicate write Unknown.
A10b		Briefly summarise resident's goals.

Item code	Required information	Considerations
Section B – Intake and initial history Complete Section B for first LTCF assessment only		
B1	Notes relate to the decision making process to come into care. Include who assisted with this decision.	If this is not the first LTCF assessment, you may leave the notes and coding and mark Section B complete.
B3	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. If not known document Unknown.	
B5a	If admitted from hospital, add a note to explain why the resident was in hospital and why they did not return home.	
B8		This relates to the five years *before* the first assessment admission to any aged residential care. It does not include respite care admissions.
B9		Dementia/Alzheimer's disease is not considered in this item.

Item code	Required information	Considerations
Section C – Cognition		
C1	Describe the area of major concern in daily decision making difficulties, if this item is coded 1-4.	Give examples of the area of major concern if this item is coded 1- 4.
C2	If scoring '1' for any of the following memory problems, use the appropriate heading(s) and describe how it affects the resident's function: • C2c – procedural memory • C2d – situational memory	
C3	If coding '2' – note what is the difference from usual functioning?	
Section D – Communication and vision		
D1/D2	Note any difficulties or considerations when communicating with the resident. Highlight communication strategies, for example, 'uses a white board for communication'.	Comment on a person's ability to make themselves understood due to speech difficulty.
D3	Note any aids used and who changes batteries.	Note instances where aids are most helpful, for example, 'in quiet environments'.

Item code	Required information	Considerations
Section E – Mood and behaviour		
E1		If the resident is taking antidepressants or receiving other therapy, and there is no symptom/sign during last 3 days, the code is '1 = present but not exhibited in last 3 days'.
E2		This is the resident's own response, not your observation.
E3	Identify when the behaviours occur, for example, 'hits out only during personal cares'.	
Section F – Psychosocial well-being		
F1a	List the long standing activities the resident continues to engage in.	This must involve two or more people and consider their pre- admission activities as well as current activities.
F1b	Document how often the resident is visited, for example, 'receives a visit from family or friends at least once a week'.	
F1c	List what type(s) of contact: phone, Skype, email, letters or texts.	
F2	Comment if this is different from their usual participation.	Consider the person's usual preferences.

Item code	Required information	Considerations
F4	Name the stressor(s).	
F5	Record the person's favourite (meaningful) parts of the day or week through your discussion and observations.	
Section G – Functional status		
G1	If the person is not independent, specify what the person is able to do for themselves and/or type of support required to complete the task under the following headings: • BATHING • PERSONAL HYGIENE • DRESSING UPPER BODY • DRESSING LOWER BODY • WALKING • MOBILITY • TRANSFER TOILET • TOILET USE • BED MOBILITY • EATING	Refer to LTCF User Manual and ADL flow chart (from www.interrai.co.nz/help/coding-help/functional-status) when coding this section. Note if the time taken to complete tasks independently impacts on the rest of their daily routine. Consider variation over look back period. Comment on weight bearing support required.
G3a		This is about physical exercise, not general activities.
G4	Describe which physical function, the resident or health professional believes, has potential for improvement.	If this is a new admission remember to consider the period before admission.

Item code	Required information	Considerations
Section H – Continence		
H1	If the code is between 2 and 4, specify any known triggers that may lead to incontinent episodes. If unknown state that this information is unknown.	Name the products that they use?
H2	Name urinary collection device.	If this information is not documented elsewhere: note size, how much water in the balloon, date of insertion, and when next due to change.
H3	If the code is between 2 and 4, specify any known triggers that may lead to incontinent episodes. If unknown state that this information is unknown.	Consider bowel pattern for care planning interventions.
H4		Name ostomy products. Record if there is an Ostomy RN involved in their care.

Item code	Required information	Considerations
Section I – Disease diagnosis		
I1	The overview diagnosis section must match Section I. I1b note the fracture site.	ICD codes are not used in interRAI assessments in New Zealand. Do not search for ICD code. I1a – note if hip fracture occurred more than 30 days ago and in the last 6 months.
Item code	Required information	Considerations
I2	If a diagnosis is coded in I1 do not code it again in I2.	To add a further diagnosis to I2, add at the Diagnosis section on Resident Overview page, not here.
Section J – Health conditions		
J1	If coded '3', list the number of falls. Provide details: • where the fall occurred • how many falls • time of day it occurred, unless this is a duplication of your incident record.	

Item code	Required information	Considerations
J2	Leave this item blank *unless* the resident has had an assessment in the last 30 days.	
J3	If this is not a usual health concern for your resident, record pertinent details to advise your clinical lead / senior staff.	If the health condition is being managed through medication, the item should be coded at least '1'.
J5		Ensure your coding and notes relate specifically to fatigue – not physical disability.
J6	Name site(s) of pain and record any variations in pain outside of the look back period (that may impact on future cares) and any known reasons.	
J8		This is the resident's response, not your observation. Ask the question as written in the manual.
Section K – Oral and Nutritional Status		
K1		Height and weight auto-populate from vital signs entered on the Resident Overview page, click on Update MDS Values. Use clinical signs and symptoms to determine dehydration status. BUN/creatinine ratio is not used in New Zealand.

Item code	Required information	Considerations
K3	Add any dietician or speech language therapist input. Describe the food or liquid modification required.	This may be a suitable place to record food preferences if not recorded elsewhere in the facility or special diet, for example, Kosher/Halal or any recent changes in appetite. Aversion to particular foods may also be recorded here.
K5a	If coded Yes specify whether partial/full/upper/lower dentures. Record any concerns, for example, Ill Fitting.	
K5f	Include details of condition of gums/mouth with or without dentures.	
Section L – Skin Condition		
L1		If L1 = code '5 Not codable', add a description in line with New Zealand Pressure Injury Guidelines: Unstageable pressure injury: depth unknown Suspected deep tissue injury: depth unknown.
L6		If no explicit skin problems, consider a comment on the general condition of the skin.

Item code	Required information	Considerations
Section M – Activity Pursuit		
M1		Note this item includes activities completed alone.
M2		Add activities that are participated in, in addition to the list.
Section N – Medications		
N1	Record in the notes any medications the resident declined in the last 3 days. Any medications with multiple components, code the **Dose** as the number of tablets and the **Unit** as Other, for example, Sinemet. Any medication that is not found in the 'look up' should be coded as N/A.	Note this item requires a code to be recorded for other medications given outside the look back period, but are active during the assessment period, if they are part of the normal routine of medications for example, Monthly B12.
Section O – Treatments and Procedures		
O1	Name any item that was declined by the resident since the last assessment.	
O2	Name any special cares or equipment required for O2l-m, for example, type of pressure care mattress.	CPAP can be included under O2j as it is considered a ventilator.

Item code	Required information	Considerations
O4	State reason(s) for hospital admission(s).	Attendance at a private medical clinic, even when attended urgently, does not count for emergency department admission in this item (O4b).
O5	Note date of last GP visit. Note other types of physicians (medical providers/specialists) seen.	Refer to: www.interrai.co.nz/help/coding-help/treatment-and- procedures for the list of New Zealand physician types.
O6	Note the type of physician (medical providers/specialists) that ordered the change(s) and what these orders were.	
O7		An enabler that cannot be removed by the resident independently is considered a restraint for interRAI coding. Refer to your organisation's restraint policy for its required documentation.
Section P – Responsibility and Directives		
P1	Code 'yes' for P1bi and Pb1ii if the completed and signed 'Health practitioner's certificate of mental incapacity for EPOA in relation to personal care and welfare' (form 5) or 'property' (form 4) is held in the resident's file.	In order to code P1b Yes you must have sighted the EPOA, as described in Momentum Section P, Section Help. Consider recording if EPOA is in the process of being obtained or altered.

Item code	Required information	Considerations
P2		Advance directives and other treatment restrictions are described on the resident's Overview Screen. They do not need to be repeated here.
Section Q – Discharge Potential		
Q2		If Q1a, Q1b and Q1c are all coded '1 Yes', then record barriers to discharge.
Section R – Discharge		
R1	If resident is not being discharged leave blank. Mark section R complete.	If the resident is being discharged, on their last day, select **ADT tab** and discharge resident with reason for discharge.
R2		As above, follow New Zealand's requirements in the ADT tab to select reason for discharge.

Item code	Required information	Considerations
Section AS – Assessment Summary		
AS	This is information collected during the assessment that is important for care planning. Complete the assessment summary to help readers or reviewers understand your clinical reasoning about how the information from the assessment is used in the persons care plan. CAPs can be combined in your care plan. Identify the reasons the CAP has triggered for this resident. Include supporting outcome scores that will help influence goals and interventions in the care plan. Where outcome scores are referenced, record as follows – score/total score, for example DRS 3/14. Record your clinical rationale for not including a triggered CAP in the care plan. If appropriate, add a clinical reason for care planning a non-triggered CAP.	You can link the assessment findings with your facility care plan by stating which section it will be found in. Any cultural considerations, sexuality and spiritualism will be addressed with CAP15.