interRAI Palliative Care (PC) Assessment

National Standards

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interRAI New Zealand National Standards

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

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

Each section within interRAI has note fields that should be used for the additional information you may need for care planning. These standards will help you use the note 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 individuals, and contribute to aggregated data for local, 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 Palliative Care User 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 as complete within 3 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/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 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 National interRAI Software System production site (from green site back to blue) from your mobile device within 3 working days.

interRAI™ New Zealand

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	All diagnoses are required to be entered individually and ranked 'Primary' to populate all palliative care reports.	
	Status	Select 'Active'	
	Status date	Enter date if known. If the status date is not known, tick box Unknown.	

Section	Sub-heading	Required information	Considerations
	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 for all diagnoses.	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.	

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 the following: • Type of EPOA: 'Property' or 'Personal Care and Welfare'. • Name and contact of the EPOA for 'Property' and 'Personal Care and Welfare'. • State who has it been sighted by. • Is the EPOA activated? • Where is the activation form held? • If no EPOA, state 'No EPOA'. *Advance Care Plan* • Must be a written document. • State who has it been sighted by? • 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: 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 organisational 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. If no secondary contact, leave blank.	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.	

Section	Sub-heading	Required information	Considerations
Mailing address			If correspondence is to be sent to a person other than the client, for instance the EPOA, record this person's name and address or email here.
Worker safety concerns		List specific, significant behaviour 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 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. Write 'Standard Precautions' if no specific precautions advised.	
Additional information		Record relevant information, otherwise leave blank, for example, 'receiving palliative care'.	

Section	Sub-heading	Required information	Considerations
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 also be found under the **History and Physical** tab of the Common Tasks menu.
Active and Recent Wounds			This module can also be found under the **History and Physical** tab of the Common Tasks menu.
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 the interRAI Palliative Care Assessments (MDS tab)

Item code	Required information	Considerations
Section A – Identification information		
A5b	Ensure this item is coded.	
A5c	Add ACC Claim number, if care is paid for by ACC.	
A8	Add notes, writing names in full and designation, to include who was involved and what documents you referred to for this assessment.	Who may be approached to provide additional information?
A9		Ensure the correct type of palliative programme identified as per definitions in the interRAI Palliative Care (PC) Assessment Form and User's Manual v 9.1.
A10	The overview diagnosis section must match A10 coded items.	ICD codes are not used in interRAI assessments in New Zealand. Do not search for ICD code.
A11		Write exactly what the person says, if unable to communicate write 'Unknown'.
A12a	Add a note to confirm source of information for this item.	
A12b	Add a note if client/family reported (whose?) understanding of prognosis differs from medical information.	User Manual: Do not probe for the person's understanding of his or her terminal status. This item is recorded only if the person makes such a statement to the assessor or others.

Item code	Required information	Considerations
A13		Document the name of the person who gave consent for item if it is not the assessed person.
A15	Outline 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.	If an assessment is completed in the person's home ensure all potential environment hazards are documented. Add a brief description of the home environment, including any accessible support in place for persons with disabilities. Record the availability of emergency assistance.
A17		If there has been a period of acute care hospitalisation, in the last 90 days, note what the admission was for. See page 22 of the interRAI Palliative Care (PC) Assessment Form and User's Manual v 9.1.: 'Examples….Last Hospital Stay' for further assistance.
	Section B – Intake & Initial History	
B1	This date field box will remain the date of the person's initial admission to their community support programme. Add the date of admission to a Palliative Care programme if it is known.	Complete Section B for first Palliative Care assessment only.

Item code	Required information	Considerations
B2	If the person identifies as Māori, comment on Iwi affiliation if known. If not known document 'Not Known'. Note the ethnicity if 'Other' is chosen. Record the person's expressed cultural needs and considerations.	
	Section C – Health Conditions	
C1a	List all site(s) of pain and if current treatment options are effective.	
C1e	List new pain sites separately from previously known sites.	
C1f	Include a note to describe pain on movement different from at rest.	Describe what movement changes the presence of pain.
C4	If coded '3' list the number of falls. Add a note recording: • where the fall occurred, • how many falls • any injuries • was the GP informed	

Item code	Required information	Considerations
C5	Leave this item blank unless the person has had an assessment less than 30 days ago.	
C6	If this is not a usual health concern for the person, record pertinent details to advise the GP.	Record any troubling symptoms that are not included in Section C. Note the cause of each symptom if it is known and whether any treatment is in place.
C6s	Code for lower limb oedema only. Comment on any upper limb oedema if present.	
C6v	List site of muscle twitching and frequency or occurrence.	
Section D – Nutritional Status		
D1	Record any issues getting weight measured.	
D2		Use clinical signs and symptoms to determine dehydration status. BUN/ creatinine ratio is not used nationally in New Zealand.
D3	Add any Dietician or Speech Language therapist input. Describe the food or liquid modification required. Whether supplements are being used.	Describe the person's eating pattern – for example, 'six small meals' or 'usual meal is fruit and toast only'. List the type of supplement if they are being used. This may be a suitable place to record food preferences or special diet such as, Kosher/Halal or any recent changes in appetite.

Item code	Required information	Considerations
	Section E – Skin Condition	
E1	Note site(s) of concern/pressure injuries.	If E1 = 5 document the description in line with New Zealand Pressure Injury guidelines document: • Unstageable pressure injury: depth unknown • Suspected deep tissue injury: depth unknown
E6	Record who cuts the person's nails and if they are seen by a podiatrist.	If no explicit skin problems you may comment on the general condition of the skin.
	Section F – Cognition	
F1	Describe the area of major concern in daily decision-making difficulties if this item is coded 1-4.	Associated safety issues such as the person forgetting to use walker. Financial vulnerability such as indiscriminate use of money or the person is taken advantage of.
F3	If scoring '1' for any of the following memory problems, use the appropriate heading(s) and describe how it affects a person's function. F3b - PROCEDURAL MEMORY F3c - SITUATIONAL MEMORY	3-word test result or other relevant, current test results (with date completed) such as MOCA Score X/30.
F4a-c	If coding '2' – note what is the difference from usual functioning?	
F5	Describe the acute change.	

Item code	Required information	Considerations
Section G – Communication		
G1	Note any difficulties or considerations when communicating with the person. 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.
G3	Comment on any hearing aids and if the person can maintain these.	Note instances where aids are most helpful, for example, 'in quiet environments' Record any visual impairment or concerns and any visual aids used. Comment on type and use of glasses such as routine use, bi-focals.
Section H – Mood		
H1		Note any self-directed management of these symptoms for example music/watching films. Comment on any indicators or symptoms outside of 3-day period. Consider, If the person is taking antidepressants or receiving other therapy, and there is no symptom/sign during last 3 days, the code is '1 = present but not in the last 3 days'.
H2	Record the person's response.	This is the person's own response not your observation.

Item code	Required information	Considerations
	Section I – Psychosocial Well-Being	
I1	List the activities that allow the person to retain meaning in their day.	If it is not possible to discuss this section with the person, obtain an opinion from the family.
I2	Record any supporting person. For example, named Chaplain from local church.	
	Section J – Functional Status	
J1	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	Whether person needs any help in any area and who helps them. Type of medication management used such as blister pack, dosset box.
J2	If the person is not independent, specify the sub- tasks / type of support that is required to complete the task under the following headings: BATHING PERSONAL HYGIENE WALKING MOBILITY TRANSFER TOILET TOILET USE BED MOBILITY EATING	Refer to Palliative Care User Manual and ADL flow chart when coding this section. Note if the time taken to complete tasks independently impacts on the rest of their daily routine. Note to include any aids/devices provided. Consider variation over look back period. Comment on weight bearing support required.

Item code	Required information	Considerations
J4	Describe the area the person / health professional believes there is potential performance or physical function improvement.	
	Section K – continence	
K1	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.	
K2	Name urinary collection device.	Whether urologist/nurse specialist/continence service involved. Name the products they use and who provides/ purchases them.
K3	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.	

Item code	Required information	Considerations
Section L – Medications		
L1	For any medications with multiple components, code Dose as the number of tablets and the Unit as Other such as Laxsol, Sinemet. This includes syringe drivers: write in the drug field the names of all the combined meds then dose; unit and frequency can all be 'oth'.	Record in the coding section 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.
	Record any medications the person has not taken in the last three days and any reason for this. Any medication that is not found in the 'look up', the drug code should be recorded as N/A.	
Section M – Treatment and Procedures		
M1	Name any item that was declined by the person since last assessment. Name any special cares or equipment required such as type of pressure care mattress.	The use of a CPAP is included here as this is considered a ventilator.
M2	Record if there is a Social Worker involved with this person.	
M3	State reason/s for hospital or Emergency Department admission/s.	Attendance at a private medical clinic, even when attended urgently, does not count for Emergency Department admission in this item. Refer to www.interrai.co.nz/help/coding-help/treatment-and-procedures for the list of New Zealand physician types.

Item code	Required information	Considerations
	Section N – Responsibility and Directives	
N1		In order to code Yes for N1b, record on the overview screen who sighted the EPOA. Consider recording if EPOA is in the process of being obtained or altered.
N2		Advance directives and other treatment restrictions are described on the Client Overview Screen. They do not need to be repeated here.
	Section O – Social Supports	
O1	Note if other people are also involved in supporting the person for example Chaplain or advocate.	
O2	Comment on any specific tasks the person has had assistance with if this differs from J1 and J2.	
O3	Note if caregiver needs to get up at night.	Level of care and supervision given over a 24-hour period. Use the calculating informal support table, in the appendix of this workbook, to calculate times of informal support hours if precise times are not available.

Item code	Required information	Considerations
Section P – Discharge		
P1	Do not fill in notes or coding, just mark complete	If the person is being transferred to another region, on their last day, select Case Activity tab and discharge the person with reason for discharge.
P2		As above, follow New Zealand's requirements in the ADT tab to select reason for discharge.
Section AS – Assessment Summary		
AS	This is information collected during the assessment that is important for care planning. CAPs can be combined in your care plan. Identify the reasons the CAP has triggered for this person and what measures you are taking to address the CAP. Include relevant outcome scores to support decision making for goals and interventions in the care plan. For example, if the Under-nutrition CAP has triggered then reference the BMI. 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.	