Assessing community people who are in hospital for fewer than 90 Days

Coding Standards for interRAI: Using Home Care Assessment in Hospital Settings:

Assessments in hospital 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 client's notes prior to assessment to complete as many 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 on going issues for the older persons
6. Aim to be as accurate as possible but 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
A8	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 11	Domicile code of residence	Code for pre-admission address	
A13	Living arrangement	Code for pre-admission living arrangements	Code regardless of client's ability to return to that home
A14	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
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 actual activity .

			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
N3	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
N4a	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
N4c	Physician visits	Code for community period within 90 days look-back period	Do not include physician visits while in hospital
P1-2	Informal Support services	Code situation prior to admission	Ask client or obtain family/caregiver report
P3	Hours of informal care	Code 0 for P3 unless look-back period includes the pre-admission time	Note what was provided preadmission
Q1	Home Environment	Code using information obtained from other sources. Refer to National Standards for full details to be captured.	Check OT clinical notes, if a home visit has occurred. Code for OT findings **or** Conversation with client/ family and add a note to identify source of coded information

Long Term Care Facility (LTCF) assessment coding in the acute hospital setting.

The table below outlines specific LTCF items.

ITEM	DESCRIPTION	CODING STANDARD	Coding guide / examples to use
F2	Sense of involvement	Code for occurrence since hospital admission	Check with family
M2	Activities	Code "regularly involved but not involved in the last 3 days" Or "preferred, not involved"s	If in hospital over the total 3 day look back *and has not been able to participate in chosen activity*
O5	Physician visits	Code for community period within 14 day look back period	Do not include physician visits *whilst* in hospital
O6	**Physician Orders**	**Code for community period within 14 day look back period**	**Do not include physician visits *whilst* in hospital**