interRAI Home Care (HC)

National Standards

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Contents

New Zealand interRAI National Standards 2
General Standards 3
Standards for assessment notes 3
Standards for software access and record management 4
National Standards for Community Client Overview 5
National Standards for interRAI Home Care assessment notes(MDS tab) 12

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New Zealand interRAI National Standards

This document is a companion to the interRAI Home Care 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 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 Home Care User manual and the interRAI website at www.interRAI.co.nz/help

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 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 client'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.

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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 3 working days.

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	Chose 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. All diagnoses are required to be entered individually.	
	Status	Select 'Active'	

Section	Sub-heading	Required information	Considerations
	Status date	Enter date if known. 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 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.	

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'. • 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 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 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, 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 the person, for example, who they have requested not to share information with. This information is printed on the Client Information sheet.

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Section	Sub-heading	Required information	Considerations
Recent Vital Signs and Weight			This module can 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 be found under the 'Risk Management and Safety' tab of the Common Tasks menu.
Active and Recent Infections Tracking			This module can be found under the 'Risk Management and Safety' tab of the Common Tasks menu.

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National Standards for interRAI Home Care assessment notes(MDS tab)

Item code	Required information	Considerations
Section A – Identification Information		
A1		This is an opportunity to add any information the person feels are important to share about them and their social history that is, their personal identity.
A5c	Add ACC claim number, if care is paid for by ACC.	
A8	Add notes, writing names in full and relationship to client, to include who was involved and what documents you referred to for this assessment.	Who may be approached to provide additional information?
A9		Document who gave consent for item if it is not the assessed person.
A10		Write exactly what the person says. If unable to communicate write 'none' (Home Care User Manual v9.1).
A13c		Record the name of the person who believes the assessed adult would be better living somewhere else and why they think this.
A14		If there has been a period of hospitalisation, in the last 90 days, note what the admission was for.
Section B – Intake and Initial History		

Item code	Required information	Considerations
B1	Complete Section B for 'First' Home Care assessment only.	
B2	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'.	
Section C – Cognition		
C1	Describe the area of major concern in daily decision-making difficulties if this item is coded 1-4.	Associated safety issues such as forgetting to lock the door. Financial vulnerability such as indiscriminate use of money or the person is taken advantage of.
C2	If scoring '1'for any of the following memory problems, use the appropriate heading(s) and describe how it affects a person's function. **C2b** - PROCEDURAL MEMORY **C2c** - SITUATIONAL MEMORY	3-word test result or other relevant, current test results (with date completed) such as MOCA Score X/30.
C3	If coding '2' – note what is the difference from usual functioning?	
Section D – Communication and Vision		

Item code	Required information	Considerations
D1 /D2	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.
D3	Note any aids used and who changes batteries.	
D4	Is the visual appliance for routine use or reading only? Note what visual appliance is used such as glasses or magnifying glass.	
Section E – Mood and Behaviour		
E1		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.
E2		This is the person's own response not your observation.
E3	Identify when the behaviour occurs, for example, 'Hits out only during personal care'.	
Section F – Psychosocial Well-Being		
F1a	List the long-standing activities the person engages in.	This must involve two or more persons.

Item code	Required information	Considerations
F1b	Document how often the person is visited. For example, receives a visit from family or friends at least once a week.	
F1c	List what type/s of contact such as phone, Skype, email, letters and texts.	
F1d- f	If the code is between 1 and 8, specify any known details.	
F2		This is the person's own response.
F3	List the changes.	
F4		Consider adding a comment on usual daily routine for example: "alone each day but has daughter come for lunch each day", which will be helpful for care planning.
F5	Name the stressor/s.	
Section G – Functional Status		

Item code	Required information	Considerations
G1	If the person is not independent, specify what the person is able to do for themselves and /or type of support that is required to complete the task under the following headings: • MEAL PREPARATION • ORDINARY HOUSEWORK • MANAGING FINANCES • MANAGING MEDICATION • PHONE USE • STAIRS • SHOPPING • TRANSPORTATION	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.

Item code	Required information	Considerations
G2	If the person is not independent, specify what the person is able to do themselves and / or type of support that is 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 Home 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 for example: dressing herself takes two hours to complete and leaves her feeling too exhausted to attend her scrabble club.
G3b	Add a description of the Timed 4 Metre Walk course.	
G4a		This is about physical exercise not general activities.
G5	Describe what area the person / health professional believes there is potential physical function improvement.	
G7b	Name the person who made the suggestion if known.	

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.	
H2	Name urinary collection device.	Whether urologist/nurse specialist involved.
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.	
H4		Name products and who purchases them. Is there a Continence RN involved in their care?
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.
I2	If a diagnosis is coded I1 do not code it again in I2.	To add a further diagnosis to I2 add at the Diagnosis section on Client Overview page.

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Item code	Required information	Considerations
Section J – Health Conditions		
J1	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	
J2	Leave this item blank unless the person has had an assessment less than 30 days ago.	
J3	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'.
J5		Ensure the 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 and any known reasons.	
J8		Always ask the question as written in the manual and write the person's response in quotation marks. This is the person's response not your observation.

Item code	Required information	Considerations
Section K – Oral and Nutritional Status		
K1	Note any issues getting weight measured.	
K2		Use clinical signs and symptoms to determine dehydration status. BUN/ creatinine ratio is not used nationally in New Zealand.
K3	Add any Dietician or Speech Language therapist input, Describe the food or liquid modification required. Whether supplements are being used.	This may be a suitable place to record food preferences or special diet. For example, Kosher/ Halal or any recent changes in appetite. Do they have any Quality of Life Decisions? for example Risk Feeding
K4	K4a - if coded 'yes' specify whether partial/full/upper/lower dentures. Record any concerns such as ill fitting.	Whether a dental professional is involved.
Section L – Skin Condition		
L1		If L1 =code '5' Not codeable, add a description in line with New Zealand Pressure Injury guidelines document: (i) Unstageable pressure injury: depth unknown (ii) Suspected deep tissue injury: depth unknown
L6		If no explicit skin problems you may comment on the general condition of the skin.
L7	Note who cuts the person's nails and if they are seen by a podiatrist.	

Item code	Required information	Considerations
Section M – Medications		
M1	Record in the notes any medications the client declined in the last 3 days. Any medications with multiple components, code 'Dose' as the number of tablets and the 'Unit' as 'Other', for example Sinemet. Any drug code that is not found in the 'medication name' '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.
M3	Record any medications the person has not taken in the last three days and any reason for this.	
Section N – Treatment and Procedures		
N1	Name any item that was declined by the person since last assessment.	
N2	Name any special cares or equipment required for N2l-n. For example, type of pressure care mattress.	N2j The use of a CPAP is included here as this is considered a ventilator.
N4	State reason/s for additional hospital admission/s if not captured at A14. Note other types of physicians (medical providers/ specialists) seen.	Attendance at a private medical clinic, even when attended urgently, does not count for ED admission in this item. Refer to: http://www.interrai.co.nz/help/coding-help/treatment-and-procedures/ for the list of New Zealand physician types.

Item code	Required information	Considerations
N5		This refers to chair restraints only. Where an enabler is used that cannot be removed by the person independently it is considered a restraint for interRAI coding.
Section O – Responsibilities and Directives		
O1	Code 'yes' for O1bi and Ob1ii if: a) you have sighted 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) **or** b) a named medical professional or lawyer has confirmed (verbally or written) that they have sighted 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). Record the name of the medical professional or lawyer who has sighted the EPOA activated form.	Consider recording if EPOA is in the process of being obtained or altered.
O2		Advance directives and other treatment restrictions are described on the Client Overview Screen. They do not need to be repeated here.
Section P – Social Supports		

Item code	Required information	Considerations
P2a - c	Record the perceived barriers to providing ongoing informal support.	
P3	Record the breakdown of areas of informal support provided over the last 3 days (72 hours).	Note if the caregiver needs to get up at night. If significant support has not been captured within the 72 hours look back period record the type here for example 'daughter completes the shopping every Saturday'. Use the 'Guidelines for Informal Hours Calculations' table to calculate times of informal support hours if precise times are not available.
Section Q – Environmental Assessment		
Q1	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.	
Q2		Record the accessible support in place for persons with disabilities.
Section R – Discharge Potential and Overall Status		
R1	Record the treatment goals met in the last 90 days.	

Item code	Required information	Considerations
R3	Record the ADLs the person was independent prior to deterioration from the following list: • Bathing • Personal hygiene • Dressing upper body • Dressing lower body • Walking • Mobility • Transfer toilet • Toilet use • Bed mobility • Eating	

Item code	Required information	Considerations
R4	Record the IADLs the person was independent prior to deterioration from the following list: • Meal preparation • Ordinary housework • Managing finances • Managing medication • Phone use • Stairs • Shopping • Transportation	
Section S – Discharge		
S	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.

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 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.	