National Standards for Contact Assessment

New Zealand interRAI National Standards

This document is a companion to the interRAI Contact Assessment Form and User Manual to help you use the notes in the most effective and consistent way.
Each section within the National interRAI Software has note fields that should be used for the additional information you may need to client safety and care- planning.

Accurate and consistent coding is imperative to the validity of your interRAI assessment. Your assessments provide information to help plan care for individuals and contribute to aggregated data for local, regional and national planning. Therefore, the interRAI Contact Assessment Form and User's Manual is the source document for intent and definition of coded items.

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 Form and User's 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 a persons' complexity increases the person may progress to being assessed with a Home Care, Community Health Assessment or Long-Term care facilities assessment. It is not appropriate to go back to a Contact assessment after this has occurred.
- 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, unless they are only to be in receipt of short-term rehabilitative services.
- 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 comments sections, software access and record management.

Guidelines for Assessment comments

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. 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/codinghelp/completinginterrai-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', you need to complete **D6** and **E9** before marking assessment complete.

Telephone assessment protocol

Purpose

This document reminds users that the interRAI Contact Assessment may be used over the telephone. International studies have confirmed the validity and reliability of the assessment including use over the telephone.

Using the Contact Assessment over the telephone is common practice for some DHBs. A telephone protocol for the Contact Assessment has been in place for assessors since 2012.

Telephone assessments are useful to understand the complexity of the Client's condition, the need for specialised services, and to understand their urgency for more in-depth assessment such as the need for an interRAI Home Care assessment.

Telephone Protocols updated for the COVID-19 pandemic

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. *For the COVID-19 situation proceed if there is another person present and ask them to use the speaker phone (if available).*

Good practice, as well as expectations of the Health and Disability Consumer Rights, requires that the person 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, allowing the person time to arrange another person to be present. *For the COVID-19 situation a phone call to arrange the assessment is recommended.*

At the beginning of the assessment the assessor should introduce themselves, provide the purpose of the assessment, outline what they can expect will happen during the call, and inform them they can seek a review of the assessment finding if they wish.

The assessment 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, but additional assessment items are not required.

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 and if desired by the person.

Discussing potential service plans or preferences with the person is reasonable, provided this is completed within the 30-minute time frame and does not pre-empt the analysis of assessment results. Allow time for the person to ask the assessor questions as well.

Contact assessments can only be undertaken by a competent interRAI Contact Assessment assessor, or those currently in interRAI Contact assessment training.

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. *For the COVID-19 situation if a home care is required urgently, a Guideline for Completing Community-Based interRAI Assessments via a Live Stream Video is available on www.interrai.co.nz.*

Overview Page

The following sections must be completed. Other sections may be completed as indicated by your organization.

If this file is transferred to other organizations (e.g. inter-NASC transfer or entry to residential care) consider the information that may be required on the Overview page.

Section	Sub Heading	Required Information
Overview	Service Address	Address type = service Add address and Domicile code
	Personal details	The following fields are mandatory: • Marital status • 'Interpreter required' • Primary and secondary language • Ethnicity – ask client 'which ethnic group do you belong to?'
	Primary Contact	Add a secondary contact when the primary contact lives in the same house. This is for use in the event of civil emergency.

	Provider	The provider is the person responsible for completing the current assessment. Delete previous provider but include Case Manager/Service Coordinator if this is a requirement of your DHB.
Common Tasks – History and Physical	Diseases and Diagnoses History	Add all diagnoses, one by one. **Description:** full name of diagnosis/condition. Abbreviations in brackets. **Date of diagnosis:** defaults to 'unknown'. Add date if known (e.g. in the case of Stroke or injury) **Status:** record 'Active' for all current diseases or diagnoses. **Use in MDS:** tick the 'Use in MDS' box to copy into the MDS assessment.
Contact Assessment MDS **When completing the CA MDS refer to the interRAI Contact Assessment Form and User's Manual for coding intent and definition. Care should be taken to ensure 'self-reported' items are coded based ONLY on the client's response. Commentary should support coding and provide any necessary information for client safety and care planning.**		
Section A **Identification Information**	A4b	Ensure this item is coded.
	A7	If the person identifies as Maori, comment on Iwi affiliation if known.
	A11	Record the reason for the referral.

Section B Intake and Initial History	B4	Identify specific environmental issues of safety for the person, either through observation or reported by person/family/whanau, e.g. smoke alarms, fire guards, house access.
Section C Preliminary Screener	C1	Describe the area of major concern in daily decision making if the item is coded '1'.
	C2	If the person is not independent, specify the subtasks /type of support that has been required to complete the task.
Section D Clinical Evaluation	D4	If the person is not independently capable, specify the subtasks/ type of support that would be required to complete the task/s.
	D6	Ensure at least one diagnosis is coded as '1' – Primary diagnosis/diagnosis for current stay'.
	D9	Name site/s of pain and record any variations in pain outside the look back period and any known reasons.
	D19	Note the support provided if not already described in C2 or D4.

Section E Summary	E1	Check the Outcome Tab at top of page to reveal all 5 algorithms for your assessment: • Assessment Urgency Algorithm • Pain Scale • Rehabilitation Algorithm • Self-Reliance Index • Service Urgency Algorithm Refer to the guidelines detailed in your workbook, as to the sort of actions you may be required to take for each algorithm. Low scores: If no action is required, no comment is required. Medium- High scores: Record the action to be taken for each algorithm score that requires a follow up assessment or referral to services, **or,** record your clinical reason for not taking these actions. (e.g. the client has refused referral).