National Standards for Home Care Assessment

New Zealand interRAI National Standards

This document is a companion to the interRAI Home Care Assessment Form and User Manual to help you use the notes in the most effective and consistent way. Each section within the interRAI software has note fields that should be used for the additional information you may need for 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 Home Care 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 the interRAI Home Care 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 the documents:

- Which assessment to use and when to use it
- interRAI Assessment Protocols

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 comments 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. 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 reference date (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'
4. Discontinuing a draft assessment: for criteria and process see 'Managing incomplete assessments/draft items'

   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.

Overview Page

The following sections must be completed. Other sections to 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 from 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	Disease 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 if the diagnosis is not included in Section I1 of the MDS assessment.

MDS Assessment **When completing the Home Care (HC) MDS assessment refer to the interRAI Home Care 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. These are the minimum requirements.**		
Section A **Identification Information**	A5b	Ensure this item is coded.
Section B **Intake and Initial History**		Complete Section B for 'First' Home Care assessment only.
	B2	If the person identifies as Māori, comment on Iwi affiliation if known.
Section C **Cognition**	C1	Describe the area of major concern that relate to both client and caregiver safety in daily decision-making difficulties if this item is coded 1-4.
	C2	If scoring '1' for any of the memory functions, provide an example.
	C3	If coding '2' comment on what the behaviour is/when it occurs.
Section E **Mood and Behaviour**	E3	Include known triggers /circumstances if behavior places the person or others at risk.
Section G **Functional Status**	G1	Performance: If the person is not independent, specify what the person did do for themselves during the observation period, and the type of support (if any) that is required to complete the task. Capacity: 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.
	G2	If the person is not independent, specify what the person did do for themselves during the observation period, and the type of support (if any) that is required to complete the task.

Section I **Disease Diagnosis/Conditions**	I1/2	Ensure at least one diagnosis is coded as '1- Primary diagnosis/diagnoses for current stay'.
Section J **Health Conditions**	J5	Name site/s of pain and record any variations in pain outside of the look back period and any known reasons.
Section P **Social Supports**	P2a-c	Record the perceived barriers to providing ongoing informal support.
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.
Section R **Discharge Potential and Overall Status**	R1	Record any treatment goals achieved if not already stated in the assessment.
Section S **Discharge**		Leave section blank.
Section AS **Assessment Summary**		This is a summary of assessment findings for care planning. • Identify the reasons the CAP has triggered, summarizing the issue(s) for the individual that need to be addressed • Identify the reason for addressing any non-triggered CAPs • Tick the box 'addressed in care plan' for all CAPs being addressed • If not addressing a triggered CAP provide a clinical reason • Where outcome scores are referenced, record as follows – score/total score, for example DRS 3/14