Placement, Drugs and Therapy…

We Can Do Better

BRITISH COLUMBIA

Office of the Seniors Advocate

www.seniorsadvocatebc.ca
1-877-952-3181

Report # 3
April 2015

Message from the Seniors Advocate

Dear British Columbia Senior,

There are over 25,000 B.C. seniors living in residential care and over 29,000 who are receiving home care. While this is only seven percent of seniors, together these two groups represent our most frail and vulnerable seniors. As such, we must ensure that we are properly monitoring their health status and their care needs.

During this first year as Seniors Advocate, one of my key priorities has been to obtain and analyze information that will help us understand the needs of our most vulnerable seniors and how well we are meeting their needs. Part of this will be achieved through standardized client/resident experience surveys my office is conducting. We will be surveying all 339 publicly-funded residential care facilities and 29,000-plus home support clients, including family members. Complementing this will be the health assessment data my office has obtained and initially analyzed, with the findings in this report.

This report, *Placement, Drugs and Therapy…We Can Do Better,* is produced as part of my mandate under the Seniors Advocate Act, to report publicly and independently on systemic issues that affect seniors. The findings in this report highlight three systemic issues I have identified:

- inappropriate placement in residential care of higher functioning seniors who could live more independently with changes to home care and assisted living;
- the overuse of both antipsychotics and antidepressants in residential care;
- the significant gap in the level of rehabilitative therapies in B.C. residential care facilities relative to other provinces.

These findings demonstrate more work is needed to better serve seniors. I will be working with health authorities, service providers and physicians to effect changes that will ensure seniors are in the right place, getting the right drugs, and receiving the right kind of therapies that best suit their needs. As always, I welcome all feedback from seniors and their family members as together we address these issues.

Sincerely,

Isobel Mackenzie

Seniors Advocate
Province of British Columbia

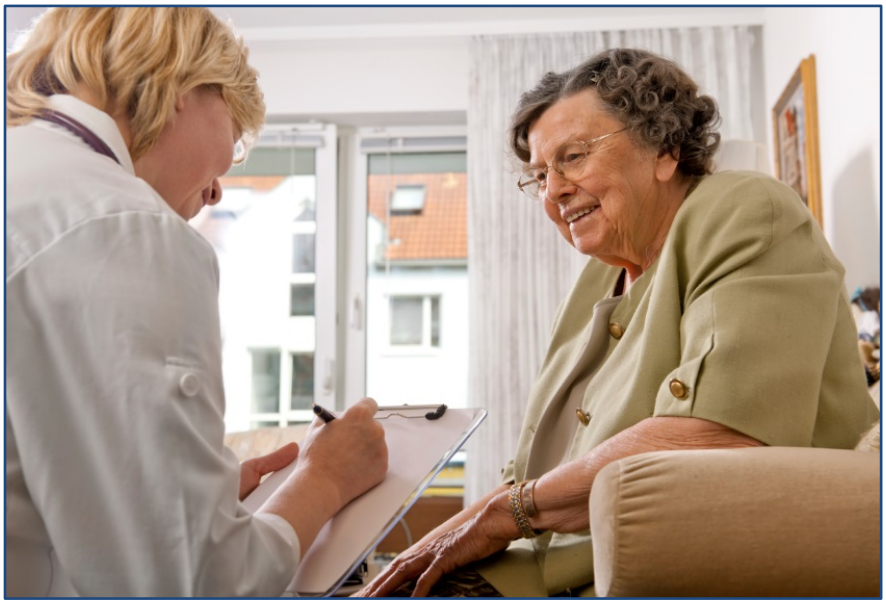
Introduction

All B.C. seniors admitted to publicly-funded residential care or assisted living, and those who receive home care, are assessed using an internationally recognized suite of assessment tools: The *InterRAI Resident Assessment Instrument-Home Care (RAI-HC)* and the *InterRAI Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS 2.0).*

The InterRAI Resident Assessment was originally developed in the 1980s in response to concerns about the quality of care in U.S. nursing homes. Since that time the "RAI", as it is colloquially known, has been implemented throughout the world. Early in the new millennium, in response to the growing use of home care, a version of RAI was created to assess those receiving home care services in the community. From a diagnostic perspective, the differences between the Home Care and Residential Care RAI are small. For brevity, one sample, the RAI-HC, is included in Appendix 1.

In Canada, the expertise in application, interpretation and Canadian design of the RAI is housed at the University of Waterloo, and the central repository for all RAI data is the Canadian Institute of Health Information (CIHI), an independent research body.

In the case of British Columbia's 31,084 home care clients (90% seniors), the RAI is normally completed at intake, at least annually, and whenever a major change has occurred. In the case of the province's 29,429 residential care clients (95% seniors), the RAI is undertaken when a senior enters a residential care facility and at least quarterly for each resident. These repeat assessments are invaluable in helping to guide the creation of appropriate care plans as well as to measure and track changes in the individual's health status over time.



www.interrai.org

www.cihi.ca

In addition to its value for the individual care plans for home care clients or residents, the RAI also provides a profile of health status capturing the needs, strengths and preferences of care recipients on a facility, health authority and provincial level. These tools assess, in a standardized way, multiple facets of an individual's health care status and their ability to be independent, including their medical conditions, medications, supports, cognition, psychological state, physical ability and ability to perform various daily tasks. With these data, we gain a complete and compelling composite of who is receiving home care and who is living in residential care.

The RAI also tracks a number of indicators that can be used to help determine if the supports needed are being provided and if the care is appropriate. Examining the frequency of physical therapy or recreational therapy along with the number of falls and use of medications can be helpful in providing a picture of some of the activities and practices in residential care facilities and the amount of home care provided relative to the assessment of need.

British Columbia has been using the RAI in residential care since 2009 and for home care since 2005. This was later than some other jurisdictions in Canada and it therefore limits the ability to monitor change over time retrospectively. However, it is now being collected and baseline data will allow us to measure progress going forward.

The Province does not currently require facilities or health authorities to report their RAI data for residential care. For home care the Province receives reporting from health authorities on only six outcome measurements under what is called "Minimum Reporting Requirements" (MRR), and these results are not published.

The Office of the Seniors Advocate (OSA) identified as a priority the gathering of RAI data to help inform B.C. seniors and their families as well as policy makers at both the provincial and health authority level. The OSA retained expertise from the University of Waterloo and worked with the Canadian Institute of Health Information (CIHI) to secure the complete data on home care and residential care for British Columbia while securing agreement to compare residential care aggregate data with Alberta and Ontario.

The information contained in these data reports is vast. The purpose of this report is not to provide a comprehensive analysis of all possible issues raised in the RAI data; the OSA will continue to analyze these data to look for emerging systemic issues. This initial report is intended to inform the public of the existence of these data and to highlight three systemic issues that are of immediate concern to the Advocate:

1. Premature admissions to residential care of up to 15 percent of residents in care facilities;
2. The overuse of drugs in care facilities;
3. The lack of physiotherapy and recreational therapy in B.C. care facilities.

Initial analysis of the RAI data examined the characteristics of seniors in residential care and home care. The table below provides a snapshot based on some of the key indicators that can help us develop a picture of who is living in residential care and who is receiving home care.

Appendix 2 contains more comprehensive data for the 2012-13 for home care in B.C. and the 2013-14 Quickstats to compare B.C. with Alberta and Ontario for residential care. More complete residential care data, available for 2012-13 was used for this report unless otherwise stated.

Snapshot of care in B.C.	Home and Community Care population (31,084 individuals)	Residential Care population (29,429 individuals)
average age	80 years	85 years
female	64%	65%
85 and older	40%	59%
married	30%	24%
diagnosis of dementia	34%	61%
primarily uses a wheelchair	11%	50%
moderate to severe cognitive difficulties (memory, following direction)	19%	64%
six or more medical diagnoses	21%	13%
moderate to severe difficulties in independently performing daily living tasks	15%	70%
instability in cognitive function, ADLs, mood or behaviour	50%	44%
caregiver co-resides	45%	n/a
taking 9 or more medications	44%	51%

These data confirm some of what we expected to find, but also highlighted a few surprises. For example, the majority of both home care clients and care facility residents are female, reflecting the longer life expectancy for females, and the average age in residential care is higher than for those receiving home care. We also noted higher-need home care clients were more likely to co-reside with their caregiver.

Among the surprises, however, was the degree to which there was similarity between those in residential care and those receiving home care. Most notably, there were very similar rates of seniors taking multiple medications, as well as similar rates of seniors with instability in their cognitive function or mood and/or in their ability to perform the activities of daily living (ADLs) in both residential care and home care.

Also surprising was the apparent complexity of health conditions among clients in the community, including a higher percentage of clients with six or more medical diagnoses than residential care.

It was also surprising to compare ourselves with Alberta and Ontario and find that those provinces have a higher percentage of seniors living in residential care who are frailer and have more complex care needs. This means B.C. has seniors in residential care who would be living in the community (with support) or assisted living if they lived in Ontario or Alberta.

Having said that, these data do indicate that we can, and do, care for highly complex clients in the community, just not consistently. The chart below illustrates that there are some seniors cared for in the community at high levels of impairment.

Seniors in the community under home care	
34%	have a diagnosis of Alzheimer's or other dementia
10%	are in renal failure (on dialysis)
21%	have a psychiatric or mood disorder
15%	have very limited function for Activities of Daily Living (ADL)
19%	have significant to severe cognitive impairment
47%	experience daily pain
44%	are on nine or more medications
50%	have an unstable diagnosis for cognition, mood or behavior
21%	are incontinent
19%	have nursing visits once a week or more

These data clearly tell us that we can care for significant levels of both cognitive and physical impairment in the community either in an assisted living setting or independent housing. This is crucial to understand as we look at the profile of seniors who are in residential care.

1. Appropriate Placement in Residential Care

Most seniors express a strong desire to live as independently as possible. To achieve this objective, we must be certain that all possible community supports such as home care and assisted living are exhausted before seniors are moved to residential care. The RAI data indicates this is not always the case and there are some seniors in residential care who could, based on their assessment, be living in the community with the appropriate home care, or in assisted living.

Using the expertise of one of Canada's foremost RAI researchers from the University of Waterloo, the OSA examined the RAI data more carefully with a view to identifying those seniors living in residential care who, based on their assessed levels of physical and cognitive function, might be able to live more independently. What emerged from the analysis are three distinct profiles of seniors who could likely be cared for either at home or in assisted living.

The first profile is of seniors with light care needs who can make their own decisions, are not at risk of wandering or getting lost, and can manage their own activities of daily living (ADLs) with minimal assistance. This profile can be referred to as having light physical and cognitive care needs. This group is easily cared for in the community with community care – if appropriate care is available.

The second profile is of seniors with a mild dementia and who need some assistance with ADLs, but who otherwise manage well with direction and support. This group can be seen as having dementia care needs. These are seniors who might do very well in assisted living with monitoring supports or indeed could remain at home with home supports and some of the electronic monitoring that is now widely available.

The third profile is of seniors who are moderately physically frail and in need of assistance for physical tasks and ADLs, but who are mentally intact and self-directing. This profile can be characterized as having physical care needs. This is a population that can easily be cared for at home or assisted living. Key to this is their ability to direct and have an awareness of their care needs. Those with high physical care needs and high cognitive function are successfully integrated in the community in young age groups and the supports that enable independence for younger populations should be equally available to seniors.

With these three profiles in mind, researchers checked the residential care RAI data to see if there were seniors who fit these profiles who were currently living in residential care. The results were surprising: it appears from these data that somewhere between five and 15 per cent of the seniors living in B.C. residential care fit one or more of these profiles -- that is 1,500 to 4,400 individuals who could potentially live more independently. Comparisons with Alberta and Ontario, where there is a significantly lower percentage of residents fitting these profiles, confirm there is room for improvement in B.C.

Three client profiles identified and their prevalence among the residential care population of B.C., compared to populations in Alberta and Ontario

RAI Client Profile	Percentage of the residential care client population		
	B.C.	AB	ON
Profile 1: LIGHT PHYSICAL AND COGNITIVE CARE NEEDS These seniors have relatively low care needs with relatively high levels of both cognitive and physical function compared to the general residential care population. Interestingly, of the three profiles, this group has the highest representation among B.C.'s residential care client population. In Alberta, these seniors may be accommodated in that province's expanded assisted living system.	6.1%	2.3%	5.6%
Profile 2: DEMENTIA CARE NEEDS This population has cognitive impairment that can make it challenging for them to live alone, but they have low physical care needs and low medical needs. These seniors are much less likely to reside in residential care settings in Alberta or Ontario and are more likely to be in assisted living or have home care.	5.4%	0.9%	1.8%
Profile 3: HIGHER PHYSICAL CARE NEEDS This group has somewhat higher physical care needs than the other two groups but, in all other respects, could potentially receive care in the community. This is a group for whom services such as physiotherapy (PT) and occupational therapy (OT) are key.	4.7%	1%	3%

The seniors fitting these three profiles have lower care needs than residential care is designed to accommodate and, based on their health, their abilities, and their care needs, these seniors could be cared for in other settings, either at home with support or in an assisted living environment rather than a residential care setting.

To be housed prematurely in a residential care facility is not generally a good experience, or fit, for the resident. With most residents experiencing complex and severe cognitive and/or physical impairment, it is difficult to form a community of interest.

It is generally accepted that community placement with supports is more desirable for those with lower care needs or who have full cognitive function. It also ensures that the scarce residential care bed is available for someone whose needs are a fit with residential care.

Residential Care is "home" for the seniors who live there. It is vital, therefore, that it serve as the appropriate type of housing for the senior who lives there. Given the results of these data, the Advocate has included an examination of this issue in her report on the affordability, availability and appropriateness of seniors' housing.

2. The Appropriate Use of Medication

One of the striking numbers in these data is the percentage of seniors both in residential care and home care who are taking nine or more medications. Fifty-one percent of residents in B.C. care facilities are taking nine or more different medications, and this drops by only seven per cent for seniors receiving home care, with 44 per cent taking nine or more medications.

The challenge around medications is two-fold. For home care clients, the managing of medications is particularly problematic. The number one reported critical incident in home care is medication error. In terms of both home care and residential care clients, there is the issue of the appropriateness of the medication for the condition being treated.

The issues around potential adverse effects of medications and drug interactions among medications are well-known. Older people are more susceptible to the effects of many drugs: the medications tend to remain in their bloodstreams for longer, reach higher concentrations, and may result in unique sensitivities and side effects. Because of these effects, which are due to various age-related changes in older people, certain medications should be avoided, or used cautiously with ongoing and careful monitoring. Taking many drugs at the same time, often referred to as polypharmacy, should be minimized as much as possible.

The RAI reports on the use of one specific classification of drugs: psychotropic medications. Psychotropic medications are drugs that alter chemical levels in the brain and are used to treat a wide range of conditions, including psychosis, depression and anxiety. They are commonly prescribed to seniors in both community care and residential care settings but, in general, seniors in residential care are more likely than those who are cared for at home to be taking these medications.

The RAI breaks down psychotropic medications, intended to be used for a specific diagnosis, into five distinct types:

1. Antipsychotic
2. Antianxiety
3. Antidepressants
4. Hypnotic
5. Analgesics

One clear indicator of potentially inappropriate medication use in residential care facilities is the extent to which one particular type of psychotropic medication, antipsychotic drugs, is prescribed to seniors without their having a diagnosis of psychosis, which is the diagnosis for which these drugs are designed. It is well-known that these drugs are sometimes used to manage aggressive or agitated behaviours in residents who have dementia. This was not what they were intended to treat, nor are there robust clinical trials involving frail seniors to properly monitor side effects.

Previous CIHI research has found that, Canada-wide, one in three long-term care

facility residents is taking antipsychotic drugs without a clinical diagnosis of psychosis, and that the use of antipsychotics is nine times higher in residential care populations than among home care populations. The B.C. RAI data shows that only four per cent of seniors in residential care have a diagnosis of a psychiatric disorder, yet 34 per cent of this client group are prescribed antipsychotic medications. This is a clear indicator that these medications are being used to treat other, non-psychotic conditions, and are probably a tool to treat behaviour issues related to cognitive or mood disorders rather than actual psychotic disorders.

Antipsychotic medications can have significant side effects including sedation, cognitive impairment, metabolic changes, muscle and movement disorders, and may also increase the risk of diabetes. Therefore, it is important that these medications not be prescribed unnecessarily to seniors whose medical conditions or behavioural symptoms are treatable through other means.

Not only can the side effects from antipsychotics range from unpleasant to

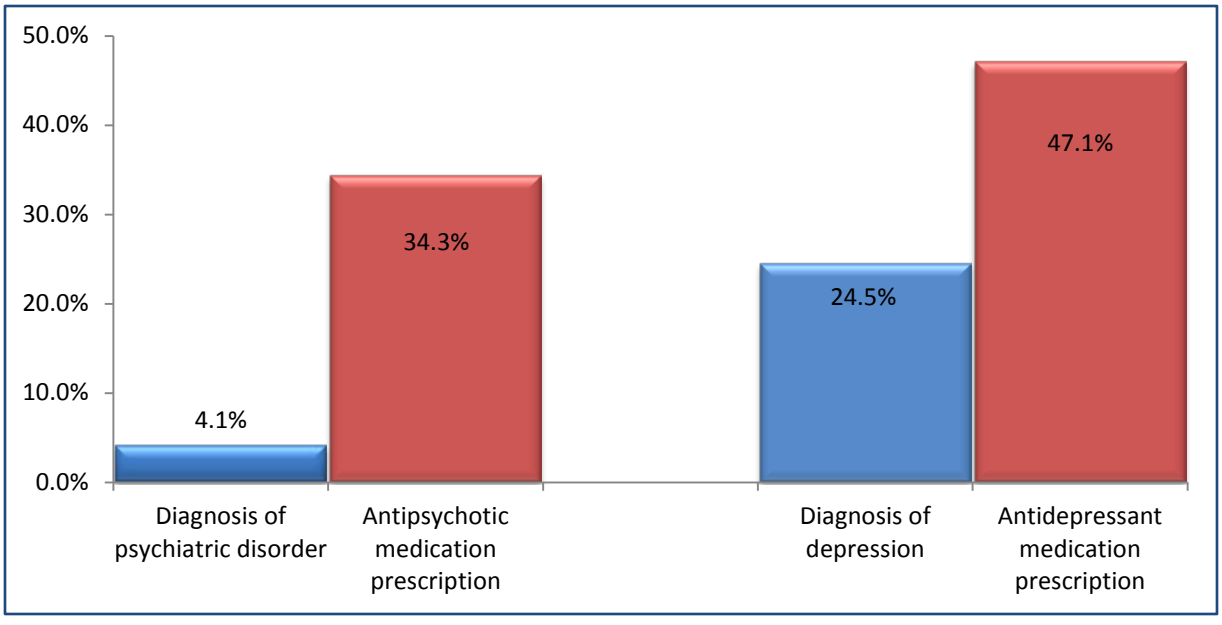
debilitating, they can also lead to misdiagnosis of conditions such as dementia and Parkinson's, which would result in more wrongly prescribed drugs.

This overuse of antipsychotic drugs has been raised before. In 2013, the BC Care Providers issued a report, *Best Practices Guide for Safely Reducing AntiPsychotic Drug Use in Residential Care.* Indeed, there is evidence to support that the overall use of antipsychotics in B.C. has been reduced. The 2011 Ministry of Health report *Review of the Use of Antipsychotic Drugs in British Columbia Residential Care Facilities* showed levels as high as 50 per cent of residential care patients were prescribed an antipsychotic in 2010/11. Despite the laudable reduction from 50 per cent to 34 per cent, the RAI comparison demonstrates B.C. still has a slightly higher use than Alberta and Ontario. Clearly, there is more work to be done.

Depression is the most common mental health problem among the elderly, and our examination of the RAI data echoes this: 24 per cent of the province's residential care clients, and approximately 21 per cent of the home care clients, were assessed as having a diagnosis of depression. As with antipsychotics, antidepressant prescriptions outpace depression diagnoses: while 24 per cent of residential care clients are assessed with depression for example, a full 47 per cent are prescribed antidepressant medications.

Although this difference between diagnosis and prescription does not seem to be as great as with the use of antipsychotics, it is still a sizable gap. Some antidepressants, particularly the newer class of serotonin re-uptake inhibitors (SSRIs), may have more side effects than others, including agitation, dizziness which can lead to falls, and drowsiness; for this reason, seniors who are prescribed antidepressants should be monitored closely and other treatment options considered.

Incidence of psychiatric disorders and mood disorders with medication prescriptions, B.C. residential care population



A related question, and one not answered by the RAI data, is whether seniors under home care and residential care who are assessed as being depressed actually fit the clinical diagnosis of depression in terms of the chemical changes that antidepressant medications are designed to treat. If a senior does not have these chemical changes, but is instead exhibiting a wholly appropriate behavioural response to changes in their health, mobility and independence, then perhaps antidepressants are not the most appropriate treatment for these seniors. Correct diagnosis is crucial.

The Advocate will continue to raise awareness of the issues around over-medication and will monitor the RAI data to look for improvements. Involvement of residents and family members in the decision of which medications residents should be taking and whether or not potential side effects are sufficiently explained is something the Advocate will be testing for in the standardized, comprehensive Residential Care survey the Office of the Seniors Advocate will be administering to all 339 B.C. publicly-funded residential care facilities.

3. The Appropriate Amount of Rehabilitation Therapy

The provision of physiotherapy, occupational therapy, speech language therapy and recreational therapy is crucial to the maintenance of function and independence for frail seniors. In all populations, the positive effects of exercise and movement are well-known and it is even more so for seniors. Emerging research has shown that, among seniors, cognitive functioning is positively impacted by physically engaging activities, and that those seniors who have some level of cognitive impairment particularly benefit from both social and physical activity. Given this knowledge, it is disappointing to see the extent to which B.C. lags behind both Ontario and Alberta in the provision of these supports.

The importance of physiotherapy (PT) cannot be minimized. Physiotherapists work with seniors to improve their strength, motor function and balance. Simple things like being able to transfer in and out of bed safely and frequently can easily become impossible with the deconditioning that happens with frail seniors if they are bedbound from a bout of flu or a fracture. With the work of physiotherapists, seniors can learn the techniques they should use in ambulation, the exercises that will restore strength and function and the warning signs of when they are pushing themselves too far or not using proper body mechanics.

All evidence supports how crucial a factor time can be in determining the extent to which a frail senior will recover from a period of inactivity or a traumatic event such as a stroke or a fall. The earlier physiotherapy begins, the greater the likelihood of regaining maximum function.

Occupational therapy (OT) ensures appropriate adaptations to the environment,

aids and techniques a senior uses to maintain and improve their ability to perform daily tasks. Having a walker set at the correct height or proper seating in a wheelchair can make the difference between maximum function or chronic pain. This is part of the work of an OT.

Occupational therapists also focus on identifying physical and cognitive strengths so that these can be integrated into a rehabilitation plan that maximizes what seniors can do for themselves in all aspects of daily life. OTs also help staff adopt care techniques that not only support the senior's independence but also facilitate staff safety when providing physical care to the senior.

Speech therapy is used mostly in the recovery from strokes, but also plays a critical role in supporting seniors with swallowing disorders. These are crucial to functions that affect a senior's quality of life.

Recreational therapy is key to ensuring that seniors in residential care are engaged in meaningful social activities with others that stimulate the mind and help maintain physical and mental wellness. Indeed, it is the presence of a strong recreational therapy program that will motivate residents to move more and engage with the world around them. This strongly correlates to improving depression and overall well-being.

In B.C., only 12 per cent of residential care clients received weekly physiotherapy, compared to 25 per cent in Alberta and 58 per cent in Ontario. Only 9 per cent of residents received occupational therapy, compared to 22 per cent in Alberta and 2 per cent in Ontario. Only 0.2 per cent received speech/language therapy, compared to 0.6 per cent of Alberta facility residents and 0.4 per cent of Ontario facility residents. Only 22 per cent of facility residents in B.C. received recreational therapy in the last seven days when surveyed, compared with 42 per cent in Alberta. Ontario only registered 7 per cent for this indicator; however, given their very high rate of physiotherapy, it is assumed there may be some substitution effect.

The Advocate is very troubled by this indicator and will begin working with health authorities and care facilities to look at ways to increase the use of rehabilitative therapies. This vital service will be subject to ongoing monitoring by the Advocate.

Incidence of rehabilitative therapy provision among the residential care population in B.C.

RAI indicator	Residential care population		
	B.C.	AB	ON
Senior received any physiotherapy in last 7 days	11.6%	25.2%	57.7%
Senior received any occupational therapy in last 7 days	8.9%	22.2%	1.8%
Senior received any speech-language therapy in last 7 days	0.2%	0.6%	0.4%
Senior received any recreational therapy in last 7 days	21.8%	42.3%	6.8%

Therapy data is from 2013/14 [2]

Summary

Bringing together the RAI data for B.C., reporting it, and comparing it to other provinces for the first time moves us closer to improving residential care and home care for B.C. seniors.

Through this first look at the data, we have learned that there is room to improve the supports for seniors in the community and meet the needs of some seniors who are moving to residential care prematurely.

We have learned that while B.C. has made some progress in the misuse of drugs in residential care, we are lagging behind other provinces and there is still room for improvement.

We have also learned that B.C. is woefully underperforming in the area of physical therapy, occupational therapy, speech language therapy and recreational therapy relative to some other provinces.

The Office of the Seniors Advocate will use these data to continue to monitor and report on the health status of, and supports for, our most frail and vulnerable seniors and to develop recommendations to support seniors in our province.

Minimum Data Set
©Home Care (MDS-HC)©
Canadian Version

- Unless otherwise noted, score for last 3 days
- Examples of exceptions include IADLs/Continence/Services/Treatments where status scored over last 7 days

Addres[illegible]aph

SECTION AA. NAME AND IDENTIFICATION INFORMATION

1	NAME OF CLIENT	a. Last/Family Name b. First Name c. Middle Name/Initial
2	CASE RECORD NO.	
3a	HEALTH CARD NO.	a. Enter the client's health card [illegible]ber, [illegible]er "0" if unknown or "1" if not applicable
3b	PROVINCE/ TERRITORY ISSUING HEALTH CARD [illegible]	b. Enter the P[illegible]inc[illegible]itory code issu[illegible] health card number. (S[illegible]RAI-HC[illegible]al for provi[illegible]/territory codes and for miss[illegible](not appli[illegible]codes)
4	POST[illegible] CODE [illegible] RESIDEN[illegible]	See RAI-HC manu[illegible] homeless/missing codes.

SECTION BB. PERSONAL [illegible]EMS

1	SEX	**M.** Male **F.** Female
2a	BIRTH DATE	Year Month Day
2b	ESTIMATED BIRTH DATE	Birth date is estimated? **0.** No **1.** Yes
3	ABORIGINAL IDENTITY	Client identifies self as First Nations, Métis, Inuit **0.** No **1.** Yes
4	MARITAL STATUS	**1.** Never married **2.** Married **3.** Widowed **4.** Separated **5.** Divorced **6.** Other
5	LANGUAGE	a. Primary language (See RAI-HC manual for additional codes.) **ENG.** English **FRE.** French b. Interpreter needed **0.** No **1.** Yes
6	EDUCATION (Highest Level Completed)	**1.** No schooling **2.** 8th grade/less **3.** 9–11 grades **4.** High school **5.** Technical or trade school **6.** Some college/university **7.** Diploma/Bachelor's degree **8.** Graduate degree **9.** Unknown

7	[illegible]NSI-BILI[illegible] ADVAN[illegible] DIRECT[illegible]S	***[illegible]de for responsibili[illegible]ed directives)*** **0.** No **1.** Yes a. C[illegible] has a legal guardian/substitute dec[illegible]n-mak[illegible] b. Client[illegible]anced medical directives in place (for exa[illegible]ple, a do not hospitalize order)
8	R[illegible]PONSI-BIL[illegible]FOR PAY[illegible]T	***(Check all codes that apply)*** a. Provincial/territorial government plan b. Other province/territory c. Federal government—Veterans Affairs Canada d. Federal government—First Nations and Inuit Health Branch (FNIHB) e. Federal government—other (RCMP, Canadian Forces, federal penitentiary inmate, refugee) f. Worker's Compensation Board (WCB/WSIB) g. Canadian resident—private insurance pay h. Canadian resident—public trustee pay i. Canadian resident—self pay j. Other country resident—self pay k. Responsibility for payment unknown/unavailable

SECTION CC. REFERRAL ITEMS *(Complete at Intake Only)*

1	DATE CASE OPENED/ REOPENED	Year Month Day
2	REASON FOR REFERRAL	**1.** Post hospital care **2.** Community chronic care **3.** Home placement screen **4.** Eligibility for home care **5.** Day care **6.** Other
3	UNDER-STANDING OF GOALS OF CARE	***(Code for client/family understanding of goals of care)*** **0.** No **1.** Yes a. Skilled nursing treatments b. Monitoring to avoid clinical complications c. Rehabilitation d. Client/family education e. Family respite f. Palliative care

Name of Client: _____ Case Record #: _____

4	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last inpatient setting ***(Code for most recent instance in LAST 180 DAYS)***	
		0. Presently in hospital **1.** No hospitalization within 180 days **2.** Within last week **3.** Within 8 to 14 days **4.** Within 15 to 30 days **5.** More than 30 days ago	☐
5	WHERE LIVED AT TIME OF REFERRAL	**1.** Private home/apt. with no home care services **2.** Private home/apt. with home care services **3.** Board and care/assisted living/group home **4.** Residential care facility **5.** Other	☐
6	WHO LIVED WITH AT REFERRAL	**1.** Lived alone **2.** Lived with spouse only **3.** Lived with spouse and other(s) **4.** Lived with child (not spouse) **5.** Lived with other(s) (not spouse or children) **6.** Lived in group setting with non-relative(s)	☐
7	PRIOR RESIDENTIAL CARE FACILITY PLACEMENT	Resided in a residential care facility at anytime during **5 YEARS** prior to case opening **0.** No **1.** Yes	☐
8	RESIDENTIAL HISTORY	Moved to current residence within last two years. **0.** No **1.** Yes	☐

SECTION A. ASSESSMENT INFORMATION

1	ASSESSMENT REFERENCE DATE	***Date of assessment*** ☐☐☐☐ Year ☐☐ Month ☐☐ Day	
2	REASON FOR ASSESSMENT	***Type of assessment*** **1.** Initial assessment **2.** Follow-up assessment **3.** Routine assessment at fix[ed] [interv]als **4.** Review within 30-day perio[d] [prior] to discharge from the program **5.** Review at return from hospital[ization] **6.** Change in [status] **7.** Other	☐

SECTION X. ASSESSMENT L[OCATION]

70	LOCATION OF ASSESSM[ENT]	***Type of location*** **1.** Private home/[apt.] with no home care services, [condominium, apartment, assisted living settings **2.** Hospital **3.** [Long-term] care facility **4.** Other	☐
71	FACILITY ADMISSION DATE	***Date of admission to facility*** ***(Leave blank if X70 is coded 1)*** ☐☐☐☐ Year ☐☐ Month ☐☐ Day	

SECTION B. COGNITIVE PATTERNS

1	MEMORY RECALL ABILITY	***(Code for recall of what was learned or known)*** **0.** Memory OK **1.** Memory problem	
		a. Short-term memory OK—seems/appears to recall after 5 minutes	☐
		b. Procedural memory OK—can perform all or almost all steps in a multitask sequence without cues for initiation	☐
2	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	a. How well client made decisions about organizing the day (e.g. when to get up or have meals, which clothes to wear or activities to do) **0.** *INDEPENDENT*—Decisions consistent/reasonable/safe **1.** *MODIFIED INDEPENDENCE*—Some difficulty in new situations only **2.** *MINIMALLY IMPAIRED*—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times **3.** *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times **4.** *SEVERELY IMPAIRED*—Never/rarely made decisions	☐
		b. Worsening of decision making as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 [days]) **0.** No **1.** Yes	☐
3	INDICATORS OF DELIRIUM	a. Sudd[en] new onset/change in mental function over [LAST 7 DAYS] (including ability to pay attentio[n], awarene[ss] of surroundings, being coherent, [fluctu]able variation over course of day) **0.** No **1.** Yes	☐
		b. In the **LAST 90 DAYS** (or [since] last assessment if less than 90 da[ys]) [client] has become agitated or disoriented such [that] his or her safety is endangered [or] client requires protection by others **0.** No **1.** Yes	☐

SECTION C. COMMUNICATION/HEARING PATTERNS

1	HEARING	***(With hearing appliance if used)*** **0.** *HEARS ADEQUATELY*—Normal talk, TV, phone, doorbell **1.** *MINIMAL DIFFICULTY*—When not in quiet setting **2.** *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to adjust tonal quality and speak distinctly **3.** *HIGHLY IMPAIRED*—Absence of useful hearing	☐
2	MAKING SELF UNDERSTOOD (Expression)	***(Expressing information content—however able)*** **0.** *UNDERSTOOD*—Expresses ideas without difficulty **1.** *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required **2.** *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required **3.** *SOMETIMES UNDERSTOOD*—Ability is limited to making concrete requests **4.** *RARELY/NEVER UNDERSTOOD*	☐
3	ABILITY TO UNDERSTAND OTHERS (Comprehension)	***(Understands verbal information—however able)*** **0.** *UNDERSTANDS*—Clear comprehension **1.** *USUALLY UNDERSTANDS*—Misses some part/intent of message, BUT comprehends most conversation with little or no prompting **2.** *OFTEN UNDERSTANDS*—Misses some part/intent of message; with prompting can often comprehend conversation **3.** *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication **4.** *RARELY/NEVER UNDERSTANDS*	☐

Name of Client: _____ Case Record #: _____

4	COMMUNI-CATION DECLINE	Worsening in communication (making self understood or understanding others) as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0.** No **1.** Yes	☐

SECTION D. VISION PATTERNS

1	VISION	***(Ability to see in adequate light and with glasses if used)*** **0.** *ADEQUATE*—Sees fine detail, including regular print in newspapers/books **1.** *IMPAIRED*—Sees large print, but no regular print in newspapers/books **2.** *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects **3.** *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects **4.** *SEVERELY IMPAIRED*—No vision or sees only light, colours, or shapes; eyes do not appear to follow objects	☐
2	VISUAL LIMITATION/ DIFFICULTIES	Saw halos or rings around lights, curtains over eyes, or flashes of lights **0.** No **1.** Yes	☐
3	VISION DECLINE	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0.** No **1.** Yes	☐

SECTION E. MOOD AND BEHAVIOUR PATTERNS

1	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	***(Code for observed indicators irrespective of the assumed cause)*** **0.** Indicator not exhibited in last 3 days **1.** Exhibited 1–2 of last 3 days **2.** Exhibited on each of last 3 days	
		a. **A FEELING OF SADNESS OR BEING DEPRESSED**, that life is not worth living, that nothing matters, that he or she is of no use to anyone or would rather be dead	☐
		b. **PERSISTENT ANGER WITH SELF OR OTHERS**—e.g. easily annoyed, anger at care received	☐
		c. **EXPRESSIONS OF WHAT AR[illegible]BE UNREALISTIC FEARS**—e.g. fe[illegible]be[illegible] abandoned, left alone, being with[illegible]rs	☐
		d. **REPETITIVE HEALTH COMPLAINT[illegible]** e.g. persisten[illegible]s medical attentic[illegible] obsessive con[illegible]n[illegible]body functions	☐
		e. **REPETITIVE A[illegible]OUS[illegible]PLAINTS, CONCERNS**—e[illegible]persiste[illegible]eks attenti[illegible] [illegible]ssurance reg[illegible]ng sched[illegible]als, laun[illegible], clothing, relations[illegible]issu[illegible]	☐
		f. **SAD, PAINED, W[illegible] FACIAL EXPRESSIONS**—e[illegible]urrowed brows	☐
		[illegible]T CRY[illegible], TEARFULNESS	☐
		h. **WITHDRAW[illegible]FRO[illegible]CTIVITIES OF INTEREST**—[illegible]no interest in long standing activities or [illegible]g with family/friends	☐
		i. **REDUC[illegible]OCIAL INTERACTION**	☐
2	MOOD DECLINE	Mood indicators have become worse as compared to status of **90 days ago** (or since last assessment if less than 90 days) **0.** No **1.** Yes	☐
3	BEHAVIOURAL SYMPTOMS	Instances when client exhibited behavioural symptoms. If EXHIBITED, ease of altering the symptom when it occurred. **0.** Did not occur in last 3 days **1.** Occurred, easily altered **2.** Occurred, not easily altered	
		a. **WANDERING**—Moved with no rational purpose, seemingly oblivious to needs or safety	☐
		b. **VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS**—Threatened, screamed at, cursed at others	☐
		c. **PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS**—Hit, shoved, scratched, sexually abused others	☐
		d. **SOCIALLY INAPPROPRIATE/ DISRUPTIVE BEHAVIOURAL SYMPTOMS**—Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smears/ throws food/feces, rummaging, repetitive behaviour, rises early and causes disruption	☐
		e. **RESISTS CARE**—Resisted taking medications/ injections, ADL assistance, eating, or changes in position	☐
4	CHANGES IN BEHAVIOUR SYMPTOMS	Behavioural symptoms ha[illegible]ecome worse or are less well tolerated [illegible]mily as compared to **90 DAYS AGO** (or[illegible]e last assessment if less than 90 days) **0.** No, or no chang[illegible]behaviou[illegible]ymptoms or acceptance by fa[illegible] **1.** Yes	☐

SECTION F. SOCIAL [illegible]NCTIONING

1	INVOL[illegible]T	a. At e[illegible]interacting with othe[illegible]kes to spend time [illegible]others) **0.** [illegible]ease **1.** Not at ease	☐
		Openly e[illegible]sses c[illegible]t or anger with family/frien[illegible] **0.** No **1.** Yes	☐
2	CHA[illegible] IN SOC[illegible] ACTIVITI[illegible]	As compared to **90 DAYS AGO** (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact **0.** No decline **1.** Decline, not distressed **2.** Decline, distressed	☐
3	ISOLATION	a. Length of time client is alone during the day (morning and afternoon) **0.** Never or hardly ever **1.** About one hour **2.** Long periods of time—e.g. all morning **3.** All of the time	☐
		b. Client says or indicates that he/ she feels lonely **0.** No **1.** Yes	☐

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SECTION G. INFORMAL SUPPORT SERVICES

1	TWO KEY INFORMAL HELPERS Primary (A) and Secondary (B)	NAME OF PRIMARY AND SECONDARY HELPERS a. (Last/Family Name) b. (First Name) c. (Last/Family Name) d. (First Name)	(A) Pri	(B) Sec
		e. Lives with client 0. Yes 1. No 2. No such helper (skip other items in the appropriate column)		
		f. Relationship to client 0. Child or child-in-law 1. Spouse 2. Other relative 3. Friend/neighbour		
		Areas of help: 0. Yes 1. No		
		g. Advice or emotional support		
		h. IADL care		
		i. ADL care		
		If needed, willingness (with ability) to increase help: 0. More than 2 hours per day 1. 1–2 hours per day 2. No		
		j. Emotional support		
		k. IADL care		
		l. ADL care		
2	CAREGIVER STATUS	***(Check all that apply)***		
		A caregiver is unable to continue in caring activities—e.g. decline in the health of the caregiver makes it difficult to continue		a.
		Primary caregiver is not satisfied with support received from family and friends (e.g. other children of client)		b.
		Primary caregiver expresses feelings of distress, anger or depression		c.
		NONE OF ABOVE		d.
3	EXTENT OF INFORMAL HELP (HOURS OF CARE, ROUNDED)	In instrumental and personal activities of daily living received over the LAST 7 DAYS, indicate extent of help from family, friends and neighbours **HOURS**		
		a. Sum of time across five weekdays		
		b. Sum of time across two weekend days		

SECTION H. PHYSICAL FUNCTIONING:
- **IADL PERFORMANCE IN LAST 7 DAYS**
- **ADL PERFORMANCE IN LAST 3 DAYS**

1	**IADL SELF-PERFORMANCE**—Code for functioning in routine activities around the home or in the community during the **LAST 7 DAYS**.			
		(A) IADL SELF-PERFORMANCE CODE **(Code for client's performance during LAST 7 DAYS)** **0**. *INDE*PENDENT—did on own **1**. SOME HELP—help some of the time **2**. FULL HELP—performed with help all of the time **3**. BY OTHERS—performed by others **8**. ACTIVITY *DID NOT OCCUR*		
		(B) IADL DIFFICULTY CODE How difficult it is (or would it be) for client to do activity on own **0**. *NO DIFFICULTY* **1**. *SOME DIFFICULTY*—e.g. needs some help, is very slow, or fatigues **2**. *GREAT DIFFICULTY*—e.g. little or no involvement in the activity is possible	(A) Performance	(B) Difficulty
		a. **MEAL PREPARATION**—How meals are prepared (e.g. planning meals, cooking, assembling ingredients, setting out food and utensils)		
		b. **ORDINARY HOUSEWORK**—How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry)		
		c. **MANAGING FINANCES**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored		
		d. **MANAGING MEDICATIONS**—How medications are managed (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
		e. **PHONE USE**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
		f. **SHOPPING**—How shopping is performed for food and household items (e.g. selecting items, managing money)		
		g. **TRANSPORTATION**—How client travels by vehicle (e.g. gets to places beyond walking distance)		
2	**ADL SELF-PERFORMANCE**—The following address the client's physical functioning in routine personal activities of daily life (for example, dressing, eating, etc. during the **LAST 3 DAYS, consider all episodes of these** activities. If clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity **(Note—For bathing, code for most dependent episode in LAST 7 DAYS.)** 0. *INDEPENDENT*—No help, setup, or oversight—OR—Help, setup, or supervision provided only 1 or 2 times (with any task or subtask) 1. *SETUP HELP ONLY*—Article or device provided within reach of client 3 or more times 2. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 3 days—OR—Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision) 3. *LIMITED ASSISTANCE*—Client highly involved in activity; received physical help in guided manoeuvring of limbs or other non-weight bearing assistance 3 or more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. *EXTENSIVE ASSISTANCE*—Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: — Weight-bearing support—OR— — Full performance by another during part (but not all) of last 3 days 5. *MAXIMAL ASSISTANCE*—Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. *TOTAL DEPENDENCE*—Full performance of activity by another 8. *ACTIVITY DID NOT OCCUR* (regardless of ability)		
		a. **MOBILITY IN BED**—Including moving to and from lying position, turning side to side, and positioning body while in bed.		
		b. **TRANSFER**—Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. (Note—Excludes to/from bath/toilet)		
		c. **LOCOMOTION IN HOME**—(Note—If in wheelchair, self-sufficiency once in chair.)		
		d. **LOCOMOTION OUTSIDE OF HOME**—(Note—If in wheelchair, self-sufficiency once in chair.)		
		e. **DRESSING UPPER BODY**—How client dresses and undresses **(street clothes, underwear)** above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.		
		f. **DRESSING LOWER BODY**—How client dresses and undresses **(street clothes, underwear)** from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners.		

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	g. **EATING**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).		
	h. **TOILET USE**—Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.		
	i. **PERSONAL HYGIENE**—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers).		
	j. **BATHING**—How client takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest abdomen, perineal area. **Code for most dependent episode in LAST 7 DAYS.**		
3	ADL DECLINE	ADL status has become worse (i.e. now more impaired in self-performance) as compared to status **90 days ago** (or since last assessment if less than 90 days) **0**. No **1**. Yes	
4	PRIMARY MODES OF LOCOMOTION	**0**. No assistive device **1**. Cane **2**. Walker/crutch **3**. Scooter (e.g. Amigo) **4**. Wheelchair **8**. ACTIVITY DID NOT OCCUR	
		a. Indoors	
		b. Outdoors	
5	STAIR CLIMBING	In the **last 3 days**, how client went up and down stairs (e.g. single or multiple steps, using handrail as needed). **0**. Up and down stairs without help **1**. Up and down stairs with help **2**. Not go up and down stairs	
6	STAMINA	a. In a typical week, during the **LAST 30 DAYS** (or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period) **0**. Every day **2**. 1 day a week **1**. 2-6 days a week **3**. No [illegible]	
		b. Hours of physical activities in th[illegible]ys (e.g. walking, cleaning house, ex[illegible]e) **0**. Two or more hours **1**. Less than two hours	
7	FUNCTIONAL POTENTIAL	***(Check all that a[illegible]***	
		Client believes he/[illegible] of increased [illegible]tional independence (ADL, [illegible]ADL, [illegible]ity)	a.
		Caregivers believe c[illegible]t is capa[illegible] increased [illegible]al independe[illegible]e (ADL, IA[illegible]bility)	b.
		Good prospects of re[illegible]very f[illegible]curre[illegible]ase or conditions, improved [illegible]tatus expected	c.
		NONE OF ABOVE	d.

SECTION I. CONTINENCE IN LAST 7 DAYS

1	BLADDER CONTINENCE	a. In **LAST 7 DAYS** (or since last assessment if less than 7 days) control of urinary bladder function (with appliances such as catheters or incontinence program employed) **0**. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device **1**. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine **2**. *USUALLY CONTINENT*—Incontinent episodes once a week or less **3**. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily **4**. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present **5**. *INCONTINENT*—Inadequate control, multiple daily episodes **8**. *DID NOT OCCUR*—No urine output from bladder	
		b. Worsening of bla[illegible]ncontinence as compared to status **90 da[illegible]go** (or since last assessment if less than 90 day[illegible] **0**. No **1**. Yes	
2	BLADDER DEVICES	(**Check all that apply i[illegible]7 DAYS**—or since last a[illegible]sment if less than 7 [illegible]s)	
		Use[illegible]ads or briefs to pro[illegible]against we[illegible]s	a.
		Use of [illegible]ndwelling urinary ca[illegible]	b.
		[illegible]ONE OF [illegible]VE	c.
3	B[illegible]EL CO[illegible]NENCE	**LAST 7 DA[illegible]**or [illegible]last assessment if less than [illegible] days), control[illegible]vel movement (with appliance or bowel continence program if employed) **0**. *CONTINENT*—Complete control; DOES NOT USE ostomy device **1**. *CONTINENT WITH OSTOMY*—Complete control with use of ostomy device that does not leak stool **2**. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly **3**. *OCCASIONALLY INCONTINENT*—Bowel incontinent episodes once a week **4**. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2–3 times a week **5**. *INCONTINENT*—Bowel incontinent all (or almost all) of the time **8**. *DID NOT OCCUR*—No bowel movement during entire 7 day assessment period	

SECTION J. DISEASE DIAGNOSES

1	DISEASES	Disease/infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in LAST 90 DAYS (or since last assessment if less than 90 days). (**blank**) Not present **1**. Present—not subject to focused treatment or monitoring by health care professional **2**. Present—monitored or treated by health care professional (If no disease in list, check **J1ac**, *None of Above*)

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		HEART/CIRCULATION		**SENSES**	
		a. Cerebrovascular accident (stroke)		q. Cataract	
		b. Congestive heart failure		r. Glaucoma	
		c. Coronary artery disease		**PSYCHIATRIC/MOOD**	
		d. Hypertension		s. Any psychiatric diagnosis	
		e. Irregularly Irregular pulse		**INFECTIONS**	
		f. Peripheral vascular disease		t. HIV infection	
				u. Pneumonia	
		NEUROLOGICAL			
		g. Alzheimer's		v. Tuberculosis	
		h. Dementia other than Alzheimer's disease		w. Urinary tract infection **(in LAST 30 DAYS)**	
		i. Head trauma		**OTHER DISEASES**	
		j. Hemiplegia/ hemiparesis		x. Cancer (in past 5 years) not including skin cancer	
		k. Multiple sclerosis		y. Diabetes	
		l. Parkinsonism		z. Emphysema/ COPD/ asthma	
				aa. Renal Failure	
		MUSCULO-SKELETAL			
		m. Arthritis		ab. Thyroid disease (hyper or hypo)	
		n. Hip fracture			
		o. Other fractures (e.g. wrist, vertebral)		ac. *NONE OF ABOVE*	
		p. Osteoporosis			
2	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-10-CA CODES	a.			
		b.			
		c.			
		d.			

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1	PREVENTIVE HEALTH (PAST TWO YEARS)	**(Check all that apply—In the LAST 2 YEARS)**			
		Blood pressure [illegible]ed	a.	In the PAST YEAR: Received pneumococcal immunization	d.
		Received influenza vaccination	b.		
		Test for blood in [illegible] endoscopy	c.	*NONE OF ABOVE*	e.
2	PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	**(Check all that are present on at least 2 of the last 3 days)**			
		Diarrhea	a.	Loss of appetite	d.
		Difficulty urinating or urinating 3 or more times at night	b.	Vomiting	e.
				NONE OF ABOVE	f.
		Fever	c.		

3	PROBLEM CONDITIONS	**(Check all present at any point during last 3 days)**			
		PHYSICAL HEALTH		**MENTAL HEALTH**	
		Chest pain/pressure at rest or on exertion	a.	Delusions	f.
				Hallucinations	g.
		No bowel movement in 3 days	b.	*NONE OF ABOVE*	h.
		Dizziness or lightheadedness	c.		
		Edema	d.		
		Shortness of breath	e.		
4	PAIN	a. Frequency with which client complains or shows evidence of pain **0.** No pain (score b–e as 0) **1.** Less than daily **2.** Daily—one period **3.** Daily—multiple periods (e.g. morning and evening)			
		b. Intensity of pain **0.** No pain **1.** Mild **2.** Moderate **3.** Severe **4.** Times when pain is horrible or excruciating			
		c. From client's point of view, pain intensity disrupts usual activities **0.** No **1.** Yes			
		d. Character of pain **0.** No pain **1.** Localized—single site **2.** Multiple sites			
		From client's point of view, medications adequately control pain **0.** Yes or no pain **1.** Medications do not adequately control pain **2.** Pain present, medication not taken			
	FALLS FREQUENCY	Number of times fell in **LAST 90 DAYS** (or since last assessment if less than 90 days). If none, code "**0**", if more than 9, code "**9**".			
6	DANGER OF FALLING	**(Code for danger of falling)** **0.** No **1.** Yes			
		a. Unsteady gait			
		b. Client limits going outdoors due to fear of falling (e.g. stopped using bus, goes out only with others)			
7	LIFESTYLE (Drinking/ Smoking)	**(Code for drinking or smoking)** **0.** No **1.** Yes			
		a. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking			
		b. **In the LAST 90 DAYS** (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e. an "eye opener") or has been in trouble because of drinking			
		c. Smoked or chewed tobacco daily			

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8	HEALTH STATUS INDICATORS	**(Check all that apply)**				
		Client feels he/she has poor health (when asked)	a.	Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.	
		Has conditions or diseases that make cognition, ADL, mood, or behaviour patterns unstable (fluctuations, precarious, or deteriorating)	b.	Prognosis of less than six months to live—e.g. physician has told client or client's family that client has end-stage disease	e.	
		Experiencing a flare-up of a recurrent or chronic problem	c.	*NONE OF ABOVE*	f.	
9	OTHER STATUS INDICATORS	**(Check all that apply)**				
		Fearful of a family member or caregiver	a.	Physically restrained—limbs restrained, restrained to chair when sitting	e.	
		Unusually poor hygiene	b.	*NONE OF ABOVE*	f.	
		Unexplained injuries, broken bones, or burns	c.			
		Neglected, abused, or mistreated	d.			

SECTION L. NUTRITION/HYDRATION STATUS

1	WEIGHT	**(Code for weight items)** 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the **LAST 30 DAYS** (or 10% or more in the **LAST 180 DAYS**)	
		b. Severe malnutrition (cachexia)	
		c. Morbid obesity	
2	CONSUMPTION	**(Code for consumption)** 0. No 1. Yes	
		a. In at least 2 of the last 3 days, ate one or fewer meals a day	
		b. **In last 3 days**, noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days	
		d. Enteral tube feeding	
3	SWALLOWING	0. *NORMAL*—Safe and efficient swallowing of a diet consistent 1. *REQUIRES D... MODIFICATION TO S... LOW SOLID FOOD...* m... al diet or able to ingest specific foods only) 2. *REQUIRES MO... FICATION... SWALLOW ... D FOODS AND LI... DS* (pure... ned liquids) 3. *COMBINED OR... AND ... E FEE...* 4. *NO ORAL INTAK...*	

SECTION M. ... (ORAL HEALTH)

1	ORAL STATUS	**(Check all that apply)**		
		Problem chewi... (e.g. poor mastication, immobile jaw, surgical r... ction, decreased sensation/motor control, pa... ile eating)	a.	
		Mou... y" when eating a meal	b.	
		Problem brushing teeth or dentures	c.	
		NONE OF ABOVE	d.	

SECTION N. SKIN CONDITION

1	SKIN PROBLEMS	Any trouble skin conditions or changes in skin condition (e.g. burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes	
2	ULCERS (Pressure/ Stasis)	Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4). **[Code 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1–4).]**	
		a. **Pressure ulcer**—any lesion caused by pressure, shear forces, resulting in damage of underlying tissues	
		b. **Stasis ulcer**—open lesion caused by poor circulation in the lower extremities	
3	OTHER SKIN PROBLEMS REQUIRING TREATMENT	**(Check all that apply)**	
		Burns (second or third degree)	a.
		Open lesions other than ulcers, rashes, cuts (e.g. cancer)	b.
		Skin tears or cuts	c.
		Surgical wound	d.
		Corns, calluses, ... ural problems, infections, fungi	e.
		NONE OF ABOVE	f.
4	PRIOR PRESSURE ULCER	0. No 1. Yes	
5	WOUND/ UL...	**(Cl... for formal care in ... T 7 D...)**	
		Antib... , systemic or topica...	a.
		Dressing	b.
		Surgical wo...	c.
		Other wound/ulcer care (e.g. pressure relieving device, nutrition, turning, debridement)	d.
		NONE OF ABOVE	e.

SE... ON O. ENVIRONMENTAL ASSESSMENT

1	... E ENVIRON-MENT	**[Check any of following that make home environment hazardous or uninhabitable (if none apply, check NONE OF ABOVE, if temporarily in institution, base assessment on home visit)]**	
		Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a.
		Flooring and carpeting (e.g. holes in floor, electric wires where client walks, scatter rugs)	b.
		Bathroom and toilet room (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g. dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		Heating and cooling (e.g. too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		Personal safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbours, heavy traffic in street)	f.
		Access to home (e.g. difficulty entering/leaving home)	g.
		Access to rooms in house (e.g. unable to climb stairs)	h.
		NONE OF ABOVE	i.

Name of Client: _____ Case Record #: _____

2	LIVING ARRANGEMENT	a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other persons—e.g. moved in with another person, other moved in with client **0**. No **1**. Yes	☐
		b. Client or primary caregiver feels that client would be better off in another living environment **0**. No **1**. Client only **2**. Caregiver only **3**. Client and caregiver	☐

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) since involving	#of:	(A) Days	(B) Hours	(C) Mins
		a. Home health aides	☐	☐	☐☐☐	☐☐
		b. Visiting nurses	☐	☐	☐☐☐	☐☐
		c. Homemaking services	☐	☐	☐☐☐	☐☐
		d. Meals	☐	☐	☐☐☐	☐☐
		e. Volunteer services	☐	☐	☐☐☐	☐☐
		f. Physical therapy	☐	☐	☐☐☐	☐☐
		g. Occupational therapy	☐	☐	☐☐☐	☐☐
		h. Speech therapy	☐	☐	☐☐☐	☐☐
		i. Day care or day hospital	☐	☐	☐☐☐	☐☐
		j. Social worker in home	☐	☐	☐☐☐	☐☐

2	SPECIAL TREATMENTS, THERAPIES, PROGRAMS	Special treatments, therapies, and programs received or scheduled during the **LAST 7 DAYS** (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis. (**Blank**) Not applicable **1**. Scheduled, full adherence as p… **2**. Scheduled, partial adherence **3**. Scheduled, not received (If no treatments provided, check *NONE ABOVE* **P2aa**)			
		RESPIRATORY TREATMENTS		**THERAPIES**	
		a. Oxygen	☐	…ercise thera…	☐
		…espirator for assistive breathing	☐	…onal therapy	☐
		c. All other respirator… treatments	☐	p. Physical therapy	☐
		…ENTS		**PROGRAMS**	
		d. Alcohol/drug… treatment pr…m	☐	q. Day center	☐
				r. Day hospital	☐
		e. Bl… …sfusion(s)	☐	s. Hospice care	☐
		f. Chemotherapy	☐	t. Physician or clinic visit	☐
		g. Dialysis	☐	u. Respite care	☐
		h. IV infusion—central	☐	**SPECIAL PROCEDURES DONE IN HOME**	
		i. IV infusion—peripheral	☐	v. Daily nurse monitoring (e.g. EKG, urinary output)	☐
		j. Medication by injection	☐		
		k. Ostomy care	☐	w. Nurse monitoring less than daily	☐
		l. Radiation	☐	x. Medical alert bracelet or electronic security alert	☐
		m. Tracheostomy care	☐	y. Skin treatment	☐
				z. Special diet	☐
				aa. *NONE OF ABOVE*	☐
3	MANAGEMENT OF EQUIPMENT (**In Last 3 Days**)	**Management codes:** **0**. Not used **1**. Managed on own **2**. Managed on own if laid out or with verbal reminders **3**. Partially performed by others **4**. Fully performed by oth…			
		a. Oxygen	☐		
		b. IV	☐		
		c. Catheter	☐		
		…stomy	☐		
4	VISITS IN LAST 90 … SINCE LAST …SESSMENT	**Ente… if none, if more tha… …9"**			
		a. Num… of times ADMITTED …OSPITAL **with** an ove…ht stay	☐		
		Number …mes VIS… EMERGENCY ROOM **without** a… …stay	☐		
		c. EMERGENT …E—including unscheduled nursing, physician, or therapeutic visits to office or home	☐		
		TREATM… GOALS — Any treatment goals that have been met in the **LAST 90 DAYS** (or since last assessment if less than 90 days)? **0**. No **1**. Yes	☐		
6	O…ALL CHA…GE IN CARE NEEDS	Overall self-sufficiency has changed significantly as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) **0**. No change **1**. Improved—receives fewer supports **2**. Deteriorated—receives more support	☐		
7	TRADE OFFS	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care **0**. No **1**. Yes	☐		

Name of Client: _____ Case Record #: _____

SECTION Q. MEDICATIONS

1	NUMBER OF MEDICATIONS	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment) *[If none, code "0", if more than 9, code "9".]*	☐
2	RECEIPT OF PSYCHO-TROPIC MEDICATION	Psychotropic medications taken in the **LAST 7 DAYS** (or since last assessment) [Note—Review client's medications with the list that applies to the following categories.] **0**. No **1**. Yes	
		a. Antipsychotic/neuroleptic	☐
		b. Anxiolytic	☐
		c. Antidepressant	☐
		d. Hypnotic or Analgesic	☐
3	MEDICAL OVERSIGHT	Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment) **0**. Discussed with at least one physician (or no medication taken) **1**. No single physician reviewed all medications	☐
4	COMPLIANCE/ ADHERENCE WITH MEDICA-TIONS	Compliant all or most of time with **medications** prescribed by physician (both during and between therapy visits) in **LAST 7 DAYS** **0**. Always compliant **1**. Compliant 80% of time or more **2**. Compliant less than 80% of time, including failure to purchase prescribed medications **3**. *NO MEDICATIONS PRESCRIBED*	☐
5	LIST OF ALL MEDICATIONS	List prescribed and nonprescribed medications taken in **LAST 7 DAYS** (or since last assessment) a. **Name**: Record the name of the medication. b. **Dose**: Record the dosage. c. **Form**: Code the route of Administration using the following list: **1**. By mouth (PO) **2**. Sub lingual (SL) **3**. Intramuscular (IM) **4**. Intravenous (IV) **5**. Subcutaneous (SQ) **6**. Rectal (R) d. **Freq**: Code the number of times per day, week, or month the medication is administered using the following list: ***PRN***. As necessary ***QH***. Every hour ***Q2H***. Every two hours ***Q3H***. Every three hours ***Q4H***. Every four hours ***QD***. Once daily ***HS***. Bedtime ***BID***. Two times daily (includes every 12 hrs) ***TID***. Three times daily ***QID***. Four times daily ***5D***. Five times daily ***QOD***. Every other day ***2W***. Two times every week ***3W***. Three times every week ***4W***. Four times every week ***5W***. Five times every week ***6W***. Six times every week ***1M***. Once every month ***2M***. Twice every month ***C***. Continuous ***O***. Other e. **If PRN**: record number of doses taken in last 7 days.	

	a. Name	b. Dose	c. Form	d. Freq	e. If PRN # of times taken in last 7 days
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					

☐ = when box blank, must enter number or letter [a.] = when letter in box, check if condition applies

SECTION R. ASSESSMENT INFORMATION

1	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT
	a. Name of Assessment Coordinator
	Title of Assessment Coordinator
	c. Assessment Coordinator signed as complete Y ☐☐ Month ☐☐ Day ☐☐

Other Signatures	Title	Sections	Date
e.			
f.			
g.			
h.			
i.			

APPENDIX 2: SUMMARY OF RAI DATA – RESIDENTIAL CARE POPULATION

CIHI Quickstats: fiscal year 2013/14			
% of provincial residential care residents unless specified	BC	AB	ON
n (assessed residents)*	29,429	18,475	94,981
female	65.3	63.2	67.7
mean age (years)	85	82	83
under 65	5.2	8.8	6.6
over 85	58.7	51.6	53.3
% married	24		
Alzheimer's or other dementia	61.4	59.7	61.9
Stroke	20.6	19.6	21.8
Diabetes	20.2	23.7	27.0
Congestive heart failure	11.5	14.1	12.8
Psychiatric or mood diagnosis (any of 4)	30.4	43.0	39.4
anxiety disorder	6.3	8.4	9.7
depression	24.5	37.3	32.3
manic depressive/bipolar	1.9	1.7	2.2
Schizophrenia	2.4	2.5	3.1
COPD/emphysema/asthma	12.9	18.7	18.4
Renal failure	8.1	8.4	10.5
6 or more diagnoses	13		
Special care dementia unit	19.2	20.5	16.5
ADL hierarchy 0	7.2	2.1	3.7
1	7.3	3.4	5.4
2	15.5	7.9	9.7
3	27.1	26.5	25.9
4	10.6	21.5	21.8
5	20.4	23.2	22.0
6	11.9	15.4	11.5
[4 or more]	42.9	60.1	55.3
Cognitive Performance Scale 0	8.8	6.3	11.8
1	11.2	10.6	9.5
2	16.5	13.9	16.0
3	30.9	33.6	33.6
4	7.6	9.2	7.9
5	14.9	13.9	10.6
6	10.2	12.6	10.5
[4 or more]	32.7	35.7	29.0
CHESS 2+	24.6	34.7	25.1
DRS 3+	21.4	42.2	33.1
Daily pain	20.5	13.8	12.4
MAPLE moderate	17.6		
MAPLE high	38.0		

CIHI Quickstats: fiscal year 2013/14			
% of provincial residential care residents unless specified	BC	AB	ON
MAPLE very high	44.4		
RUG-III Rehab case mix group	1.2	4.1	6.9
Bladder incontinence frequent or more	56.9	68.5	64.7
Bowel incontinence frequent or more	36.6	52.1	46.6
Any aggressive behaviour	34.5	52.1	46.5
Any wandering	17.2		
Hallucinations or delusions	6.6		
Fell last 30 days	14.8	16.3	16.0
Stage 2 or higher pressure ulcer	4.4		
Wheelchair primarily used indoors	50.4		
Resident feels ADL improvement possible	15.6		
Staff feel ADL improvement possible	10.5		
9 or more different meds last 7 days	51.4	68.5	66.0
Antipsychotic medications	34.3	29.0	31.3
Antianxiety medications	14.2	11.5	13.3
Antidepressant medications	47.1	51.7	53.9
Hypnotic medications	20.9	19.9	5.3
Analgesic medications	65.7	74.2	69.2
Diabetes + medication by injection	4.6		
Cognitive, ADL, mood or behaviour unstable	44.4		
Flare-up of chronic or recurrent problem	4.5		
End-stage	1.5		
Nursing-specific	13.9		
SLP last 7 days	0.2	0.6	0.4
OT last 7 days	8.9	22.2	1.8
PT last 7 days	11.6	25.2	57.7
Recreation therapy last 7 days	21.8	42.3	6.8
Restraint use last 7 days	12.0	11.7	8.4
High weight: >300 pounds	0.5		
Resident preference to return to community	8.3		
Support person positive towards discharge	2.0		
Light care criteria	6.1		
Dementia care criteria	5.4		
Overall, last 90 days: improved	2.0		
Overall, last 90 days: declined	20.6		
Limited or no social engagement (ISE 0,1,2)	52.3	49.0	44.9
Admitted from (during this fiscal year):			
home	23.7	16.0	40.9
hospital	43.9	73.8	36.5
retirement home (board and care)	7.9	2.9	12.3
transfer from another res care facility	23.2	6.4	10.0

Note: not all statistics are available for every RAI indicator in all provinces. Sourced from: www.cihi.ca/quickstats
* Population data for residential care residents is from 2012/13 as data was not consistently available for 2013/14

APPENDIX 3: SUMMARY OF RAI DATA – HOME CARE POPULATION

Fiscal year 2012/13		
% of provincial home care residents unless specified		BC
n (assessed clients) (2013-14) [2]		31,084
female		63.5
mean age		80.3
under65		10.9
over85		40.1
% married		29.5
Alzheimer's or other dementia		34.4
Stroke		19.5
Diabetes		22.6
Congestive heart failure		14.5
Psychiatric or mood diagnosis		21.0
mood or anxiety disorder		
schizophrenia or bipolar disorder		
COPD/emphysema/asthma		18.3
Renal failure		10.3
Multiple Sclerosis		1.6
Parkinson's		4.9
Hip Fracture		4.4
Other fracture		8.7
Osteoporosis		21.4
Cancer		10.1
6 or more diagnoses		20.7
Special care dementia unit		
ADL hierarchy	0	56.8
	1	12.0
	2	16.2
	3	8.1
	4	3.6
	5	2.4
	6	1.0
Cognitive Performance Scale	0	26.1
	1	16.3
	2	38.7
	3	11.7
	4	2.1
	5	4.3
	6	0.7
CHESS 2+		37.2
DRS 3+		19.2
Daily pain		47.0

Fiscal year 2012/13	
% of provincial home care residents unless specified	BC
MAPLe moderate, mild, low	46.8
MAPLE high	37.6
MAPLE very high	15.6
RUG-III case mix index (expected resource use)	1.02
Bladder incontinence frequent or more	20.9
Any aggressive behaviour	10.8
Any wandering	3.4
Hallucinations or delusions	4.9
Fell last 90 days	37.2
Stage 2 or higher pressure ulcer	1.9
wheelchair primarily used indoors	11.3
Client feels improvement possible	15.1
Caregivers feel improvement possible	6.2
9 or more different meds last 7 days	43.6
Antipsychotic medications	13.5
Antianxiety medications	12.8
Antidepressant medications	28.1
Hypnotic or analgesic medications	30.3
Diabetes and medication by injection	3.2
cognitive, ADL, mood or behaviour unstable	49.8
flare-up of chronic or recurrent problem	8.7
end-stage	2.2
Nursing-specific	19.0
Any PT/OT/SLP last 7 days	9.2
Any recreation therapy last 7 days	25%
Restraint use	0.3
High weight: >300 pounds	
Resident preference to return to community	
Support person positive towards d/c	
Overall, last 90 days: improved	5.2
Overall, last 90 days: declined	45.1
Overall, improved, excluding new admits	5.5
Overall, declined, excluding new admits	39.3

Note: not all statistics are available for every RAI indicator. Sourced from CIHI RAI data.


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