Routine use of a standardised assessment instrument for measuring the outcome of social care

Iain Carpenter
Janet Field
David Challis
Michael Calnan
Cameron Swift

2001

Routine Use of a Standardised Assessment Instrument for Measuring the Outcome of Social care

FINAL REPORT

Principal Investigator:

IAIN CARPENTER

Senior Lecturer in health care of older people

GKT School of Medicine and Dentistry, London,

Centre for Health Service Studies, University of Kent at Canterbury

East Kent Hospitals NHS Trust

Research Associate:

Janet Field Ph D

Co-investigators:

Professor David Challis
Professor Michael Calnan
Professor Cameron Swift

MARCH 2001

Iain Carpenter, MD FRCP
Associate Director (older people)
CHSS
George Allen Wing,
University of Kent
Canterbury CT2 7NF

G.I.Carpenter@ukc.ac.uk

CONTENTS

Routine Use of a Standardised Assessment Instrument for Measuring the Outcome of Social care

Iain Carpenter, Janet Field, David Challis, Michael Calnan, Cameron Swift

1. Introduction

This study had as its primary aim determining the extent to which standardised assessment can contribute to monitoring the outcomes of social care. It also addressed the comparison of resource use between individual clients, groups of clients with similar characteristics and between Social Service Departments (SSD's). An important part of the study was exploring the views of Social Workers and Care Managers on assessment in general and standardised assessment and the MDS-HC in particular. It has succeeded in achieving the majority of its goals and its findings have been incorporated into a revised MDS-HC assessment system including the development of a simplified screening assessment. It has also identified how attitudes to assessment, the manner in which assessment is done, and the organisation of assessment and on going management of services provided was significantly different between the two social service departments that took part in the study. Some of the issues identified are important for the development of policy on assessment in community care. It is likely that the findings are widely generalisable.

2. Background

Assessment is the basis for many decisions in the care of older people; identification of need and the provision of care: eligibility for different levels of care: to support threshold decisions - entry to residential nursing or NHS long term care and the review of needs and care provided. As it is undertaken in one form or another at almost every professional health or social care contact, it is not surprising that it has been identified as the potential source of information for monitoring quality and outcome of health and social care. It is widely agreed that the key to improving quality, effectiveness and outcome of care of elderly people is through the use of Comprehensive Geriatric Assessment (CGA) [1]. CGA has demonstrated improvements in outcome of healthcare in a variety of settings [2]. Although there has in recent years been much interest in standardised assessment to enable measurement and comparison of outcome in geriatric medicine in the United Kingdom[3] [4] there has been less work in community and social care settings. The routine use of standardised assessment could

generate information that could produce routinely available outcome information for clinicians, managers and policy makers [5].

The NHS Community Care Act (1990) [6]required local authorities to provide social care services on the basis of individually assessed needs, the responsibility for the assessments lying with Social Services. The NHS Guidelines on Responsibility for Meeting Continuing Healthcare Needs (HSG (95)8) [7] required local health authorities to set criteria against which people would be assessed for appropriate continuing care management. Furthermore, mechanisms were to be set in place so that patients and their carers could request authorities "to review a decision which has been made eligibility for NHS continuing inpatient care". This places further immediate importance on the outcome of the assessment process.

In spite of the requirements of the Community Care Act and HSG 95(8), no details were provided as to how staff should conduct assessment nor was there any guidance on the information items essential for monitoring and planning, nor how information should be standardised and collected. Publication of guidance for social services [8 9] and 'Good Practice' guidance for health authorities had the aim of showing how "aggregated information from individuals can be combined with broad population needs to allow authorities to make better informed planning decisions and where variances occur to identify areas where a change to service provision may be required" [10]. However, the methodology and data required were not described, leaving it unclear how local authorities should actually take this forward [11].

The consequence of these requirements was an investment in procedures and modes of assessment to implement them more effectively. Much of the investment was employed at a local level, frequently without reference to work undertaken elsewhere or with adoption of scales or parts of scales developed for research rather than service purposes. The 1993 review of assessment procedures conducted by the Social Services Inspectorate (SSI) found that there was a great deal of variation in content and quality, poor categorisation of needs and a lack of reliability and validity in information collected[11]. It also reported too little healthcare staff involvement, a lack of clarity about: the purpose of the assessment record, agency accountability, guidance for the assessor to inform the user of service planning, or some combination of these. Assessment tools frequently focus on functional domains and financial aspects with consequently less focus upon others[12]. These and many other reports describe the failure to cover all areas of need and frequent inadequacy of the information for organising detailed care and constructing care plans. A significant finding of the SSI study was that there was considerable duplication of paperwork by health and social services

because of different assessment standards not being fully reconciled due to difficulties in information sharing.

In 1995 the NHS Executive, SSI Community Care monitoring report[13] reported a gradual maturing of assessment systems, but the aim of "open, needs-led, collaborative and participative" systems had not yet been realised in many areas. Service focused responses from staff remained hard to eradicate. A 1996 review of assessment instruments from 50 local authorities in the UK examined the extent to which they covered areas important for adequate assessment of need and the extent to which the assessments were structured, necessary for reliable comparisons to be made on the basis of the assessment information. Of 33 assessment domains, 39% were not covered in a fifth of assessments, 20% were covered by fewer than half, standardised items were rarely used and only 24% were used jointly by health and social services[14].

In spite of the importance of assessment therefore, it is clear that variability of assessment remains high and comparability and the capacity to generate standardised information low. Poor assessment may lead to poor targeting and delivery of care, quite apart from the difficulties in determining the benefits.

A recent history of standardised reliable assessment

Concerns about the quality of care and the inability to monitor quality costs and outcome of care in nursing homes in the United States led to a contract for the development of an assessment instrument that would improve care through links to care planning and provide a method for monitoring quality and outcome of care[15]. A critical review of over 60 assessment instruments was carried out and concluded that no instrument could be used as is. This led to the development of the Minimum Data Set/Resident Assessment Instrument (MDS/RAI), a standardised multidisciplinary assessment for use in institutional care of the elderly [16]. Used for assessment and assistance for the development of care plans it has demonstrated abilities to monitor quality (and outcome) of care[17] and also to improve both quality of process and quality of outcome [18]. It has been rigorously tested and the system can be used for both clinical, administrative and research purposes with confidence[19].

The Minimum Data Set - Home Care (MDS-HC)

In order to address community care in the same manner, an international team, including one of us (GIC) and the original developers of the MDS/RAI, developed the Minimum Data Set Home Care (MDS-HC) [20 21], for use by health and social care workers based on the same principles as the MDS/RAI. For assessment domains common to institution based and

community care, the MDS/RAI assessment items were used in the MDS-HC to ensure comparability. The MDS-HC was designed to provide a comprehensive view of the problems, strengths and preferences of homecare clients. Problems identified in the assessment trigger assessment protocols (CAPS) which incorporate multidisciplinary guidance for the best practice in developing care plans. Although the principal purpose of the of the MDS-HC is care planning, like the MDS/RAI it has been systematically designed to enable an accurate assessment of client outcomes and thus quality of the care provided. Data can be aggregated to inform management and policy makers of population needs.

The MDS-HC was developed systematically. First domains important for managing people at home were identified. Panels of individuals with expertise in these areas then set about designing the client assessment protocols (CAPs) for each domain. The work began with a literature review of each subject area to obtain latest research and practice information. The CAPs were then constructed according to a standard framework consisting of specified objectives, clear triggers, background and careplanning guidelines. The objective of the CAP is to define the nature of the problem and the course of action to be undertaken. The triggers frame the questions required to identify the problem to be included in the assessment and to trigger the CAP, the background describes the nature and epidemiology of the problem and finally the guidelines provide descriptions and supplementary questions to be used to develop an appropriate care plan for that problem. The guidelines can be thought of as a check list to ensure that all factors that could be causing the problem or which might be suitable for an intervention to relieve the problem are included or considered in the care planning process. Once the CAPs had been written they were sent to individuals with appropriate expertise for comment on the adequacy of content and structure. The assessment instrument was then constructed around the trigger items.

The MDS-HC could address the problems surrounding assessment in England and Wales such as those described above. Other countries which face similar issues around community care of the elderly have explored the potential for its use. Preliminary field testing was undertaken in the United States, Czechoslovakia, Italy, Japan and Canada. In 208 dual assessments average weighted Kappa across the 62 assessment areas was .74, (range .43 for one item on weight change to 0.93 for seven items on Instrumental Activity of Daily Living). 730 assessments were assembled and the populations profiled from the data. The design steps, inter-rater reliability and preliminary prevalence data have been published [21] and the potential role of the instrument in a UK setting has also been described[22]. A recent publication illustrates outcome measures of the MDS-HC in a variety of client groups and in two US

States, Canada, Japan and Italy [23]. It is now in routine use in a number of US States and Canadian provinces, in Italy, Iceland, Canada and Japan and is being evaluated in Switzerland, France, Germany and a number of Scandinavian countries. It forms the core of an EU Vth framework project starting in March 2001 examining community care in 13 European countries [24].

Assessment, casemix and resource use in the community

The costs of the non acute care of older people in hospitals and nursing homes is determined not by diagnosis and procedures as in Diagnosis Related Groups (DRGs), but by their clinical characteristics including physical and cognitive function, mood and some clinical conditions[25]. These are covered in the routine assessment of older people as is demonstrated by Resource Utilisation Groups (RUGs), a casemix system for institutional care of the elderly derived from the MDS/RAI[26]. RUGs have been validated in England and Wales[27].

However measurement of resource use in a community setting is more complicated than in institutions[28 29] as there are considerably more variables (e.g. availability of informal carer) and the purpose of care (cure, maintenance or palliation) which play a roll in determining cost. However, as with RUGs, it is likely that the areas covered by routine assessment, possibly with the addition of items on availability of informal care, could form the basis of a community casemix system for the elderly. The MDS-HC covers these domains, and may provide data that could be used for generating groupings similar to that of RUGs for use in the community. The MI-CHOICE level of care case-mix algorithm was developed from the MDS-HC and classifies clients into 5 levels of care[30]. In ascending order of complexity of care needs these are; information and referral (those generally needing only advice): home help type care: personal care (such as can be provided by care assistants): nursing care at home (personal care plus nursing care): and nursing home (a need for care that might otherwise be provided in a nursing home). A resource use case-mix system for community care based on the MDS-HC and similar to RUG-III has recently been published[31].

3. Summary of the project design:

Primary research question.

Does the use of a standardised comprehensive assessment instrument, with care planning guidelines, the Minimum Data Set-Home Care (MDS-HC) improve the ability to monitor outcome of care compared with current community care assessments (CCA)?

Secondary research aims.

To produce resource use casemix groups from routine assessment data thus enabling relating resource inputs to outcomes of care.

To act as a pilot to determine sample size for a study on whether standardised assessment improves outcome of social care compared with the use of current assessments

Subject Group and sample

People aged over 65 referred for complex assessment in 2 local authorities, one in South London, one in East Kent. 105 people in intervention and 105 people in control group per authority, total sample 210 intervention, 210 control.

Methods of working

Subjects randomised for assessment with the MDS-HC (intervention group) by a trained social worker or the CCA (control group) by usual social worker and reassessment at 6 months and 12 months.

People consenting were re-assessed by research team using Gold Standard instruments after initial referral and at first and second reassessments.

Social workers in intervention and control groups interviewed to determine views of the assessment process and the use of standardised assessment.

Measures of care input collected from service records. Analysis relating assessment data to resource use.

Diagrammatic representation of the study design

	Control Group	Intervention Group
sample size	210	210
	Referred and assessed using current assessment instrument	*Referred and assessed using MDS-HC*
	Assessment by independent assessor using well know standard assessment instruments	
measurement of care inputs	Home care hours Community nurse hours informal carer hours Meals on wheels Day centre attendance Day Hospital attendance institutional care admissions and days in institutional care hospital admissions and days in hospital	
	Reassessment using assessment instruments as before at 6 months and 12 months on the same cohort	
	+	
care outcome	accommodation, survival, ADL, IADL, cognitive function, mood, quality of life/social status, carer burden, client view.	

4. Summarised key findings

Organisation of the social services departments

The two Social Service Departments (SSD's) in the study employed different styles of operation which are described in order to give some insight into the extent to which they had a bearing on the findings of the study.

Kent operates a system of care management with referrals allocated by a team leader to care managers who have responsibility for all assessment, including financial, ordering services and checking invoices and reviews. Lewisham referrals are passed on by the duty team to Social workers who are linked to GP practices. The SW's are responsible for the needs assessment and a simple financial assessment based on receipt of benefits. They assess the clients, order services but then close the case, with significant change in circumstance triggering re-referral, possibly to a different SW. Reviews are conducted by telephone by the duty team unless specifically kept on the books of the original SW. Checking of service against invoice is the responsibility of administrative staff. In both sites there was concern that services may be paid for but not received and that reviews 'slip' because of pressure of work.

Kent uses a less structured assessment form than Lewisham with more reliance on free text (see appendix). Checking against eligibility criteria is a task separate from assessment and considered a bureaucratic process in both sites. This is a problem which appears endemic in both health and social care settings, and needs to be addressed. It could be largely overcome by creating a direct link between structured assessment instruments and eligibility criteria based on the standardised assessments. The incorporation of preferences and professional opinion should not be undermined by the development of these direct links.

Findings from the assessment data

The social services clients in Kent were less likely to be living alone and more likely to have an informal carer. The Kent community care assessments (CCA's) had very many missing data items and summary scales for examining key outcome indicators could not be computed from the assessments nor comparisons made between initial assessment and re-assessment. Even when free text was coded by hand, it is probable that important potential problems were under reported. The Lewisham CCA's, although not as comprehensive in coverage as the MDS-HC were more likely to be able to produce valid summary scales for monitoring

outcome of care. Comparisons between initial assessment and reassessments were limited by missing data and the limited number of the relevant standardised outcome assessment items.

There were very few incomplete MDS-HC assessment items in either site. The summary scales for monitoring outcome were valid (when compared with the Gold Standard Instruments) with the exception of the depression scale which needs further research (currently underway). The assessment of cognitive function and informal carers was better than that of both the Kent and the Lewisham assessment forms. The information from the assessments produced aggregated data enabling examination of outcome, relationship of assessment with services provided and changes at the level of the individual and the whole population.

Clear differences in the way services provided were related to client characteristics were evident between the two SSD's. In Lewisham the MDS-HC data showed a strong relationship between services provided and physical dependency and whether the person was living alone. In Kent this relationship was with living alone only and not with dependency. The MDS HC level of care grouping system showed that people Lewisham were clearly receiving services on the basis of level of care need. This relationship did not exist in Kent.

It was not possible to make any comparisons between Kent and Lewisham on the basis of their current community care assessment instruments because of non comparable data and missing items. It may be that items were only filled in if the person was believed to have a problem or that the problem was recorded in free text and therefore not accessible for computer analysis. However recoding of free text in Kent assessments showed that it was likely that problems were being missed as the prevalence of some problems appeared to be lower in the control than the intervention groups. If a problem was identified at reassessment, but there was no record of presence or absence of the indicator at initial assessment, then one could not know if the problem was absent at initial assessment or simply had not been recorded.

The MDS-HC demonstrated the major benefits of standardised assessment. It included valid informative outcome scales, could compare populations over time and showed changes in individuals over time and the impact of changes on informal carers. The Level of Care case mix system gave clear information at a macro level of the differences in outcome between people with differing levels of disability. Clear relationships between client characteristics and services provided and informal carer burden could also be demonstrated. These would be

helpful in providing assessment related criteria for eligibility for different levels of service provision.

Interviews with the Social workers

Overall, structured assessment forms were preferred but all SW's wanted to be able to include free text descriptions. There was a view in Kent that standardised assessment was 'medical', this was less prevalent in Lewisham. It may be that in Lewisham this view was less prevalent for two reasons. First because there was already standardisation of responses in some areas of the Lewisham assessment and second because there was a closer relationship between SW's and GP practices as they were practice linked, whereas in Kent they were not. All found the MDS-HC health orientated, but Lewisham were more positive about the inclusion of health items in the social care assessment. The Kent care managers generally felt that health matters were not their responsibility. There was a general view that nearly all areas in the MDS-HC were relevant to community care, although there was no agreement on which areas were not. Housing needs, apart from an assessment of environmental risk were generally not considered to be the responsibility of social workers. Though they clearly remain in some quarters, some of these views on 'health' and 'housing' matters are antithetical to modern approaches to assessment. Housing impacts not just on risk but is a determinant of ADL, mobility and other factors, and 'health' factors are frequently remediable factors underlying disability.

When asked how long it took to complete a full assessment, there seemed to be little difference between the time taken to complete an MDS-HC and that taken to complete the current assessment of needs, although assessors did complain that it tended to take too long to complete an HC. There was a view that they explored more areas using the HC and that the resulting assessment interview was a more formal process. There was however concern that using the standardised responses alone did not allow a reliable record of the needs and that the resulting assessments were difficult to interpret. Many also wanted to be able to leave out sections that were clearly not relevant to the clients they were assessing.

The social care element that may currently be missing from the MDS-HC is the relationship between the clients' disability as a result of chronic (and non remediable disease) and the responses that they have in place. The gap between needs as a result of non-remediable disability and existing support for these needs is the focus of "social care". With focussed attention, the MDS-HC could be developed to address this aspect in which it is relatively weak in a way that complements its clear existing strengths.

Conclusions

The case for standardised assessment is overwhelming as it will provide clear benefits in monitoring outcomes of social care and relationships between assessed needs and services provided. The assessment instruments should at least all cover the domains important for monitoring outcomes. Even if SSD's do not use the same assessment instrument, then the assessment items should be comparable so that accurate comparison can be made between sites. It is impossible to make comparisons using non-standardised assessment and there was evidence that problems were being missed when non-standardised items were used. Furthermore, both the CCA's in this study did not include some important domains and comparisons between the two sites was not possible using CCA data. Standardised assessment may well improve outcomes, but this remains unproven in this study, if for no other reason than that the sample size was too small, as was anticipated in the design.

The MDS-HC could be used as a common assessment if the format were revised to make it easier to use and interpret, free text boxes were included in the assessment and a mechanism provided for assessing clinical areas that assessors found particularly difficult, such as diagnoses and some of the more clinical services. A further benefit would be a reduced assessment instrument for use as a 'screener' so that lengthy assessments need not necessarily be completed for all light care clients. A structured link between a screening assessment and a full assessment for people found to have problems by the screener would be an important feature. This would reduce the risk of remediable problems being missed as a consequence of insufficiently comprehensive assessments for people that it would benefit.

Concerns about reliability of accurate recording of ADL's, cognitive function and carer burden using standardised items was not borne out by the evidence from the gold standard assessments which showed adequate correlation with the MDS-HC items, with the exception of the assessment of mood.

A link between assessment and further guidelines is helpful as there was a general feeling that the assessment protocols in the HC were informative although the manual provided with the HC was used for 'dipping into' rather than systematically to assist with the assessment process. Clearer links between the MDS-HC assessment form, the assessment protocols and care planning could address this need.

Incorporation of the study findings into a revised standardised assessment

As a consequence of the study findings, the MDS-HC layout has been improved. The system of triggers linking assessments to Client Assessment Protocols (e.g. potential for rehabilitation) has been clarified. Free text can now be recorded in specific domains to assist care planning and clarification of important factors related to the assessment.

A shortened form, the MDS-HC Screener, has been developed for assessment of less complex clients. It consists of a sub-set of MDS-HC items including the key outcome scales and algorithms of the full HC and sections organised into domains for free text entry. A supplement has been developed that includes additional items from the HC so that a more complete assessment can be conducted where there have been found to be problems or risk of problems identified using the screener. Both the screener and the supplement include links to the Client Assessment Protocols of the HC to support care planning. For clients with complex needs the full MDS-HC can still be used.

The revised assessment forms retain the integrity of the MDS assessment system permitting reliable and valid comparisons with people assessed in other settings using MDS instruments including nursing homes, acute care and mental health care institutions.

High quality PC based computer software for direct or post assessment entry of assessment data with the capacity to produce immediate CAP reports and outcome scales, aggregate assessment data for management and policy makers and for benchmarking services and providers is now available.

Further work on the "social care" aspects as described above remains the final piece to be put in place.

5. Organisation of the social services departments

The Social Service departments operated different management styles and assessment forms. This had significant consequences on the way assessments were conducted and the information on outcomes that could be extracted from the assessment forms.

Case allocation and case load

Management of referrals and case load were significantly different between Kent and Lewisham. Kent care managers kept their cases and had greater on going case-loads. In Lewisham cases were closed once services had been supplied and the situation was stable. In

Kent referrals are allocated by the duty team manger with time from referral to assessment about 2-3 weeks. In Lewisham allocation is determined by the social workers' links to specific GP practices. Time from referral to assessment was usually 2-10 days

Kent

When a person is first referred to the SSD they are allocated a care manager who will remain that person's care manger with on-going responsibility for him/her. Incoming referrals go to the duty team. Some are screened out at this stage. Referrals requiring further assessment are allocated to individual care managers at weekly meetings. Assessments are undertaken within 2-3 weeks of allocation depending on work load. Urgent referrals are usually dealt with by the duty care manager. The care managers also undertake a financial assessment to determine the contribution to be made by the client. Clients' financial contributions to the costs of care were significantly greater in Kent than in Lewisham.

Lewisham,

When a person was referred, they would be allocated to a social worker who would conduct the assessment, devise a care plan and arrange for the care to be delivered. Social Workers are linked to individual GP practices. Referrals are taken by a duty officer who grades the urgency of the referral and sends it on to the appropriate Social Worker or an alternative if the appropriate person was not available. Assessments are usually undertaken between 2-10 days after referral to the appropiate social worker. Some delays occur as a result of allocation to the linked social worker rather than to a SW who was available. Urgent cases are dealt with by the duty officer.

After assessment when services were in place and the situation was perceived to be stable the social worker would "close" the case. Any change in circumstance that may have required a change in service provision would be re-referred and could as easily be allocated to a different social worker as to the original SW. The social worker had to conduct only a simple financial assessment.

The Kent care managers thus had a) a significant ongoing administrative work load which was greater than that in Lewisham and b) a greater caseload 90 vs 20 c) longer duration of case management, up to 2 years cf. 6 weeks and c) a lower turn-over of clients about 50% turn over of cases per year.

Ordering of care services

In Kent, service orders and changes are the responsibility of care managers as is checking services provided against invoices. This is a considerable burden, probably resulting in inaccuracies in invoicing by and payment to providers. In Lewisham, changes are organised by the duty team and checked by administrative staff resulting in some doubt about whether paid for services are always delivered. Major changes trigger reallocation to a SW.

Kent

The care managers are responsible for all service ordering and service changes however minor and for entering orders into the computer system for billing purposes. Minor changes to services are on occasions made by telephone to the provider. There is considerable uncertainty about the accuracy of billing as the care managers are also responsible for checking invoices, all contributing to a perceived large administrative burden.

Lewisham

Minor service ordering and service changes are arranged by the duty team, or sometimes by the client direct with the service provider, particularly in the case of service reductions. Major changes in service need trigger reallocation to a SW and reassessment. There is concern that services may have been billed for but not received, as administrative staff have difficulty in keeping track of changes when the client did not have an ongoing allocated social worker.

Review Assessments

In Kent, care managers should conduct reviews at 6 months or change in circumstance and a financial review yearly or when there is a change in service provision. In Lewisham telephone reviews are done at six months by the duty team and social workers conduct only simple financial assessments as there is a low maximum contribution required from clients. Some people are reviewed by the SW at 6 weeks and some marked specifically for review by the initial SW at one year. In both sites reviews 'slip' as a result of pressure of work.

Kent

Reviews are supposed to take place every six months and when there is a change in circumstances. People in Nursing and Residential homes should be reviewed yearly. If there is a substantial change in circumstance then a full reassessment should be carried out. A new financial assessment should be triggered by any change in service and in any case should be done annually. Reviews were perceived as "slipping" because of pressure of work.

Lewisham

There should be yearly reviews in NH and RH and six monthly by telephone in the community. SW's mark some people for telephone review by the duty team at three months and some specifically for review by themselves at one year. Some they review themselves at six weeks. The process is seen as rather ad hoc and generally unsatisfactory because of pressures of workload.

Drop Outs

In Kent many people appeared to drop out after referral and before full assessment. In Lewisham there appeared to be few drop outs (table 1).

Kent

The SW team felt that there were few drop outs apart from people dying or moving away. The data from this study however suggest that a significant number of people dropout between referral and assessment or at least before full assessment. Reasons include the person not wanting or not needing services and some people dying after referral and before full assessment.

Lewisham

Very few drop outs. Reasons cited included that between referral and assessment the need had changed or gone.

6. Assessment data analysis

The study population

The target samples were achieved except for the Lewisham control group where 50% was achieved. No 2nd reassessments and few Gold Standard Assessments could be conducted in Kent.

The numbers of people recruited and assessed during the course of the study are shown in tables 1 and 2. 100% of target numbers were recruited in intervention and control groups in Kent and the intervention group in Lewisham. Just over 50% of the target number was achieved in the control group in Lewisham. Consent for assessment by the research team using gold standard instruments (GSI's) was difficult and resulted in very few GSI's in Kent and a significant dropping off of reassessments in Lewisham, as people declined to take part

in further assessments during the course of the study. There was an average of 181 days (std. dev. 41) between initial assessment and 1st reassessment and 168 days (std. dev. 47) between 1st and 2nd reassessments.

People in Lewisham were more likely to be living alone and not have an informal carer

There was no significant difference between the intervention and study groups or between sites in the age and gender distribution of the population. There was no information in the Lewisham CCA on whether the person lived alone although significantly more people in the intervention group lived alone than did in Kent. Fewer people in Lewisham had an informal carer, table 3.

Withdrawals from the study were similar in both sites and intervention and control groups although only 29% of Lewisham control group had a 2nd reassessment

Reasons for withdrawal from the study are shown in table 4. There was no significant difference in numbers dying or not completing the study for other reasons between centres or between intervention and study groups. The reasons summarised under "other" included declined further assessment, moved, changed social worker and no longer received services. In Lewisham many control group 2nd reassessments were not completed because of operational difficulties.

Criteria for determining ability to monitor outcomes

We chose a number of criteria with which to determine the ability of the MDS-HC and the CCA assessment instruments to monitor outcomes of care. The indicators for the study were change of living accommodation, survival, Activities of Daily Living (ADL), bowel and bladder continence, extended/instrumental activities of daily living (IADL), cognitive function, mood, quality of life and assessment of social status and carer burden. These criteria are displayed in Box 1.

BOX 1

Criteria for comparing the ability of assessment instruments to measure outcomes of care

	Criterion	How measured	MDS-HC	Current Assessments	
				Kent	Lewisham
1	Can the assessment data be computerised?	The capacity to code assessment items for computer analysis	Yes	Partially only	Most outcome items
2	Are the outcome indicators present in the assessment?	% of outcome indicators completed/present	Nearly 100% completed for most items	Several missing Av. 50% completed	Most present Av. 75% completed
3	Are the outcome indicators valid and reliable?	Correlation of indicators with gold standard instruments "secondary" validity by comparing prevalence of indicators in the control and intervention groups Reliability not reported in this study	Acceptable except for depression	No Under reporting probable	Acceptable
5	Can the assessment instrument monitor change in population over time?	Data presented	Yes	Limited because of missing items	Limited because of missing items
6	Can the assessment instrument monitor change in individuals over time?	Data presented	Yes	Limited because of missing items	Limited because of missing items
4	Can the assessment instrument identify different sub-populations?	Identify people who should look different and have different outcomes	Generally yes	Probably not	Limited because of missing items
7	Can the assessment instrument produce produce timely information?	Discussed	If computerised yes	Paper form only	Mainly paper form only
8	Is information showing change/outcome readily available to assessors and managers?	Discussed	Yes if computerised paper form if modified and with experience in use	Individual basis only, limited by missing data	Some on aggregated basis, limited by missing data
9	Is the assessment instrument usable by assessors	Addressed in report of interviews with care managers/social workers	Some strengths and weakness, needs modification	Issues discussed	Issues discussed
10	Is the assessment instrument acceptable to those assessed?	Not addressed in this study			

Can the assessment data be computerised?

All of the MDS-HC and most of the Lewisham CCA could be easily computerised.

The MDS-HC was designed to be easily entered into a computer for analysis. The Kent CCA had some items with Y/N responses, but some were difficult to answer. All assessment domains had associated free text and the social workers generally relied on free text to record their assessment findings. These could only be computerised for analysis after lengthy encoding which would not be practicable outside a research project. The Lewisham CCA was structured in such a way that the majority of the indicators could be entered into a computer.

Are the outcome indicators present in the assessment?

We recorded presence or absence of outcome indicators in the assessment instruments and the percentage of assessments in which the item was completed.

We also examined a) whether completion rates remained consistent at reassessments and b) whether the indicators present could be used to create subscales for ADL, IADL, depressed mood and cognitive function scales.

Accommodation, ADL, bowel and bladder continence.

Some items were not present in the CCA's. An average of 50% were completed in Kent CCA's and 85% in Lewisham CCA's. Almost 100% of HC items were completed

The percentage of completed items for accommodation, who the person was living with, ADL and bowel and bladder continence is shown in table 5.

The type of accommodation was recorded in half of Kent CCA's and nearly all of Lewisham CCA's. Who the person lived with was recorded in 39% of Kent CCA's and not present as an item in the Lewisham CCA's. Both these indicators were completed in nearly all of the Kent and Lewisham HC's.

There are 9 ADL items in the MDS-HC and the Lewisham CCA and 7 in the Kent CCA which did not include the ability to bathe or use the toilet. They were more likely to have been completed in the Lewisham than the Kent CCA (86% cf 48%). ADL items were completed in nearly all HC assessments (table 5).

The prevalence of completed items changed little from the initial to 1st reassessment in Kent (table 6), although in Lewisham fewer were completed in the first CCA reassessment (table 7). HC items were completed in nearly 100% at all assessments (tables 6&7).

The MDS-HC has a validated 4 item ADL scale composed of early, mid and late loss ADL's (washing/personal hygiene, mobility, ability to feed oneself and ability to use the toilet) [32]. We used this as a minimum number of items to create a scale that could have general utility.

In Kent, each ADL was recorded as two separate items: whether the person was able to carry out the ADL unaided (recorded Yes or No) and whether the person required assistance (recorded Yes or No). Using only the ability to carry out the ADL unaided in three areas (ability to use the toilet not present in the Kent CCA), an ADL scale could be created for only 25% of assessments compared with a 4 item scale created for 67% of Lewisham CCA assessments. The ADL scale could be completed for nearly 100% HC assessments in both areas (table 5).

IADL's and speech, hearing and vision

The Kent CCA had only 1 IADL item. In Lewisham IADL items were recorded in 73% of CCA assessments but only 54% of the 2nd reassessments. Sensory items were recorded in 65% of CCA assessments in Kent and nearly all in Lewisham. Almost 100% of HC items were completed. IADL scales could be completed for no Kent assessments and 47 – 60% of Lewisham assessments, and for nearly all HC assessments.

The presence and completion of IADL items in the CCA's and HC assessments for each area are shown in table 8. There were a total of 8 IADL assessment items as well as one each for speech, hearing and vision. The Kent CCA included only one IADL item (mobility outside the home/use of public transport) of which 28% had been completed. Between 58 and 67% of the other items were completed. The Lewisham CCA included 6 IADL items of which 73% were completed. The MDS-HC IADL items were completed in nearly all assessments.

There was little change in the completion rates of IADL items at 1st reassessments although at 2nd reassessment the percentage completed in the Lewisham CCA fell from a mean of 75% to 54% (tables 9-10).

An IADL scale can be constructed by adding the scores for each item. This was not possible in Kent with just one IADL item, but in Lewisham a scale could be scored for 47% at the initial assessment, 60% at 1st reassessment and just 31% at the 2nd. An IADL scale could be completed for nearly all HC assessments.

Speech, hearing and vision were completed in nearly all HC assessments and in >85% in the Lewisham CCA's. The items were not completed in >35% of Kent CCA's. There was little variation between initial and 1st and 2nd reassessments.

Cognition Mood and Behaviour

Mental state items were completed in around half of Kent CCA's. Lewisham had only 2 cognition items. They were completed in around 80% of assessments. Behaviour items were completed in 30% of Kent CCA's and very few Lewisham CCA's reflecting the low prevalence of these items. They were completed in nearly all HC assessments.

There are 5 domains covering memory, confusion, comprehension, anxiety and depression in the MDS-HC. The Kent CCA covers all of these domains, Lewisham just 2 – memory and depression. The items were completed in nearly all HC assessments, in between 36% and 60% of Kent CCA's and 69% and 99% of Lewisham CCA's (table 11). There was little variation between initial and 1st and 2nd reassessments (tables12-13).

The HC has 6 behaviour items, the Kent CCA 7 and Lewisham 6 (table 11) but they were not the same in all the three assessment instruments. The Lewisham CCA items were designed so that they would only be completed where a problem was present. Only 30-33% of the Kent CCA items were completed, nearly 100% of the HC items. Low rates of completion of the Lewisham CCA items reflected the low prevalence of these problems in this population .

Carer status

Items on carer status were poorly represented in the CCA's. They were completed in nearly all HC's where there was an informal carer.

The MDS HC has items that address presence of informal carers, carer burden and care input from informal carers. In the Kent CCA's, there was a single item on carer input, but it was not possible to determine if this referred to formal or informal care. It was completed in just 12% of cases. In Lewisham CCA's a single item on carer's situation was completed in 67% of assessments.

Where the older person had an informal carer, the items on care burden and carer input were completed in nearly 100% of the HC assessments in Kent and over 90% in Lewisham.

Are the outcome indicators valid and reliable?

Validation of outcome indicators was by comparison with Gold Standard Instrument assessment scales (GSI's). The GSI's used in this study were the Barthel ADL scale, the Lawton IADL scale, the Mini-Mental State Examination (MMSE), the Geriatric Depression Scale and the Relatives Strain Scale (RSS). The Barthel, Lawton IADL, MMSE and GDS were completed on people consenting to assessment by the research team and the RSS in the carers of consenting clients.

There was great difficulty in gaining consent from people in Kent and attempts to recruit for the validation assessments had to be abandoned.

During the course of the study increasing numbers of people declined GSI assessments. 65% of Lewisham initial intervention group assessments, 57% of 1st reassessments and 46% of second reassessments had GSI assessments. Corresponding response rates for the Lewisham control group were 50%, 42% and 63%. There were large numbers of people who had no informal carer in Lewisham and the numbers completing the RSS was very low. Correlation with the GSI's was used as the indicator of validity of the HC and the CCA scales.

Validity of the ADL and IADL, cognitive function, mood and carer burden scales and continence items

There was no correlation of the GSI's with the Kent CCA scales. In Lewisham correlation was adequate except for bowel continence. For the HC, correlation was adequate except for the mood scale. If only negative affect items of the GDS were used, correlation with the HC mood scale was better. Correlation with the GSI carer items was not possible for the CCA's in either site. Although there were too few carer GSI's to confirm validity conclusively, a relationship with HC assessment items was demonstrated.

There were few GSI's completed in Kent and correlation of the GSI's with the CCA items where a scale could be constructed was non significant in all domains.

The Lewisham ADL and IADL scales were taken almost directly from the Barthel and Duke OARS and correlations with CCA items were excellent ADL ($R = -.081$, $p < 0.001$), IADL ($R = -0.87$, $p < 0.001$). Correlation for assessment of cognitive function (2 items only), mood and continence were also acceptable. There was poor correlation for the bowel continence item.

Correlations of GSI with HC items was acceptable and significant for all the domains except mood, where correlation was low although significant (table 15). When only the negative affect items of the Geriatric Depression Scale were compared with the HC mood scale correlation was better ($R = 0.33$, $p < .001$).

Only 37 carer questionnaires were returned complete. Mean RSS score for those with an HC indicator of carer strain was 30.6 compared with 21.8 for those with no indicator of carer strain (t-test $p < 0.05$).

The HC clearly is weak in assessment of mood, but sound in assessment of the other domains. The Lewisham assessment items that could be used were well correlated with the exception of bowel continence.

Further analysis of Kent CCA

When free text from the Kent CCA's was coded, prevalence of dependency in ADL was broadly similar to that in the Kent study group. However there was probably under-reporting of IADL dependency, communication difficulties and cognitive impairment in the Kent CCA.

The Kent CCA had free text boxes for every section of the assessment that contained Y/N tick boxes. We postulated that where the tick boxes had no information recorded, the free text boxes may have contained information relevant to those assessment items. We therefore reviewed all the free text and where possible coded the relevant assessment item using an MDS–HC coding system for each item. We then combined the Y/N coded items with the recoded free text and re-analysed the forms. Using the recoded CCA's items we compared the prevalence of dependency in the control group with the intervention group in Kent. These data are shown in tables 16-18

For ADL's the proportions was broadly similar in the two groups. More people assessed with the CCA were recorded as dependent in mobility in bed and walking. Significantly more of the people assessed using the HC were recorded as dependent in toileting, bowel continence and ability to use stairs.

There was very little information on IADL's in the Kent CCA, but where recorded (shopping, using appliances/cooking and mobility outside the home/using public transport) more were dependent in the HC sample than in the CCA. The same was true for speech and hearing, presence of confusion and difficulties with comprehension, although depressed mood and memory loss were recorded in similar proportions of both groups.

With the exception of most ADL's, it is probable that information of use for monitoring outcomes was under-recorded in the Kent CCA.

Can the assessment instrument monitor change in population over time?

MDS-HC data show that there was a gradual increase in physical dependency and cognitive impairment over time and that carer burden reduced after the initial assessments. People with greater physical dependency tended to die sooner. Where comparisons could be made in the Lewisham control group, they did not show a similar pattern, there being little difference between assessments. No comparisons could be made using Kent CCA's.

Tables 19-21 show the mean scores of MDS-HC outcome scales for the intervention group at each assessment. Table 19 shows these scores for all assessments, table 20 for those assessed twice and table 21 for those assessed on three occasions. ADL and IADL scores tended to increase over time and carer burden decreased. The initial scores for those who were assessed on three occasions were

generally lower than for those who were assessed only once. This is explained by the fact that people with higher scores at initial assessment were more likely to die before subsequent assessments.

Comparisons were not possible with Kent CCA forms because of inconsistencies in recording the presence and absence of significant problems. On some occasions people no record was made for an assessment item when it may have meant that the person did not have a problem and on other occasions the item was simply not completed. Comparisons were possible for some of the outcome indicators in Lewisham and these are shown in tables 22-23. The patterns of change seen in the HC assessments were not apparent, there being little difference between assessments. The reason for this is not evident.

Can the assessment instrument monitor change in individuals over time?

Case histories can be constructed from MDS-HC data to show a clear picture of change in an individual's circumstances over time.

Information from HC assessments of three people have been used to construct a picture of change in circumstance of these individuals over time:

Case history 1.

Mr X was an 86 year old man with dementia and chronic obstructive airways disease (case-id 349) who lived with his wife. She felt distressed and unable to continue caring for him at the time of initial assessment. They lived in accommodation specially designed for older people where he was not dependent in his personal activities of daily living but completely unable to carry out any instrumental activities of daily living. He wandered and was physically and verbally abusive to his wife. They stayed in their home where over the course of the year his cognitive function deteriorated. By the first reassessment however, care goals had been met and his wife was no longer distressed and felt able to continue caring for him. See figure 1.

Case history 2.

Mrs Y was an 88 year old widow living alone in private accommodation. Her condition had deteriorated during the previous 90 days and she had been in hospital. A relative was staying with her at the time of the initial assessment and was providing a lot of support 7 days a week. She had some visual impairment and was feeling depressed. She was able to perform her activities of daily living with some 'set up help' but was unable to prepare her meals, do her housework, shopping or use public transport. Her short term memory was not good and she had some difficulty making

decisions about her daily life. She had arthritis, was unsteady on her feet and was taking an antibiotic. She had been receiving radiotherapy, and had also had some physiotherapy and occupational therapy and a visiting nurse. 1 year later, her cognitive function had improved and she was able to do some of her housework and use public transport with assistance. Her informal carer was no longer needing to provide support, she was receiving meals on wheels and the community physiotherapist was visiting. Her care needs had reduced. Although now alone, she was not distressed by it and she no longer felt depressed. See figure 2.

Case history 3.

Mr Y was a 75 year old gentleman (case-id 203) who was living alone in private accommodation at his initial assessment. He suffered from arthritis and osteoporosis, had fallen and was having dressings for cuts or skin tears. He was suffering from pain in multiple sites that was not adequately controlled with medication provided. He was disabled but not cognitively impaired. He was alone all the time, was ill at ease with others and his social activities had declined which distressed him. He received meals on wheels 7 days a week. His informal carer was unable to provide any additional support with activities of daily living or emotional support and he and his carers felt that he would be better off in alternative accommodation as neither he nor they felt that his condition was likely to improve. By his first reassessment he had moved to long term care. He was no longer alone, no longer distressed by his circumstances, and was now at ease with others. His mood had improved and was no longer in uncontrolled pain.

Can the assessment instrument identify different sub-populations?

MDS-HC data has sufficient information to show relationships between dependency and services provided and showed a relationship with ADL score in Lewisham only and with living alone in both sites. A casemix grouping system showed that in Lewisham care time was associated with Level of Care groups indicating higher levels of need. These higher need groups were also more likely to die or deteriorate than the lower need groups.

The CCA data requires at least resource use information from another source to determine a relationship with services provided and certainly a more standardised assessment than that used in Kent.

Published research data report characteristics of individuals who may be expected to die or decline in physical function over time. In addition, one would expect to identify characteristics of individuals that relate to the support services they receive and possibly strain in their carers. Comparison of populations using individual assessment items, such as ability to walk or bladder

continence is of interest, but aggregated measures such as ADL and cognitive performance scales increase the utility of assessment data. Furthermore, information that can be aggregated to a higher level such as is achieved by casemix groupings can provide even greater understanding of the characteristics of populations and are important for monitoring the performance of service providers.

The MDS HC records service input from health and social care professionals. We examined the relationships of the total care assistant and nursing care provided with clients' personal characteristics at the 1st and 2nd reassessments. People in Lewisham received significantly more personal and nursing care in the 14 days prior to the first reassessment than those in Kent (4.8, s.d. 6.1 vs 12.3, s.d. 30.9, t-test $p < 0.05$). The relationships were different in the two sites.

Table 24 shows the relationship of initial ADL, IADL, cognitive function, living alone and the presence of an informal carer with personal and nursing care time in the 2 weeks prior to the first re-assessment, on the grounds that the care provided at this time would have been on the basis of the information gathered at the initial assessment. There was a significant relationship with ADL score and care provided in Lewisham, but there were no other significant relationships in Kent. The results of a linear regression model with personal and nursing care time as the dependent variable and ADL, living alone and presence of a formal carer as independent variables is shown in Table 25. In Kent there was a significant relationship only with whether the person was living alone ($p = 0.02$), whereas in Lewisham ADL score ($p < 0.01$) and living alone ($p = 0.01$) were significantly related to care time.

The MI-CHOICE level of care casemix grouping system gives five levels of care (LoC) on the basis of an MDS-HC assessment. These LoC's in ascending order of complexity of care needs are; information and referral only: home help type care: personal care such as can be provided by care assistants: nursing care at home (personal care plus nursing care): and nursing home (a need for care that might otherwise be provided in a nursing home). Table 26 shows no difference between the two sites in the distribution of the populations by MI-CHOICE level of care group at initial assessment. Table 27 shows average care time in the 2 weeks prior to the 1st re-assessment by LoC in Kent and Lewisham. It is clear that the provision of care in Lewisham was related to LoC whereas there was no relationship with LoC in Kent.

A further use of a casemix grouping system is for comparing outcomes in sub populations. Table 28 shows that people in the LoC groups with higher care needs were more likely to have died by the end of the study. Figure 3 shows that in general, people in the more dependent groups deteriorated and those in the less dependent improved by the 1st re-assessment.

7. Interviews with the care managers and social workers

Perceptions of the current assessment process and forms

Assessors generally liked good structure in assessment forms. In Lewisham where there was some standardisation and gradation of responses to assessment items, tick boxes were viewed more positively than in Kent, where the tick boxes were Y/N and difficult to answer. All wanted areas for free text. Assessment visits in Kent had to cover several areas and was particularly time consuming and potentially tiring for the client.

Assessment was seen as providing a picture of need, anything from a full assessment of need to a snapshot of need, including a record of biographical details, likes and dislikes and information on informal carers views and a record of tensions etc. Uses of the assessment form included making information available to others, keeping a reference point for future comparison and also as a basis for justifying services offered (to the client as well) and ordering them. In Kent, assessment was generally felt as being an on-going process, in Lewisham it was closely linked to completion of the assessment form.

There were varied views on the amount of structure required. Both forms had sections with tick boxes and areas for free text. In Kent the text boxes were Y/N and in Lewisham they tended to be a tick that selected one of several options for a particular domain of assessment – e.g. walking, dressing, feeding etc. The Kent tick boxes were not felt to be particularly helpful and some were actually impossible to answer –(e.g. mobile unaided/wheelchair bound - Y/N). In Lewisham where tick boxes gave more graded responses, they were viewed more positively. All wanted free text sections to give further information that qualified anything recorded in tick boxes. There was a general feeling that an assessment form should be structured to assist thoroughness and also that it should be not just about disability but also potential. Similarly there was a desire to allow for some record of the actual process of assessment:–

> *"There's nowhere to put well you feel this about her but she says this. There's nothing very much about the assessor's view."*

There were also differing views on how much the assessment form should include information on the informal carer. Some felt that there should be a separate assessment form for carers. There was a shared view that the process should not be too long as many of the old frail people tired easily.

The assessment process was seen as complex with many components. In Kent the assessors typically felt that they had to proceed through a number of steps:

1 Reassure the person that they were not going to be "put in a home"

2 Establish trust

3 Conduct a financial assessment

4 Conduct a formal assessment of need

5 Include an assessment or at least contribution of views of informal carers

6 Agree a care package.

This meant that the client was often tired before the actual assessment of need commenced. Also it was frequently difficult to determine if information supplied by the person being assessed was accurate and true.

Eligibility Criteria

Completing and using an eligibility criteria assessment was thought bureaucratic and not necessarily helpful in meeting the client's needs. The numerical eligibility scoring system in Kent was considered sometimes frustrating as it did not allow for recording general ability to cope or problems related to cognitive impairment.

Kent care managers were required to complete a formal eligibility criteria checklist. In Lewisham there were written criteria but they were not used in the same way as in Kent. There was concern that they did not accurately describe the level of need as two people could look the same on paper but one could be far better able to "cope" and therefore need fewer support services. Both groups of social workers did use being ineligible as a reason for not providing services however. In Kent using the current eligibility scoring system was found frustrating, as it could not differentiate the need for supervision or support resulting from cognitive impairment. Completing separate eligibility criteria was generally considered a bureaucratic task, not always relevant to the care of the person.

Financial Assessment

In Kent financial assessments were time consuming, thorough and frequently seen as intrusive by the clients. Results of the financial assessment had profound effects on whether the person agreed to receive services or not. In Lewisham where the maximum charge was £14.50 and was dependent on a relatively simple check on receipt of benefits, there seemed to be less of a problem.

Kent

Financial assessment was a significant part of the assessment and work of the care managers. It

involved recording information on all sources of income and inspecting documentary evidence. The care managers felt that it was time consuming and intrusive and often they would not complete the financial assessment at the first visit. The old people themselves frequently resented the assessment and having to produce bank statements etc. Many would opt to pay for all services privately rather than go through the financial assessment process. It was generally felt to have a profound effect on the actual services finally provided.

Lewisham

The maximum charge for a care package in Lewisham was £14.50 and charges were determined by receipt of means and non-means tested benefits. The assessment documents included a simple benefits check. If residential or nursing home care was required then a member of the finance department completed the financial assessment.

The process of conducting and recording the assessment

Both sites had the option of using a briefer assessment if needs were considered low. The way assessment forms were completed varied, some SW's filled them in during the visit, some after, and some left sections blank if they were felt not to be relevant. In Kent the assessment process could take place over a number of visits. Time taken to complete a full assessment of need varied from between a half and two hours.

Assessments were conducted in a more or less formal manner varying from one assessor to another. Some would formally work through the assessment documentation asking questions in the order and form that they appeared on the form and others would have a less structured discussion covering the areas of assessment. Some would complete the assessment documentation at the time and some after the assessment.

In Kent care managers had the option of completing a simple assessment of need rather than a full assessment if the cost of the care package was less than £100. The full assessment process could take place over a number of visits in many cases. Some social workers would complete only the parts of the assessment documentation they felt applied to that individual.

In Lewisham there is now meant to be a simple assessment form and then a full assessment for those requiring more information. The social workers tended to use the full assessment only. Again not all would complete the whole assessment, some only those parts felt relevant for that individual.

The time taken to complete an assessment of need ranged from half an hour to two hours. The mean was between one and one and half hours. It was difficult to be definitive about exact time

however as in Kent the assessors were frequently assessing someone they partially already knew, and frequently the assessment was completed over a number of visits.

Identifying health and housing needs

There were mixed views on whether the assessment should cover health needs. Inclusion of structured assessment of health needs was generally welcomed in Lewisham. Apart from an assessment of environmental risk, housing needs were not considered as part of their assessment.

There were mixed views about the extent to which the Social workers should be identifying health needs. A common view was that if there appeared to be a health need then the person should be referred to the GP or community nurse for assessment. In both settings the existing assessment forms were designed to record disability or handicap rather than impairment or medical diagnosis. In Lewisham there was general support for a more structured health assessment component as they felt that this would enable them to make more appropriate referrals to the GP practices.

In both settings the identification of housing need was not felt to be a key issue. Both groups did record some information on environment and need for adaptations and did make referrals to occupational therapists for assessment and provision of aids on occasions.

Views on the MDS-HC

There was much variation in the way in which the structured nature of the HC (which in this study did not include free text boxes) was viewed. Some assessors tried to ensure that every item with scoring or coding was recorded precisely as worded, others used the precise assessment guidance as guidance only. Some items were found to be difficult, for example recording the actual grade of a pressure sore if one existed and also recording diagnoses which was felt to be too medical.

How completed and time required

Some SW's worked through the form systematically, some completed it in a less structured way from deduction of appropriate responses during conversation. It led to more questions being asked and a more formal interview process. It became easier to complete as they became more familiar with it. Average time to complete was between one and a quarter and one and a half hours, but some took longer.

The way in which the MDS-HC was completed varied, but in general the assessors would work systematically through the assessment domains. The extent to which they asked the questions exactly as worded or recorded the code that best matched what the information they had elicited varied. They all said that as they became more familiar with the form it became considerably easier

to complete. They felt that using the HC required them to explore more than they would normally undertake in an assessment and also felt that it made the process more formal. They were also more likely to complete the whole assessment in the client's home than complete it afterwards as was common with existing assessment documentation.

One social worker said that they could complete the entire assessment in 45 minutes, some said that it took up to two hours. Average time to complete was one and a quarter to one and a half hours with those that tried to get higher precision tending to take longer.

Accuracy of information

SW's reported difficulty with some items, especially with the time scales within some items and the more medical items such as diagnosis, and also with some items on support from informal carers.

Some social workers questioned the accuracy of the information they recorded. Particularly difficult was information on disease diagnoses, medication, which health professionals were visiting and the therapies and treatments they were receiving.

Another difficulty related to the time scales for which some problems had been present and whether the person was giving an accurate report of their true ability. Mood and behaviour items were also found to be difficult to ask because of sensitivity. Some of these questions they felt could not be answered at a single visit. They expressed difficulty in determining how much and in what way informal carers spent time helping the client.

Relevance of content

Some SW's were impressed with the extent to which the HC identified health matters that may need further investigation but it was generally felt to be too health oriented leading to discomfort in asking some questions and insufficient attention to social care matters. However there was general agreement that it was all relevant and little agreement on what should be left out.

The HC was generally considered to be too health oriented and the assessors felt uncomfortable asking questions about health items. This appeared to be related to asking question about matters such as urinary and bowel incontinence as well as more specific questions about symptoms and some clinical diagnoses. When asked what items were not relevant there was no consistent view. Some saw the assessment as a radical improvement on their current assessment as it identified health related matters which were important and others felt that health related matters should not be their concern. When asked which parts were not relevant, there was no agreement on what could be omitted as generally they said that it was all relevant. However while the HC did help to identify

Useability of the information

Assessors generally found that it was not easy to get an overall picture of the person they had assessed or interpret the information they had recorded on the HC assessment form. They found the interpretation of scored items more difficult than reading textual reports of abilities.

Using the triggers, CAPs and HC manual

Using the trigger sheets as designed for the project was found time consuming, although with increasing familiarity with the HC, some SW's completed the triggers 'intuitively'. The manual was used as a reference and considered interesting to 'dip into' although it was not much used to assist with completing assessments. Some thought it would be useful for training purposes. Kent SW's generally did not think the assessment and triggers increased referrals to health services, in Lewisham several did.

The HC has a system of assessment protocols (CAPs) which give information on problems, risk factors or potential for improvement triggered by the assessment. These CAPs give general information on the relevant item as well as guidance for further assessment of the triggered item. Some of these triggers are complex and the assessors found using the trigger sheets time consuming. By the end several had started to use the CAP trigger sheets intuitively. A CAP recording sheet was used in the project to record further action taken on triggered areas. Many of these areas were felt to be already being dealt with.

In Kent, the care managers felt that the assessment system including the triggers did not increase the number of referrals to health care services as they felt that they majority of the problems were already known and being dealt with . Lewisham SW's however did feel that more referrals were made and that there was more contact with health services but not always with expected result. The following quote gives an example:

> *"So I rang his doctor and I don't know if he got a bit irritated that I was a bit concerned that this man was having a lot of medication, he's been falling and I'm just wondering really whether. I said I'm not questioning your judgement. I thought I'd better get that in. But I just wondered whether it was all right really because I said about the falling. He was obviously looking at the computer screen and he said no, I think he's fine on what we've given him. I think that's fine. And I really felt like I'd really like to speak to another doctor just for my own peace of mind and I thought maybe that's not the done thing, doctors don't comment on what other doctors have said or what they do."*

health care issues, there was a consistent concern that it did not identify social care issues such as clients' ability to cope and their attitudes to life. Some SW's were concerned that if used *as is* there would be insufficient time to address some important social care issues.

> *"I am concerned that if something like the MDS-HC form came into general usage I think that would be medicalising people. I can see that it would identify people's medical needs more clearly if that's what the aim is but it wouldn't recognise individuality, it wouldn't recognise people's social needs, it wouldn't take into account their attitudes to life, their capacities to cope."*

Weaknesses in content and lack of flexibility of use

SW's generally wanted to be more descriptive in recording information on ADL's, cognitive function and the contribution of informal carers. They also wanted to be able to leave out some areas when they were clearly not relevant to the person they were assessing. There was some confusion caused by time frames for some items being different from the time frames for others.

The assessors expressed concern at the accuracy of the assessment information they recorded with respect to memory loss, cognitive skills for decision making and ability to perform activities of daily living (ADL). For ADL's they stated that while the HC recorded the ability to perform these activities it did not record the difficulty that they had. The instrumental activities of daily living section (IADL's) did record this information. SW's wanted to relate risk to cognitive function and were also concerned that proper assessment of cognitive function could take more than one visit.

Some items of the HC require recording of changes or performance over specific time frames. Assessors often found these difficult to ascertain accurately and also found confusing the fact that some time frames were different for different items.

Assessors wanted to record more information about the feelings, attitudes and contributions of informal carers than they could on the HC assessment form.

There was a feeling amongst some of the assessors that requiring completion of the entire HC assessment for all people resulted in unnecessary extra use of time as some domains were clearly not relevant to some of the people they assessed. They would like to feel able to leave blank items that they felt were not relevant. Also they wanted to have areas for recording free text modulation of some of the areas that they assessed on the highly structured format of the HC. This would enable description of significant in category variance, such as managing to dress independently, but only with great difficulty.

While there was general concern about using the HC assessment form, mainly because of pressure of time, SW's were generally very positive about the MDS-HC manual stating that although they didn't use it to assist with completing the assessment, they thought it was a useful reference on health matters. They had found it very interesting to 'dip into' from time to time. One or two of the assessors indicated that they didn't feel that they had learnt anything new from the manual but most felt that they had learnt new and valuable information. Amongst the positive comments made, one assessor thought that the manual constituted a good, quick reference volume, another felt that it could be useful for training purposes.

Effect on ongoing practice

The majority of the assessors felt that the MDS-HC had had a lasting effect on their assessment practice with greater awareness of health related matters.

The majority of the assessors reported that the use of the MDS-HC had had a lasting effect on their assessment practice. Most indicated that it had increased their awareness of health care issues. Some felt that they now routinely made more referrals to health care professionals, some that it had broadened their focus. However, there was little consensus regarding what they would be more likely to explore in their routine practice. One stated that she was now more likely to ask about older people's teeth and feet, another that she was more aware of skin conditions and sensory impairment, another stated that she was more likely to explore issues surrounding alcohol use. One assessor felt that she was now asking sharper questions in some key areas as an ongoing result of using the MDS-HC as part of the project.

8. Discussion and conclusions

The principal findings of this study are in the context of existing arrangements for managing referrals and assessment in the two sites, the attitudes of the assessors to assessment in general, and their views on their current assessment and the MDS-HC. The case for standardised assessment is overwhelming. The use of the MDS-HC in this study has shown some issues that will be of importance for the developing of policy on assessment in community care in general and the introduction of a common assessment for health and social care. The findings in relation to standardised assessment and the MDS-HC in particular have led to significant changes in its structure to that should make it one of the candidates for use as a common assessment for England.

Care management appears to have a significant influence on the views of the Care Managers and Social Workers

The implementation of care management in Kent clearly gives rise to some perceived difficulties with managing case load and administrative work in relation to monitoring and checking invoicing and the provision of services by care providers. Reviews of need and services provided was different and almost certainly frequently not carried out consistently in either site. The financial assessments and liability for contribution to costs of care was very different and probably had a profound effect on the services actually provided to clients and the extent to which they met need. While not a major focus of this study, this factor is relevant to the findings of the study in understanding some of the differences between the two sites.

Standardised assessment will lead to improvement in the ability to monitor outcomes and would probably be acceptable to assessors.

It is clear that the more standardised assessment of Lewisham was associated with a more complete assessment of domains that are important for successful care in the community than the assessment used in Kent. The MDS-HC assessments were more complete in content and recording of key domains. The fewer incomplete HC assessments could not totally be explained by it being the experimental component of the study. Both the Kent and Lewisham CCA's had significant omissions of key areas. Some of these areas were probably covered in the free text sections of the assessments, but the analysis of the Kent CCA's after coding of the free text suggest that some problems were missed. The non standardised structure meant that data could not be aggregated for the analysis of population need and outcomes of care provided. The differences in the relationships between care provided and client characteristics in the two sites illustrate the importance of using

standardised comparable assessment instruments. "Postcode care" was clearly in evidence but could not be identified by the CCA's.

An additional benefit of the use of standardised assessment is the possibility of identifying groups of clients with different levels of need and different outcomes. The MI-CHOICE level of care case-mix grouping system of the MDS-HC gave easily accessible information on the structure of need in the client groups and the differences in outcome within case mix groups. This system illustrates that the issue of eligibility for care which causes frustration for care managers and social workers could be made simpler by linking eligibility criteria directly to assessment information, with the important proviso that client preference and professional opinion still contribute to final decisions.

There were clear messages about the MDS-HC

There were clear messages about the MDS-HC. Some items were difficult for Social Workers to complete because of their medical nature. Social workers wanted to have areas of free text to give a more flexible description of the client and informal carers circumstances, feelings and preferences and to qualify within category variance. Also clear however, is that there was not much of the MDS-HC that was consistently considered not relevant nor that there was much missing apart from the already mentioned issues relating to the desire for free text and description of some more social care issues. In spite of a frequently stated view on first sight of the MDS-HC that it would take a long time to complete, this did not emerge as a major factor in this study.

In spite of concerns expressed primarily by the Kent Care managers that the structured responses to the assessment items may not give a reliable picture of the client, the correlation of responses with the responses to the Gold Standard instruments with proven validity suggests that this was not so. It may be more due to the fact that Social workers are generally unaccustomed to using standardised assessment items, a view reinforced by the fact that in Lewisham, where the CCA contains some standardised responses, these anxieties were less frequently reported.

The statements that the MDS-HC was too "health oriented" needs exploration. Though not clearly articulated, it is likely that this perception was as a result of the fact that the MDS-HC is designed to identify difficulties in health and social care arenas and recommend intervention to remedy underlying factors or support where these cannot be remedied. The social care element that may be missing is the relationship between the clients' disability as a result of chronic (and non remediable disease) and the responses that they have in place. The gap between needs as a result of non-remediable disability and existing support for these needs is the focus of "social care". With focussed attention, the MDS-HC could be developed to address this aspect in a way that complements its clear existing strengths.

Changes in layout, content and structure of the MDS-HC assessment

Data extracted from the computerised HC assessment records do give extensive information on important outcome domains in the populations assessed, the relationship with services provided and insight into key facts about individuals and their carers. Some SW's found it difficult to get a clear overall picture of their clients from the assessment forms as used in the study. All SW's found the form easier to use with time and would likely find it easier to interpret with improved layout and experience in its use.

In the light of these findings, the MDS-HC assessment system has been modified. The lay out has been improved to make it easier to read, CAP trigger information has been included within the assessment form itself, and an additional section has been added for recording free text. For clients with relatively simple needs requiring a briefer assessment, a new screener has been created from MDS-HC items. The screener was developed systematically on a precise logical basis. It includes the key assessment domains, all the scales and MI-CHOICE case-mix items and a section for free text entry. A supplementary section includes more of the MDS-HC items to provide a more thorough assessment where people are found to have more than the simplest needs during assessment with the screener. The screener incorporates links to the most commonly triggered CAP's, and the supplement incorporates the majority of the remaining CAP triggers.

Further work on the "social care" aspects as described above remains the final piece to put in place.

Conclusions

Introduction of standardised assessment in Social Services would bring key benefits. The MDS-HC and its manual may be able to fulfil this role, and with the amendments made following this study should be one of the candidates for a common assessment instrument for health and social care. Direct input of the assessment into a computer at the time of assessment (such as is already done in Devon) or after completing a paper form is essential for improving the understanding and management of community care.

Whether or not standardised assessment will *improve* outcomes will depend on :

1. The extent to which it identifies facts that would otherwise be missed and the extent to which those missed factors affect care outcome
2. The extent to which the assessor is able to and actually does provide appropriate care planning for identified factors.

Recommendations

General recommendations

Standardised assessment should be introduced into all community care

This should be the same instrument or at least assessment instruments that contain the same items for key domains so that comparison can be made between health and social care providers.

Introducing guidelines linked to the assessment areas may lead to improvement in outcome.

Eligibility criteria should be derived in a large part from the assessment while still taking account of client preference and professional opinion.

Clear guidance on the extent to which health and housing should be addressed by social workers is required.

Benefits of introducing standardised assessment

The benefits of introducing standardised assessment in all social service departments are that it would:

Provide a mechanism by which new health and social care evidence can be introduced into standard practice by modification of the assessment and guidelines

Allow greater control over implementation of policy

Improve monitoring of quality and outcome of care, particularly when case-mix eligibility groups can be derived from the assessment

Provide a mechanism for monitoring the effects of policy decisions

May provide mechanisms for setting funding levels

Requirements for successful introduction of standardised assessment:

If standardised assessment is to be widely introduced, then one must:

Overcome the view of many social workers that standardised assessment is a 'medical model'

Resolve the barrier between health and social care in the eyes of some SW's

Ensure that free text recording is possible in addition to standardised items

Conclusions with respect to the MDS-HC

The MDS-HC could be used in routine practice subject in the light of the following:

The layout has been be improved

It now includes free text areas

There must be additional areas for assessment of a person's biographical details, likes and dislikes and the views and relationships of informal carers in the assessment process. This need not be part of the MDS-HC and could be determined by local preferences

A shorter form of the MDS-HC has been developed for those people who clearly do not have complex needs and has a supplement which can be completed where greater need is identified in the screening assessment.

An improved link between the assessment and the assessment protocols for care-planning has been included in the assessment form

Addressing the fact that some items are difficult for social workers (eg diagnosis and pressure sores) is included in the revised manual

Further (limited) development to improve the social care aspects of management of disability

10. Study design and the assessment instruments used

The Minimum Data Set-Home Care

The MDS-HC has been developed by inter RAI, an international research team, which was initially formed to develop cross national research projects using the Minimum Data Set/ Resident Assessment Instrument (MDS-RAI) (Challis et al., 1996; Hirdes and Carpenter, 1997). The MDS-RAI is a standardised multi-disciplinary assessment instrument for use with older people in an institutional setting and in this setting has been used extensively to measure both the quality and the outcome of care. The MDS-HC has been developed from the MDS-RAI specifically for use with older people in a non-institutional setting (Morris et al., 1997). The MDS-HC is a highly structured standardised assessment instrument, which covers a broad range of assessment domains relevant to both health and social care. A full list of the assessment domains is shown in Box1.

Box 1

MDS-HC Assessment Domains

Cognitive patterns

Communication/hearing patterns

Vision patterns

Mood and behaviour patterns

Social functioning

Informal support services

Physical functioning, self-performance of instrumental and personal activities of daily living

Continence

Disease diagnoses

Health conditions and preventative health measures

Nutrition/ hydration status

Dental status (oral health)

Skin condition

Environmental assessment

Service utilisation

Medications

Responses to individual assessment items within domains are typically recorded by the use of a code which is a digit representing a response category. The MDS-HC assessment form is used in conjunction with the MDS-HC Manual. The manual supplies additional information that clarifies response categories, helping the assessor to chose the appropriate coded response for each item. The assessment form is designed so that specific responses to MDS-HC items or combinations of

responses 'trigger' reference to 30 Client Assessment Protocols (CAPs). Each CAP has a four or five page section in the manual. The CAPS provide the assessor with background information relevant to the identified problem and raise awareness of the presence of problems that may require intervention from health care professionals or other services. The CAPs cover a broad range of topics, these are listed in Box2.

Box2

Client Assessment protocols

Activities of daily living/ rehabilitation potential	Instrumental activities of daily living
Health promotion	Institutional risk
Communication disorders	Visual function
Alcohol abuse and hazardous drinking	Cognition
Behaviour	Depression and anxiety
Elder abuse	Social function
Cardio-respiratory	Dehydration
Falls	Nutrition
Oral health	Pain
Pressure ulcers	Skin and foot conditions
Adherence	Brittle support system
Medication management	Palliative care
Preventative health measures, immunisation and screening	

The MDS-HC has been designed to identify health care issues in addition to the need for social care interventions. As such it recognises that health and social care needs are inter-related and the

resolutions of problems in one arena may affect the requirement for service provision in the other arena.

The highly structured nature of the MDS-HC assessment form potentially enables change in each of the assessment domains to be monitored over time.

Design

The project was designed as a randomised, controlled trial that would compare the MDS-HC with current community care assessment instruments. The primary purpose of the trial was to compare the ability of the MDS-HC and current community care assessment instruments to measure the outcomes of social care in circumstances where individuals are reassessed at intervals.

Study population

210 people of 65 years or over from each local authority newly referred for a 'complex assessment'. A complex assessment was defined as an assessment for multiple service inputs (e.g. home care, meals on wheels), which may be provided by a single agency or multiple agencies (e.g. social services, housing department, NHS).

Methodology

Intevention and control groups. The population was randomised to an intervention and a control group in both the County and in the London Borough. The intervention group were assessed by social workers using the MDS-HC assessment form after receiving training in its use. The control group were assessed using the community care assessment currently in use in that authority. Both control and intervention workers attended meetings where the project design was explained.

Reassessments. All people included in the study were reassessed at intervals of six months and one year after their initial assessment by the same social worker using the same assessment instrument as at the initial assessment.

Gold Standard Instrument interviews. People in the intervention and control groups who gave their consent were interviewed after their SW assessment by a member of the research team using Gold Standard Instruments (GSIs). Informal carers of those assessed using the GSI's were sent a carer's questionnaire to assess carer burden. The GSI's are listed in Box 3.

Box3

Gold Standard Instruments

Those consenting to assessment by research team

Barthel Activities of Daily Living,

Duke OARS,

Mini-Mental State Examination,

Geriatric Depression Scale,

Philadelphia Geriatric Centre Morale Scale,

Informal carers of those assessed by research team

The Relatives' Stress Score,

General Health Questionnaire,

Resource use information. Information on use of health and social care services were collected from the relevant authority data sets and from GSI interviews.

Qualitative component. Semi structured interviews were undertaken with the social workers/ care managers involved in the project, exploring matters relating to community care assessment and their experience of using the MDS-HC or the usual community care assessment instrument.

1. Tables of the data from the assessments

Table 1 **Total numbers assessed using the MDS-HC or Community Care Assessment**

	Initial assessment		1st reassessment	2nd reassessment	Total assessments
	Eligible	Assessed	Assessed	Assessed	
Kent					
Intervention	105	74	57		131
Control	113	80	52		132
Lewisham					
Intervention	110	110	90	70	270
Control	56	56	43	16	105

Table 2 **Total number assessed using Gold Standard and Carers assessments**

	Initial assessment		1st reassessment		2nd reassessment		Total assessments	
	GSI	Carer	GSI	Carer	GSI	Carer	GSI	Carer
Kent								
Intervention	17						17	
Control	22						22	
Lewisham								
Intervention	71		51		32		154	
Control	28		18		10		56	

Table 3 **Age, percentage female, whether living alone and presence of a carer**

	Age in yrs. (std.dev)	Female %	Living alone %**	No carer %***
Kent				
Intervention (n=74)	83.6 (7.6)	61.1	45.8†	7.5
Control (n=80)	82.3 (6.6)	69.7	65.5†	11.8
Lewisham				
Intervention (n=110)	83.6 (8.1)	75.5	64.5	27.6††
Control (n=56)	82.2 (6.8)	68.2	*	42.5††

* no data on living alone in Lewisham CCA

** difference between Kent and Lewisham intervention group only- chi. sq. p = 0.02

*** difference between Kent and Lewisham - chi. sq. p < 0.01

† difference between intervention and control – chi sq. p=0.03

†† difference between intervention and control – chi sq. p=0.05

Table 4 **Reasons for withdrawal from the study.**

	Before 1st reassessment			After 1st before 2nd reassessment			
	Died (%)	Other (%)	Total (%)	Died	Other	Not known	Total
Kent							
Intervention (n = 74)	10 (14)	7 (10)	17 (24)				
Control (n= 80)	21 (26)	7 (9)	28 (35)				
Lewisham							
Intervention (n=110)	17 (15)	3 (3)	20 (18)	9	8		17
Control (n=56)	8 (14)	5 (9)	13 (23)	3	3	21	27

Differences are not significant

Table 5 **Accommodation, ADL and Continence**

Percent of Completed Items

	Kent		Lewisham	
Indicator	CCA N=132	MDS-HC N=129	CCA N=114	MDS-HC N=270
Type of Accommodation	48	97	100	84
Who living with	39	98		84
Bed mobility	47	100	86	99
Bathing		100	75	99
Washing	55	100	90	99
Toileting		99	88	99
Dressing	53	100	86	100
Feeding	39	100	90	99
Walking	34	100	81	99
Transfers	43	100	89	100
Ability to use stairs		99	75	100
Bladder Continence	65	98	85	100
Bowel Continence	53	97	92	95
Proportion of domains present out of total	10/13	13/13	12/13	13/13
Total percent of items completed for each form	48	99	86	97
ADL score Possible	25*	99	67	97

* ADL score composed of washing, mobility, eating only

Table 6 **Kent – Accommodation, ADL and Continence**

Percent of completed items at each assessment

Indicator	CCA			HC		
	Initial Assessment N=132	1st Reassessment N=52	2nd Reassessment N=	Initial Assessment N=129	1st Reassessment N=56	2nd Reassessment N=
Type of Accommodation	48	52		97	100	
Who living with	39	44		98	95	
Bed mobility	47	42		100	100	
Bathing				100	100	
Washing	55	52		100	100	
Toileting				99	98	
Dressing	53	50		100	100	
Feeding	39	35		100	100	
Walking	34	35		100	100	
Transfers	43	40		100	100	
Bladder Continence	65	67		98	96	
Bowel Continence	53	54		97	100	
Ability to use stairs				99	100	
Proportion of domains present out of total	10/13	10/13		13/13	13/13	
Total percent of items completed for each form	48	47		99	99	
ADL* score Possible	**25**	**31**		**99**	**98**	

*ADL score composed of washing, mobility, eating only

Table 7 **Lewisham – Accommodation, ADL and Continence**

Percent of completed items at each assessment

	CCA			HC		
Indicator	Initial Assessment N=114	1st Reassessment N=42	2nd Reassessment N=16	Initial Assessment N=270	1st Reassessment N=88	2nd Reassessment N=70
Type of Accommodation	100	100	100	84	100	100
Who living with				84	85	56
Bed mobility	86	88	88	99	100	99
Bathing	75	81	69	99	100	96
Washing	90	93	100	99	99	99
Toileting	88	91	81	99	99	99
Dressing	86	91	81	100	100	99
Feeding	90	93	94	99	98	99
Walking	81	83	88	99	99	99
Transfers	89	93	100	100	100	99
Bladder Continence	85	76	100	100	100	99
Bowel Continence	92	88	100	95	99	87
Ability to use stairs	75	86	75	100	100	99
Proportion of domains present out of total	12/13	12/13	12/13	13/13	13/13	13/13
Total percent of items completed for each form	86	74	90	97	98	95
ADL score Possible	**99**	**74**	**63**	**97**	**96**	**99**

Table 8

IADL and Senses

Percent of completed items

	Kent		Lewisham	
Indicator	CCA N=132	MDS-HC N=129	CCA N=114	MDS-HC N=270
Shopping		100	71	97
Finances/pension		99	65	97
Housework		100	74	98
Laundry			66	
Using Appliances/ Cooking		100	77	97
Mobility outside home/using transport	28	99		96
Managing Medications		99	85	97
Using Phone		99		98
Speech	58	100	95	100
Hearing	65	100	91	99
Sight	67	100	86	99
Proportion of domains present out of total	4/11	10/11	9/11	10/11
Total percent of items completed for each form	55	100	79	98
IADL scale possible		**97**		**94**

Table 9

Kent – IADL and Senses

Percent of completed items at each assessment

	CCA			HC		
Indicator	Initial Assessment N=132	1st Reassessment N=52	2nd Reassessment N=	Initial Assessment N=129	1st Reassessment N=56	2nd Reassessment N=
Shopping				100	100	
Finances/pension				99	100	
Housework				100	100	
Laundry						
Using Appliances/ Cooking				100	100	
Mobility outside home/using transport	28	33		99	100	
Managing Medications				99	100	
Using Phone				99	100	
Speech	58	42		100	100	
Hearing	65	67		100	100	
Sight	67	67		100	100	
Proportion of domains present out of total	4/11	4/11		10/11	10/11	
Total percent of items completed for each form	55	52		100	100	
IADL scale possible				**97**	**100**	

Table 10 **Lewisham - IADL and Senses**

Percent of completed items at each assessment

	CCA			HC		
Indicator	Initial Assessment N=114	1st Reassessment N=42	2nd Reassessment N=16	Initial Assessment N=270	1st Reassessment N=88	2nd Reassessment N=70
Shopping	71	71	50	97	99	91
Finances/pension	65	69	44	97	100	93
Housework	74	76	56	98	100	93
Laundry	66	69	44			
Using Appliances/ Cooking	77	81	75	97	100	93
Mobility outside home/using transport				96	96	91
Managing Medications	85	88	89	97	99	93
Using Phone				98	100	93
Speech	95	93	100	100	100	100
Hearing	91	88	94	99	100	97
Sight	86	91	70	99	98	100
Proportion of domains present out of total	9/11	9/11	9/11	10/11	10/11	10/11
Total percent of items completed for each form	79	81	69	98	99	94
IADL scale possible	**47**	**60**	**31**	**94**	**94**	**91**

Table 11

Cognition, Mood and Behaviour

Percent of completed items

	Kent		Lewisham	
Indicator	CCA N=132	MDS-HC N=129	CCA N=114	MDS-HC N=270
Memory	41	100	90	99
Confusion	60	100		99
Comprehension	40	100		100
Depression	36	99	69	99
Anxiety	36	100		99
Wandering	32	100	83	99
Disturbing at night	29	100	1	99
Hazardous behaviour				
Physical aggression	32	99	1	99
Verbal aggression	33	99	2	99
Hoarding	30		1	
Restlessness	33		5	
Disinhibition			0	
Challenging behaviour	30	100		99
Change in behaviour		100	1	97
Proportion of domains present out of total	12/15	11/15	10/15	11/15
Total percent of items completed for each form	36	100	25	99

Table 12 **Kent – Cognition, Mood and Behaviour,**

Percent of completed items at each assessment

	CCA			HC		
Indicator	Initial Assessment N=132	1st Reassessment N=52	2nd Reassessment N=	Initial Assessment N=129	1st Reassessment N=56	2nd Reassessment N=
Memory	41	35		100	100	
Confusion	60	62		100	100	
Comprehension	40	62		100	100	
Depression	36	35		99	100	
Anxiety	36	33		100	100	
Wandering	32	31		100	100	
Disturbing at night	29	29		100	100	
Hazardous behaviour						
Physical aggression	32	29		99	98	
Verbal aggression	33	29		99	98	
Hoarding	30	31				
Restlessness	33	31				
Disinhibition						
Challenging behaviour	30	29		100	100	
Change in behaviour				100	100	
Proportion of domains present out of total	12/15	12/15		11/15	11/15	
Total percent of items completed for each form	36	36		100	100	

Table 13 **Lewisham - Cognition, Mood and Behaviour**

Percent of completed items at each assessment

	CCA			HC		
Indicator	Initial Assessment N=114	1st Reassessment N=42	2nd Reassessment N=16	Initial Assessment N=270	1st Reassessment N=88	2nd Reassessment N=70
Memory	90	91	100	99	100	99
Confusion				99	99	97
Comprehension				100	100	100
Depression	69	67	69	99	100	99
Anxiety				99	99	99
Wandering	83	86	88	99	100	99
Disturbing at night	1	2	0	99	100	99
Hazardous behaviour						
Physical aggression	1	2	0	99	99	99
Verbal aggression	2	7	6	99	100	99
Hoarding	1	5	0			
Restlessness	5	5	6			
Disinhibition	0	0	0			
Challenging behaviour				99	100	99
Change in behaviour	1	2	0	97	98	99
Proportion of domains present out of total	10/15	10/15	10/15	11/15	11/15	11/15
Total percent of items completed for each form	25	27	30	99	100	99

Table 14 **Carer items**

Percent of completed items

	Kent		Lewisham	
Indicator	CCA	MDS-HC	CCA	MDS-HC
Carer input	12	85		79
Carer's situation		83	67	67

Table 15 **Correlation of MDS-HC ADL, IADL and cognitive function outcome scales with GSI scales**

	Initial assessment (n= 70)	1st reassessment (n= 46)	2nd reassessment (n=16)
MDS ADL score cf Barthel	-0.77**	-0.69**	-0.39
MDS IADL score cf Duke OARS	-0.49**	-0.64**	-0.78**
CPS cf MMSE	-0.75**	-0.79**	-0.59**

** $p < .001$

Table 16 Kent HC Valid Items and CCA with recoded free text items Accommodation, ADL and Continence

Frequency and Percent of Population recorded as NOT independent at initial assessment

	Kent CCA	Kent CCA + coded free text⊙	Kent HC
Indicator	Not Independent N=80 (%)	Not Independent N=79 (%)	Not Independent N=72 (%)
Bed mobility	22 (28)	35 (44)	13 (18)***
Bathing		59 (75)[a]	60 (83)
Washing	36 (45)	54 (68)[b]	38 (53)
Toileting		11 (14)	30 (42)***
Dressing	30 (38)	52 (66)	40 (56)
Feeding	7 (9)	14 (18)	14 (20)
Walking	17 (21)	43 (54)[c]	28 (39)*
Transfers	13 (16)	26 (33)[d]	24 (33)
Bladder Continence	13 (16)	28 (35)	30 (42)
Bowel Continence	2 (3)	6 (8)	17(24)**
Ability to use stairs		6 (8)	25 (35)[e]***
			53 (74)[f]

*- coding with supervision etc. as independent

⊙ - coding with supervision etc. as dependent

[a] – includes washing item from CCA and coding from bathing item in HC

[b] – includes washing item from CCA and coding from personal hygiene item in HC

[c] – includes mobility item from CCA and coding from mobility in the home item in HC

[d] – includes chair mobility item from CCA and coding from transferring item in HC

[e] – excluding 8 unknown

[f] – including 8 unknown as not independent

* chi sq P <0.05

** chi sq P <0.01

*** chi sq P <0.001

Table 17 Kent HC Valid Items and CCA with recoded free text items IADL and Senses

Frequency and Percent of Population recorded as NOT independent at initial assessment

	Kent CCA	Kent CCA + coded free text⊙	Kent HC
Indicator	Not independent/ Impairment present N=80 (%)	Not Independent Impairment present N=79 (%)	Not independent/ Impairment present N=72 (%)
Shopping		6 (8)	68 (94)***
Finances/pension			52 (72)
Housework			65 (90)
Using Appliances/ Cooking		38 (48)	57 (79)***
Mobility outside home/using transport	20 (25)		65 (90)
Managing Medications			44 (61)
Using Phone			5 (49)
Speech	6 (8)	12 (15)	3 (32)*
Hearing	18 (23)	21 (27)	7 (51)**
Sight	40 (50)	35 (44)	0 (42)

*- coding with supervision etc. as independent

⊙ - coding with supervision etc. as dependent

* chi sq P <0.05

** chi sq P <0.01

*** chi sq P <0.001

Table 18 Kent HC Valid Items and CCA with recoded free text items Cognition, Mood and Behaviour

Frequency and Percent of Population recorded as NOT independent (indicator present) at initial assessment

	Kent CCA	Kent CCA + coded free text⊙	Kent HC
Indicator	Indicator Present N=80 (%)	Indicator Present N=79 (%)	Indicator Present N=72 (%)
Memory	19 (24)	31 (39)	28 (39)
Confused	5 (6)[a]	12 (15)[c]	34 (47)
	8 (10)[b]	14 (18)[d]	
Comprehension	12 (15)	17 (22)[e]	26 (36)***
Depression	8 (10)	16 (20)	8 (11)

*- coding with supervision etc. as independent

⊙ - coding with supervision etc. as dependent

[a] – lucidity item from CCA

[b] – confused item from CCA

[c] – includes lucidity item from CCA and coding from cognitive skills items in HC

[d] – includes confused item from CCA and coding from cognitive skills item in HC

[e] - includes comprehension item from CCA and coding from cognitive skills item in HC

[f] - includes disruptive behaviour from CCA and coding from socially inappropriate behaviour in HC

*** chi sq P <0.001

Table 19 Mean scores of HC outcome variables at each assessment
All assessments

Indicator	Assessed once only	Initial max n = 182	1st reassessment max n = 145	2nd reassessment max n = 72
ADL score	5.5 (5.1)	2.6 (3.6)	2.8 (4.1)	2.9 (3.1)
IADL score	5.0 (2.1)	4.6 (2.0)	4.9 (1.7)	5.2 (1.6)
Cognitive function score	1.9 (1.9)	1.5 (1.6)	1.5 (1.7)	1.3 (1.5)
Mood	1 (1.7)	1.0 (1.8)	1.1 (1.9)	0.7 (1.2)
Bladder incontinent	25%	23%	26%	28%
Bowel continent	21%	10%	12%	7%
Carer unable to continue	13%	8%	4%	4%
Carer distressed	10.5%	8%	4%	1%

Table 20 Mean scores of HC outcome variables at each assessment
People assessed on 2 occasions

Indicator	Assessed once only	Initial max n = 144	1st reassessment max n = 144
ADL score	5.5 (5.1)	1.8 (2.5)	2.8 (2.0)
IADL score	5.0 (2.1)	4.4 (2.0)	4.9 (1.7)
Cognitive function score	1.9 (1.9)	1.4 (1.5)	1.4 (1.7)
Mood	1 (1.7)	1.0 (1.8)	1.1 (1.9)
Bladder incontinent	25%	22.9%	24.9%
Bowel incontinent	21%	8%	11.1%
Carer unable to continue	13%	6.3%	4.2%
Carer distressed	10.5%	6.9%	3.5%

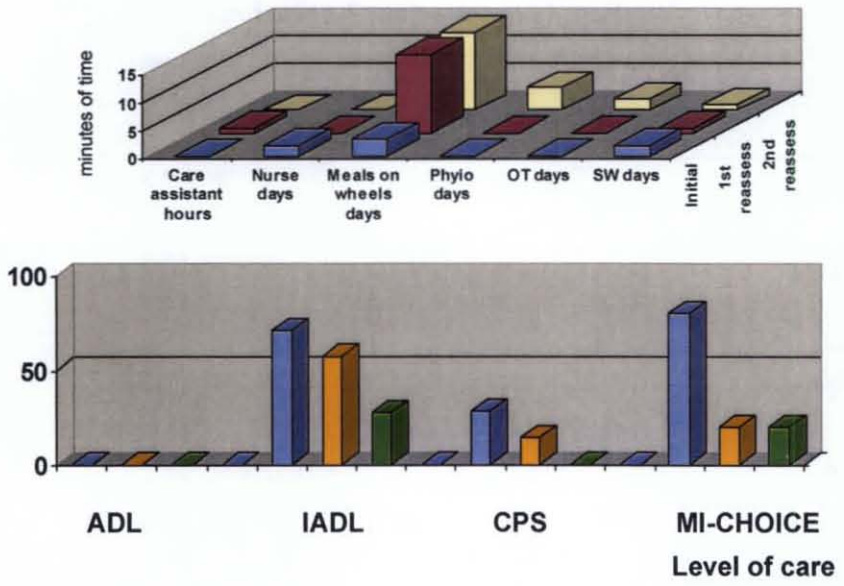
Table 21 Mean scores of HC outcome variables at each assessment
People assessed on 3 occasions

Indicator	Assessed once only	Initial max n = 72	1st reassessment max n = 72	2nd reassessment max n = 72
ADL score	5.5 (5.1)	1.5 (2.0)	2.2 (3.4)	2.9 (3.1)
IADL score	5.0 (2.1)	4.4 (2.0)	4.8 (1.7)	5.2 (1.5)
Cognitive function score	1.9 (1.9)	1.3 (1.4)	1.2 (1.4)	1.3 (1.5)
Mood	1 (1.7)	1.0 (1.7)	0.8 (1.5)	0.7 (1.5)
Bladder incontinent	25%	24.6%	22.2%	27.8%
Bowel incontinent	21%	9.7%	4.2%	7%
Carer unable to continue	13%	4.2%	2.8%	4.2%
Carer distressed	10.5%	8.3%	2.8%	1.4%

Table 22 Mean scores of Lewisham CCA outcome variables at each assessment
all assessments

Indicator	Assessed once only max n = 13	Initial max n = 52	1st reassessment max n = 38
ADL score	6.2 (2.8)	6.3 (2.2)	7.5 (4.0)
IADL score	13 (2.4)	11.9 (3.1)	12.3 (3.2)
Memory score	2.3 (0.9)	2.1 (1.1)	2.4 (1.5)
Bladder incontinent	35%	20%	16%
Bowel continent	28%	23%	18%

Figure 2 **Case History 2**



Scale shows percent of maximum score

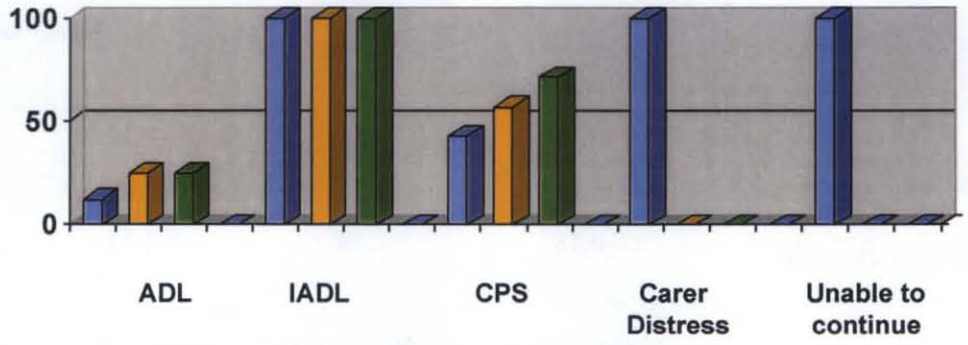
Table 24 **Factors related to the provision of care by personal and nursing care staff in 14 days prior to the first reassessment**

		Kent				Lewisham			
		Pearson's R		P		Pearson's R		P	
ADL scale		-0.17		0.23		0.32		< 0.01	
IADL scale		0.12		0.34		0.19		0.1	
Cognitive performance scale		-0.18		.18		-0.05		0.65	
		Mean hrs	Std. Dev	Std. Err.	T-test sig.	Mean hrs	Std. Dev	Std. Err.	T-test sig.
Lives alone	Yes (n)	6.1 (28)	6.3	1.2	0.09	16.4 (41)	43.2	6.7	0.24
	No (n)	3.4 (27)	5.5	1.1		8.4 (43)	9.3	1.4	
Has informal carer	Yes (n)	5.8 (44)	6.4	0.96	0.02	17.1 (21)	35.2	4.4	0.14
	No (n)	1.5 (3)	1.9	0.16		6.8 (63)	9.6	2.1	

Table 23 **Mean scores of Lewisham CCA outcome variables at each assessment**
People assessed on 2 occasions

Indicator	Assessed once only max n = 13	Initial max n = 39	1st reassessment max n = 38
ADL score	6.2 (2.8)	6.3 (2.1)	7.5 (4.0)
IADL score	13 (2.4)	11.5 (3.3)	12.3 (3.2)
Cognitive function score	2.3 (0.9)	2.1 (1.2)	2.4 (1.5)
Bladder incontinent	35%	14%	16%
Bowel incontinent	28%	21%	18%

Figure 1 **Case History 1**



Scale shows percent of maximum score

Table 25 Linear regression of factors related to the provision of care time at the 1st reassessment

	Kent	Lewisham
Lives alone	p = 0.02	p = 0.01
Has informal carer	p = 0.09	p = 0.21
ADL scale	p = 0.64	p < 0.01

Table 26 Distribution by MI-CHOICE level of care at initial assessment

MI-CHOICE Level of Care	Kent (%)	Lewisham (%)	Total (%)
Information and referral	4 (5.4)	10 (9.1)	14 (7.6)
Home help	10 (13.5)	11 (10.0)	21 (11.4)
Personal care	25 (33.8)	46 (41.8)	71 (38.6)
Nursing care at home	22 (29.7)	26 (23.6)	48 (26.1)
Nursing home	13 (17.6)	17 (15.5)	30 (16.3)
Total	74 (100)	110 (100)	184 (100)

Table 27 Mean hours of care by personal and nursing care staff in 14 days prior to the first reassessment by MI-CHOICE level of care

		Kent	Lewisham
		Av. hours	Av. hours
MI-CHOICE Level of Care	Information and referral	1.67	1.50
	Home Help	5.29	4.83
	Personal Care at Home	5.50	9.21
	Nursing Care at Home	5.81	17.64
	Nursing Home	2.73	19.93

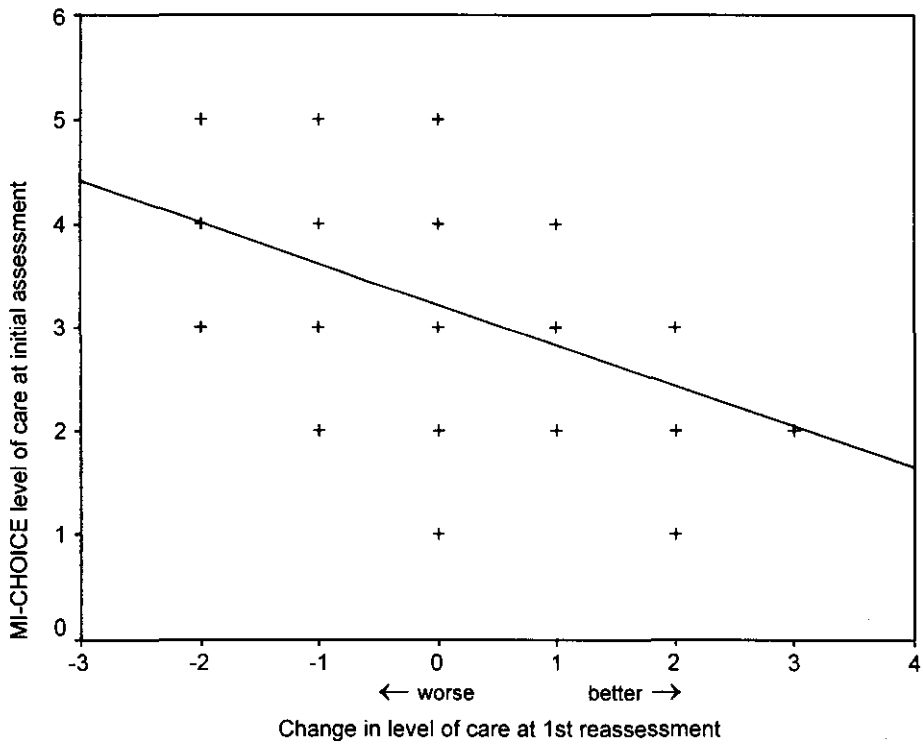
In Lewisham, 2 people had >200 hours of care, excluding these, the difference between areas, chi. sq. = p < 0.05

Table 27 **Reason for withdrawal by initial MI-CHOICE level of care case-mix group**

		Reason for withdrawal			
		did not withdraw	died	withdrew for other reason	Total
MI-CHOICE Level of Care	Information and referral	12	1	1	14
		85.7%	7.1%	7.1%	7.6%
	Home Help	18	2	1	21
		85.7%	9.5%	4.8%	11.4%
	Personal Care at Home	56	6	9	71
		78.9%	8.5%	12.7%	38.6%
	Nursing Care at Home	33	10	5	48
		68.8%	20.8%	10.4%	26.1%
	Nursing Home	11	17	2	30
		36.7%	56.7%	6.7%	16.3%
Total		130	36	18	184
		70.7%	19.6%	9.8%	100.0%

Chi sq. P < .001

Figure 3 **Change in MI-CHOICE level of care at 1st re-assessment**



R −0.38, p <.001

12. References

1. Rubenstein L, Calkins D, Greenfield S, Jette A, Meenan R, Nevins M, et al. Health Status Assessment for Elderly Patients. Report of the Society of General Internal Medicine Task Force on Health Assessment. *Journal of the American Geriatric Society* 1988;37:562-569.

2. Stuck AE, Siu AL, Wieland GD, Adams J, Rubenstein LZ. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 1993;342(October 23):1032-1036.

3. Hopkins A, Costain D. *Measuring outcomes of medical care*. London: Royal College of Physicians, 1990.

4. Royal College of Physicians, British Geriatrics Society. *Standardised Assessment Scales for Elderly People*. London: Royal College of Physicians of London and the British Geriatrics Society, 1992.

5. Parker SG, Du X, Bardsley MJ, Goodfellow J, Cooper RG, Cleary R, et al. Measuring outcomes in care of the elderly. *Journal of the Royal College of Physicians of London* 1994;28(5):428-433.

6. Department of Health. The National Health Service and Community Care Act. London: HMSO, 1990.

7. Department of Health. NHS responsibilities for meeting continuing health care needs. London: Department of Health, 1995.

8. Department of Health, Social Services Inspectorate. Management and Assessment: managers' guide. London: HMSO, 1991.

9. Department of Health, Social Services Inspectorate. Care Management and Assessment: practitioners' guide. London: HMSO, 1991.

10. Department of Health. Implementing Community Care: population needs assessment good practice guidance. London: HMSO, 1993.

11. Leicester MC, Pollock AM. Community care in South Thames (West) Region: is needs assessment working? *Public Health* 1996;110:109-113.

12. Caldock K. The new assessment: moving towards holism or new roads to fragmentation? In: D C, B D, K T, editors. *Community Care: New Agendas and Challenges from the UK and Overseas*. Aldershot: Arena, 1994.

13. SSI/NHSE. Community Care Monitoring Report 1994: Findings from Local Authority self monitoring and NHS surveys. London: Department of Health, 1995.

14. Stewart K, Challis DJ, Carpenter GI, Dickinson E. Assessment approaches for older people receiving social care: content and coverage. *International Journal of Geriatric Psychiatry* 1999;14:147-156.

15. Institute of Medicine. *Improving Quality of Care in Nursing Homes*. Washington DC: National Academy Press, 1986.

16. Morris JN, Hawes C, Fries BE, Phillips CD, Mor V, Katz S, et al. Designing the National Resident Assessment Instrument. *The Gerontologist* 1990;30(3):293-307.

17. Zimmerman D, Karon S, Arling G, Clark B, Collins E, Ross R, et al. The development and testing of nursing home quality indicators. *Health Care Financing Review* 1995;16:107-128.

18. Phillips C, Hawes C, Mor V, Fries B, Morris J. Evaluation of the Nursing Home Resident Assessment Instrument: Executive Summary. Washington: Health Care Financing Administration, 1996.

19. Hawes C, Phillips CD, Mor V, Fries BE, Morris JN. MDS Data Should be Used for Research. *The Gerontologist* 1992;32(4):563-4.

20. Morris JN, Fries BE, Bernabei R, Steel K, Ikegami N, Carpenter GI, et al. *RAI-Home Care (RAI-HC) Assessment Manual*. Boston MA: Hebrew Rehabilitation Center for the Aged, 1996.

21. Morris JN, Fries BE, Steel K, Ikegami N, Bernabei R, Carpenter GI, et al. Comprehensive clinical assessment in community setting - Applicability of the MDS-HC. *Journal of the American Geriatrics Society* 1997;45:1017-1024.

22. Carpenter GI. Standardised assessment in the community. In: Challis DJ, Darton RA, Traske KJ, editors. *Community Care, Secondary Health Care and Care Management*. Aldershot: Arena, 1998.

23. Morris JN, Carpenter GI, Berg K, Jones RN. Outcome measures for use with home care clients. *Canadian Journal on Aging* 2000;19 S2:87-105.

24. inter*RAI* European Collaboration. The AD HOC Project, EU Vth Framework project contract no. QLK6-2000-00002.

25. Turner GF, Main A, Carpenter GI. Casemix, Resource Use and Geriatric Medicine in England and Wales. *Age and Ageing* 1995;24:1-4.

26. Fries BE, Schneider DP, Foley WJ, Gavazzi M, Burke R, Cornelius E. Refining a case-mix measure for nursing homes: Resource Utilisation Groups (RUG-III). *Medical Care* 1994;32:668-685.

27. Carpenter GI, Main A, Turner GF. Case-mix for the Elderly In-patient. Resource Utilisation Groups (RUGs) validation project. *Age and Ageing* 1995;24:5-13.

28. Gliddon T, Finch C. *Patient Dependency and Resource Allocation in Domiciliary Nursing*. Australia: Australian Council of Community Nursing Services, 1991.

29. Community Resource Management Project - patient dependency classification for district nurses. Winchester: National Casemix Office, 1989.

30. Fries BE, Morris JN, James M, Carpenter GI. Building Eligibility Criteria from systematic assessment data. *Age and Ageing* 1999;28 S2:30.

31. Bjorkgren MA, Fries BE, Shugarman LR. A RUG-III case-mix system for Home Care. *Canadian Journal on Aging* 2000;19 S2:106-125.

32. Morris JN, Fries BE, Morris SA. Scaling ADL's within the MDS. *J Gerontol* 1999;4(11):M546-53.

13. Appendices

MDS-HC as used in the intervention group

Kent Community Care Assessment as used in the Kent control group

Lewisham Community Care Assessment as used in the Lewisham control group

Gold Standard Assessments form

MDS-HC UK version 2.0

MDS-HC UK version 2.0 Problem recording sheet

MDS-HC screener UK version 1.0

MDS-HC as used in the intervention group

MINIMUM DATA SET - HOME CARE (MDS-HC)©

(Status in last 7 days unless other time frame indicated—Note, if less than 7 days since last assessment, code all items that reference last 7 days on the basis of status since last assessment)

SECTION AA. NAME AND IDENTIFICATION NUMBER

1.	NAME OF CLIENT	(Surname) (First name, Middle initial)
2.		
3.	CLIENT ADDRESS	House/Building name Flat/House number, Street Village, Town, Postcode

SECTION BB. PERSONAL ITEMS *(Complete at Intake Only)*

1.	GENDER	1. Male 2. Female
2.	BIRTHDATE	Day Month Year
3.	RACE/ ETHNICITY	
4.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated 6. Other
5.	LANGUAGE	0. English 3. Other
6.	EDUCATION (highest level completed)	
7.	RESPONSI-BILITY DIRECTIVES	a. Client has a legal guardian 0. No 1. Yes b. Client has advanced medical directives in place 0. No 1. Power of attorney 2. Enduring power of attorney

SECTION CC.

1.		
2.	REASON FOR REFERRAL	1. Post hospital care 4. Eligibility for home care 2. Community chronic care 5. Day care 3. Home placement screen
3.	WHERE LIVED AT TIME OF ASSESS-MENT	1. Long-term care (hospital) 2. Nursing home 3. Residential home 4. Supported accommodation 5. Very sheltered housing 6. Sheltered housing 7. Specially designed/designated housing for older people 8. Independent/private accommodation
4.	WHO LIVED WITH AT ASSESS-MENT	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)
5.	PRIOR NH PLACEMENT	Lived in a nursing home at anytime during 5 years prior to case opening 0. No 1. Yes
6.	RESIDEN-TIAL HISTORY	Moved to current residence within last 2 years 0. No 1. Yes

SECTION A. ASSESSMENT INFORMATION

1.	ASSESSMENT REFERENCE DATE	Date of assessment Day Month Year
2.	REASONS FOR ASSESSMENT	TYPE OF ASSESSMENT 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from the programme 5. Review at return from hospital 6. Change in status 7. Other

SECTION B. COGNITIVE PATTERNS

1.	MEMORY	Short-term memory OK — seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem
2.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	How well client made decisions about organising the day (e.g. when to get up or have meals, which clothes to wear or activities to do) 0. *INDEPENDENT*—decisions consistently reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions
3.	INDICATORS OF DELIRIUM	a. Sudden or new onset/change in mental function (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes b. In the **last 90 days** (or since last assessment if less than 90 days), 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 aid 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 UNDER-STOOD	*(Expressing information content—however able)* 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*
3.	ABILITY TO UNDER-STAND OTHERS	*(Understands verbal information—however able)* 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*—may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*

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 not 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 DEPRES-SION, ANXIETY, SAD MOOD	***(Code for indicators observed in last 30 days (or since last assessment if less than 30 days), irrespective of the assumed cause)*** 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

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 appear to be unrealistic fears—e.g. fear of being abandoned, left alone, being with others

d. Repetitive health complaints—e.g. persistently seeks medical attention, obsessive concern with body functions

e. Repetitive anxious complaints, concerns—e.g. persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

f. Sad, pained, worried facial expressions — e.g. furrowed brows

g. Recurrent crying, tearfulness

h. Withdrawal from activities of interest—e.g. no interest in long-standing activities or being with family/friends

i. Reduced social interaction

When box blank, must enter number or letter [a.] = When letter in box, tick if condition applies

MDS Draft NU2 — 13/03/98

2.	BEHAVIOURAL SYMPTOMS	In the last 7 days, instances when the client exhibited following behavioural symptoms. If EXHIBITED, ease of altering the symptom when it occurred. 0. Did not occur in last 7 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, swore 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 undressing in public, smears/throws food/faeces, rummaging, repetitive behaviour, rises early and causes disruption)
		e. AGGRESSIVE RESISTANCE OF CARE (e.g. threw medications, pushed carer)
3.	CHANGES IN BEHAVIOURAL SYMPTOMS	Behavioural symptoms have become worse or are less well tolerated by family as compared to **30 days ago** (or since last assessment if less than 30 days) 0. No, or no change in behavioural symptoms 1. Yes

SECTION F. SOCIAL FUNCTIONING

1.	INVOLVEMENT	a. Client is at ease interacting with others (e.g. likes to spend time with others) 0. At ease 1. Not at ease
		b. Openly expresses conflict or anger with family/friends 0. No 1. Yes
2.	CHANGE IN SOCIAL ACTIVITIES	As compared to **180 days ago** (or since last assessment if less than 180 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE HAS BEEN 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

SECTION G. INFORMAL SUPPORT SERVICES

			(A) Prim	(B) Secn
1.	TWO KEY INFORMAL HELPERS	PRIMARY AND SECONDARY HELPERS		
	Primary (A) and secondary (B)	a. (Surname) b. (First name)		
		c. (Surname) d. (First name)		
		e. Lives with client 0. Yes 1. No 2. No such helper [skip other items]		
		f. Relationship to client 0. Child or child-in-law 2. Other relative 1. Spouse 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 1. 1-2 hours per day 2. No		
		j. — Emotional support		
		k. — IADL care		
		l. — ADL care		

2.	CARER STATUS	*(Tick all that apply)*	
		A carer is unable to continue in caring activities—e.g. decline in the health of the carer makes it difficult to continue	a.
		Primary carer is not satisfied with support received from family and friends (e.g. other children of client)	b.
		Primary carer expresses feelings of distress, anger or depression	c.
		NONE OF ABOVE	d.
		Primary carer is dissatisfied with support from statutory services	e.
3.	EXTENT OF HELP (HOURS OF CARE, ROUNDED)	For 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 5 weekdays	
		b. Sum of time across 2 weekend days	

SECTION H. PHYSICAL FUNCTIONING (SELF-PERFORMANCE OF INSTRUMENTAL [IADL] AND PERSONAL [ADL] ACTIVITIES OF DAILY LIVING)

			(A) Performance	(B) Difficulty
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. *INDEPENDENT*—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 tires 2. *GREAT DIFFICULTY*—e.g. little or no involvement in the activity is possible		
a.	MEAL PREPARATION	How meals are prepared (e.g. planning meals, cooking, assembling ingredients, setting out food and utensils)		
b.	ORDINARY HOUSE WORK	How ordinary work around the house is performed (e.g. washing-up, dusting, making bed, tidying up, laundry)		
c.	MANAGING FINANCE	How bills are paid, chequebook is balanced, household expenses are balanced		
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		

			(A)	(B)
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 7 days**, considering all episodes of these activities. For 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		
A		0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. *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 3. *EXTENSIVE ASSISTANCE*—While client performed part of activity, over last 7-day period, 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 7 days 4. *TOTAL DEPENDENCE*—Full performance of activity by another during entire 7 days 8. *ACTIVITY DID NOT OCCUR* during entire 7 days (regardless of ability)		
B		**B. ADL SUPPORT PROVIDED**—Code for most support provided during the **last 7 days.** 0. No set-up or physical help 1. Set-up help only 2. One person physical assist 3. Two or more persons physical assist 8. ADL ACTIVITY DID NOT OCCUR DURING ENTIRE 7 DAYS		
			(A)	(B)
a.	MOBILITY IN BED	Including moving to and from lying position, turning side to side, and positioning body while in bed.		
b.	TRANSFERRING	Including moving to and between surfaces — to/from bed, chair, wheelchair, standing position [Note — *Excludes to/from bath/toilet*]		
c.	MOBILITY (IN HOME)	The ability to move indoors from room to room on level surfaces		
d.	DRESSING	The ability to put on, take off, secure and unfasten all garments and, as appropriate, braces, artificial limbs and other surgical appliances		
e.	FEEDING	The ability to feed oneself once food has been prepared and made available		
f.	TOILETING	The ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene		
g.	PERSONAL HYGIENE	Including combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands, and perineum (EXCLUDE baths and showers)		
3.	BATHING	In the **last 7 days** (include shower, full tub or sponge bath; exclude washing back or hair) 0. *INDEPENDENT*, did on own 1. *SUPERVISION*— oversight help only 2. *RECEIVED ASSISTANCE IN TRANSFER ONLY* 3. *RECEIVED ASSISTANCE IN PART OF BATHING ACTIVITY* 4. *TOTAL DEPENDENCE* 8. *ACTIVITY DID NOT OCCUR*		
4.	USE OF ASSISTIVE DEVICES	0. No assistive device 1. Cane 2. Walker/crutch 3. Scooter (e.g. Amigo) 4. Wheelchair 5. Activity does not occur 6. Other - give details		
		a. Indoors		
		b. Outdoors		

5.	STAIR CLIMBING	In the last 7 days, how client went up and down stairs (e.g. single or multiple steps, using handrail as needed). If client did not go up and down stairs, code client's capacity for stair climbing 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs—could do without help 3. Not go up and down stairs—could do with help 4. Not go up and down stairs—no capacity to do it 8. *UNKNOWN*—did not climb stairs and assessor is unable to judge whether the capacity exists	
6.	STAMINA	a. In a typical week, during the **last 30 days**, code the number of days client usually went out of the house or building in which client lives (no matter for how short a time period) 0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days	
		b. Hours of physical activities in the **last 7 days** (e.g. walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	
7.	FUNCTIONAL POTENTIAL	Client believes he/she capable of increased functional independence (ADL, IADL, mobility)	a.
		Carers believe client is capable of increased functional independence (ADL, IADL, mobility)	b.
		Good prospects of recovery from current disease or conditions, improved health status expected	c.
		NONE OF ABOVE	d.

SECTION I. CONTINENCE IN LAST 14 DAYS

1.	BLADDER CONTINENCE	In **last 14 days** (or since last assessment if less than 14 days) control of urinary bladder function (with appliances such as catheters or incontinence programme employed) [Note—if dribbles, volume insufficient to soak through underpants] 0. *CONTINENT*—Complete control 1. *USUALLY CONTINENT*—Incontinent episodes once a week or less 2. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily 3. *FREQUENTLY INCONTINENT*—Tends to be incontinent daily, but some control present 4. *INCONTINENT*—Inadequate control, multiple daily episodes	
2.	BLADDER DEVICES	(*Tick all that apply in last 14 days*—or since last assessment if less than 14 days)	
		Use of pads or briefs to protect against wetness	a.
		Use of an indwelling urinary catheter	b.
		NONE OF ABOVE	c.
3.	BOWEL CONTINENCE	In last 14 days (or since last assessment if less than 14 days), control of bowel movement (with appliance or bowel continence programme if employed) 0. *CONTINENT*—Complete control 1. *USUALLY CONTINENT*—Bowel incontinent episodes less than weekly 2. *OCCASIONALLY INCONTINENT*—Bowel incontinent episode once a week 3. *FREQUENTLY INCONTINENT*—Bowel incontinent episodes 2-3 times a week 4. *INCONTINENT*—Bowel incontinent all (or almost all) of the time	

SECTION J. DISEASE DIAGNOSES

Disease/infection that doctor has indicated is present and affects client's status, requires treatments, or requires symptom management. Also include if disease is being monitored by health professional or is the reason for a hospitalisation in **last 90 days** (or since last assessment if less than 90 days)

0. Not present
1. Present—not subject to focused treatment or monitoring by home care nurse
2. Present—monitored or treated by home care nurse

1.	DISEASES	HEART/CIRCULATION		o. Osteoporosis	
		a. Cerebrovascular accident (stroke)		SENSES	
		b. Congestive heart failure		p. Cataract	
		c. Coronary artery disease		q. Glaucoma	
		d. Hypertension		PSYCHIATRIC/MOOD	
		e. Irregularly irregular pulse		r. Any psychiatric diagnosis	
		f. Peripheral vascular disease		INFECTIONS	
		NEUROLOGICAL		s. HIV infection	
		g. Alzheimer's		t. Pneumonia	
		h. Dementia other than Alzheimer's disease		u. Tuberculosis	
		i. Head trauma		v. Urinary tract infection (in **last 30 days**)	
		j. Multiple sclerosis		OTHER DISEASES	
		k. Parkinsonism		w. Cancer—(in past 5 years) not including skin cancer	
		MUSCULO-SKELETAL		x. Diabetes	
		l. Arthritis		y. Emphysema/COAD asthma	
		m. Hip fracture		z. Renal failure	
		n. Other fractures (e.g. wrist, vertebral)		aa. Thyroid disease (hyper or hypo)	

2.		a.	____._
		b.	____._
		c.	____._
		d.	____._

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1.	PREVENTIVE HEALTH	(*Tick all that apply—in past 2 years*)	
		Blood pressure measured	a.
		Received influenza vaccination	b.
		IF FEMALE: Received breast examination or mammography	c.
		NONE OF ABOVE	d.
2.	PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS	(*Tick all that were present on at least 2 of the last 7 days*)	
		Diarrhoea	a. Loss of appetite
		Difficulty urinating or urinating 3 or more times at night	b. Vomiting
		Fever	c. *NONE OF ABOVE*
3.	PROBLEM CONDITIONS IN LAST WEEK	(*Tick all present at any point during last 7 days*)	
		PHYSICAL HEALTH	Oedema
		Change in sputum production	a. Shortness of breath
		Chest pain at exertion or chest pain/pressure at rest	b. MENTAL HEALTH
		Constipation **in 4 of last 7 days**	c. Delusions
		Dizziness or lightheadedness	d. Hallucinations
			NONE OF ABOVE
4.	PAIN	a. Frequently complains or shows evidence of pain (**in last 7 days**) 0. No pain 1. Pain less than daily 2. Pain daily [skip to Item K4e]	
		b. Pain is unusually intense 0. No 1. Yes	
		c. Pain intensity disrupts usual activities 0. No 1. Yes	
		d. Character of pain 0. No pain 1. Localized - single site 2. Multiple sites	
		e. Pain controlled by medication 0. No pain 1. Medication offered no control 2. Pain is partially or fully controlled by medication	
5.	FALLS FREQUENCY	Number of times fell in **last 180 days** (or since last assessment if less than 180 days) If none, code "0"; if more than 9, code "9"	
6.	DANGER OF FALL	a. Unsteady gait 0. No 1. Yes	
		b. Client limits going outdoors due to fear of falling (e.g. stopped using bus, goes out only with others) 0. No 1. Yes	
7.	LIFE STYLE (Drinking/ Smoking)	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 0. No 1. Yes	
		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 0. No 1. Yes	
		c. Over a typical week **in the last month, record the number of** days (0-7) client had one or more drinks	
		d. On days client had a drink, **record the number of drinks** usually consumed per day (*code 0 for no drinks, 9 for 9 or more drinks*)	
		e. Smoked or chewed tobacco daily 0. No 1. Yes	
8.	HEALTH STATUS INDICATORS	Client feels he/she has poor health (when asked)	a.
		Has conditions or diseases that make cognition, ADL, mood, or behaviour patterns unstable (fluctuations, precarious, or deteriorating)	b.
		Experiencing a flare-up of a recurrent or chronic problem	c.
		Treatments changed in **last 30 days** (or since last assessment if less than 30 days) because of a new acute episode or condition	d.
		Prognosis of less than 6 months to live—e.g. physician has told client or client's family that client has end-stage disease	e.
		NONE OF ABOVE	f.
9.	OTHER STATUS INDICATORS	Fearful of a family member or carer	a.
		Unusually poor hygiene	b.
		Unexplained injuries, broken bones, or burns	c.
		Neglected, abused, or mistreated	d.
		Physically restrained (e.g. limbs restrained, used bed rails, constrained to chair when sitting)	e.
		NONE OF ABOVE	f.

SECTION L. NUTRITION/HYDRATION STATUS

1.	WEIGHT CHANGE	Unintended weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days 0. No 1. Yes	
2.	CONSUMPTION	a. In at least 4 of the last 7 days, ate one or fewer meals a day 0. No 1. Yes	
		b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes 0. No 1. Yes	
		c. Insufficient fluid—did not consume all/almost all fluids during last 3 days 0. No 1. Yes	
3.	NUTRITIONAL TREATMENTS	Number of days formal care received in last week	
		a. Intravenous or infusion therapy—hydration (not including TPN)	
		b. Fluids by mouth	
		c. Parenteral nutrition (TPN or lipids)	
		d. Enteral—tube feeding	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	ORAL STATUS	(Tick all that apply)	
		Problem chewing or swallowing (e.g. pain while eating)	a.
		Mouth is "dry" when eating a meal	b.
		Problem brushing teeth or dentures	c.
		NONE OF ABOVE	d.

SECTION N. SKIN CONDITION

1.	SKIN PROBLEMS	Any troubling skin conditions or changes in the last 30 days (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); and 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	(Tick 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 Wounds Sites: Thorax — d.; Abdomen — e.; Extremities — f.; Other — g.; *NONE OF ABOVE* — h.	
4.	HISTORY OF RESOLVED PRESSURE ULCERS	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes	
5.	WOUND/ ULCER CARE	Number of days formal care received in last week	
		a. Antibiotics, systemic or topical	
		b. Dressings	
		c. Pressure reduction/relieving devices	
		d. Nutrition or hydration	
		e. Turning/repositioning	
		f. Debridement	
		g. Surgical wound care	
6.	FOOT PROBLEMS	(Tick all that apply)	
		Corns, callouses, structural problems, infections, fungi	a.
		Open lesions on the foot	b.
		Foot not inspected in last 90 days by client or other	c.
		NONE OF ABOVE	d.

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	HOME ENVIRONMENT [Tick any of following that make home environment hazardous or uninhabitable (if none apply, tick *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 toiletroom (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		Kitchen (e.g. dangerous cooker, 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.
2.	LIVING ARRANGEMENT	a. As compared to 90 days ago, 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 carer feels that client would be better off in another living environment 0. No 1. Client only 2. Carer only 3. Client and carer	

SECTION P. SERVICE UTILISATION

1.	FORMAL CARE (Minutes rounded to even 10 minutes)	Extent of care or care management in last 14 days (or since last assessment if less than 14 days) involving	(A) # of Days / (B) Hours / (C) Mins
		a. Home care assistants (ADL and IADL)	
		b. Visiting nurses	
		c. Homemaking services (IADL only)	
		d. Meals on wheels	
		e. Volunteer services	
		f. Physiotherapy	
		g. Occupational therapy	
		h. Speech therapy	
		i. Day care or day hospital	
		j. Social worker in home	
2.	SPECIAL TREATMENTS, THERAPIES, PROGRAMMES	Special treatments, therapies, and programmes received or scheduled during the last 14 days (or since last assessment if less than 14 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis. 0. Not applicable 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received	
		TREATMENTS	
		a. Alcohol/drug treatment programme	
		b. Blood transfusions	
		c. Chemotherapy	
		d. Cardiac rehabilitation	
		e. Continuous positive airway pressure (CPAP)	
		f. Dialysis-peritoneal (CAPD)	
		g. Dialysis-renal	
		h. Holter monitor	
		i. IV infusion - central	
		j. IV infusion - peripheral	
		k. Medication by injection	
		l. Ostomy care	
		m. Oxygen therapy - intermittent	
		n. Oxygen therapy - continuous (concentrator)	
		o. Oxygen therapy - continuous (other)	
		p. Radiation therapy	
		q. Respiratory therapy (equipment but no professional assistance)	
		r. Tracheostomy care	
		s. Ventilator	
		THERAPIES	
		t. Exercise therapy	
		u. Occupational therapy	
		v. Physiotherapy	
		w. Respiratory therapy (involves professional assistance; includes suctioning, IPPB)	
		PROGRAMMES	
		x. Day centre	
		y. Day hospital	
		z. Hospice care	
		aa. Doctor or clinic visit	
		bb. Respite care	
		SPECIAL PROCEDURES DONE IN HOME	
		cc. Daily nurse monitoring (e.g. ECG, urinary output)	
		dd. Nurse monitoring less than daily	
		ee. Community alarm/electronic security alert	
		ff. Skin treatment	
		gg. Special diet	
		hh. Other	

3.	ANAGE- IENT OF QUIPMENT (In Last 14 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 others	
		a. Oxygen b. IV c. Catheter	
4.	VISITS IN AST 90 AYS OR NCE LAST SSESS- MENT	*Enter "0" if none, if more than 9, code "9"* a. Number of times ADMITTED TO HOSPITAL with an overnight stay b. Number of times VISITED CASUALTY without an overnight stay c. EMERGENT CARE—including unscheduled nursing, physician, or therapeutic visits to office or home	
5.	EATMENT 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.	VERALL HANGE 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 doctor care, adequate food, home care 0. No 1. Yes	

ECTION Q. MEDICATIONS

1.	JMBER OF EDICA- TIONS	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 *[If none, code "0", if more than 9, code "9"]*	
2.	RECEIPT OF SYCHO- TROPIC DICATION	Psychotropic medications taken in the last 7 days [Note—Review client's medications with the list that applies to the following categories] 0. No 1. Yes	
		a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic	
3.	EDICAL UPERVI- SION	Doctor reviewed client's medications as a whole in last 180 days 0. Discussed with at least one doctor (or no medication taken) 1. No single doctor reviewed all medications	
4.	COMPLI- ANCE/ HERENCE WITH EDICA- TIONS	Compliant all or most of time with medications prescribed by doctor (both during and between therapy visits) 0. Always compliant 1. Compliant 80% of time or more 2. Compliant less than 80% of time 3. *NO MEDICATIONS PRESCRIBED*	

5. LIST OF ALL MEDICATIONS ⓪

List prescribed and nonprescribed medications taken in last 7 days

a. Name and Dose—Record the name of the medication and dose ordered.

b. Form: Code the route of Administration using the following list:

1=by mouth (PO) 5=subcutaneous (SQ) 8=inhalation
2=sub lingual (SL) 6=rectal (R) 9=enteral tube
3=intramuscular (IM) 7=topical 10=other
4=intravenous (IV)

d. Freq: Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary 2D=(BID) 2 times daily (includes every 12 hrs) QO=every other day
1H=(QH) every hour 4W=4 times each week
2H=(Q2H) every 2 hours 3D=(TID) 3 times daily 5W=5 times each week
3H=(Q3H) every 3 hours 4D=(QID) 4 times daily 6W=6 times each week
4H=(Q4H) every 4 hours 5D=5 times daily 1M=(Q month) once every month
6H=(Q6H) every 6 hours 1W=(Q week) once each wk 2M=twice every month
8H=(Q8H) every 8 hours 2W=2 times every week C=continuous
1D=(QD or HS) once daily 3W=3 times every week O=other

a. Name and Dose	b. Form	c. Number Taken	d. Freq.
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

Kent Community Care Assessment as used in the Kent control group

COMMUNITY CARE ASSESSMENT

Health | Housing | Social Services

Category

IIS/Genisys No [redacted]

Title 41 Sex M/F M

Forename

Surname

Address

Post Code

Tel No

Current Location

Address

Key Holder

Tel No

Date Of Birth

Marital Status

Next Of Kin Name

NOK Relationship

NOK Address

NOK Tel No

Ethnic Origin

Religion

Key Workers

Social Services [redacted]

Health

Housing

Joint Assessment Y/N

Disability Diabetes
Strokes
Angina

Registered Y/N

Date Assessment Commenced 7/1/99

GP Name [redacted]

GP Address [redacted]

GP Tel No

Primary Contact Name

Relationship

Address

Tel No

Referral Source

Referral Date

Referral Reason

Assessment

Other Agencies Involved	Contact Name	Tel No	Date

CLIENT INFORMATION SHARING AGREEMENT

The details contained in this assessment can be shared with other agencies involved in my care.

Client/Patient signature

Date

CC: 1.

Care plan.

KentCare

Current Accommodation Circumstances (Tick As Appropriate)

[redacted]

☐ House ☐ Bungalow ☐ Sheltered Housing ☐ Ground floor Flat ☐ Flat above Ground level ☐ Caravan

☐ Owner Occupier ☐ Council Tenant ☐ Housing assn Tenant ☐ Private Tenancy ☐ Lodgings ☐ Hospital

☐ Living Alone ☐ Living With Spouse ☐ Living With Offspring ☐ Living with Siblings ☐ Living with Other relatives ☐ Living with A friend

Other circumstances:

[redacted]

DOES THE PATIENT/CLIENT HAVE DIFFICULTY WITH ANY OF THE FOLLOWING ?
(tick and give details as appropriate) No problems ☐

SUITABILITY OF ACCOMMODATION ☐ No Other Problems ☐ Some Defects Structural ☐ Serious Structural Defects ☐ Some difficulty Due to Disability ☐ Confined to Small area due To disability

HEATING ☐ Central Heating ☐ Electric Fires ☐ Gas Fires ☐ Calor gas Fires ☐ Coal Fires

COOKING ☐ Microwave Oven ☐ Oven Electric ☐ Gas Oven ☐ Calor gas Oven ☐ Solid Fuel

TOILET ☐ Inside down-stairs ☐ Inside Upstairs ☐ Outside ☐ Elsan ☐ Commode

BATHROOM ☐ Downstairs Shower ☐ Downstairs Bath ☐ Upstairs Shower ☐ Upstairs Bath ☐ None

Access ☐ Level Front ☐ Level Back ☐ Stairs/Vertical Lift ☐ Step Or steps ☐ Flight Of stairs

Comments & Any Other Problems:

CLIENT / PATIENT ASSESSMENT

SENSORY IMPAIRMENT

	YES	NO
Complains of diminished vision		
Wears glasses		
Complains of diminished hearing		
Wears hearing aid		
Speech impairment		

Any other comments

Wears glasses for reading and TV
Eyes water often due to diabetes.
Hearing fine.

PERSONAL CARE

Weight

	Yes	No
Washes unaided		
Requires assistance/supervision		
1/2 carers needed		
Dresses unaided		
Requires assistance/supervision		
1/2 carers needed		

Ascertain degree of independence, state of mouth & teeth (note if dentures are worn) & any prostheses

Lost sensation in left hand/arm/shoulder. Hand is very cold, Requires supervision/help with bathing.

MOBILISING

Able to get out of bed unaided Y/N	
Requires assistance/supervision (specify Y/N)	
Able to get out of chairs unaided Y/N	
Requires assistance/supervision (specify Y/N)	
Mobile unaided/wheelchair bound Y/N	
Requires assistance (specify Y/N)	
Mobile with zimmer/stick/wheelchair	
Requires assistance (specify Y/N)	
Able to go out alone/with supervision Y/N	

COMMENTS

Has fallen getting in & out of bed.
Mobilise in doors with Zimmer frame. Feels that to go out alone.
~~Limited means to go out~~

FOOD & DRINK

	Yes	No
Fully independent		
Needs assistance/supervision		
Requires special diet (Specify below)		

Note any special dietary needs, difficulties in swallowing or digestion, normal meal patterns, amount of alcohol consumed or any recent weight loss.

COMMENTS

Unable to prepare hot meal at the moment Diabetic - controlled by diet.

PAIN

Type and location ? Note non-verbal signs of pain. Ask what helps

No pain

BREATHING

Note any difficulty or distress, cough (type)

	Yes	No
Smoking		✓
Breathing Difficulties		

If yes, please specify

SOB, Chest tightens up when lying down.

Kent Care
West Kent Community Social Services

CLIENT / PATIENT ASSESSMENT

Date

CONTINENCE

	YES	NO
Incontinent of urine (day)	☐	☐
Incontinent of urine (night)	☐	☐
Incontinent of faeces (day)	☐	☐
Incontinent of faeces (night)	☐	☐
Permanent catheter	☐	☐
Permanent colostomy	☐	☐
Needs Prompting	☐	☐

Comments:

Has prostrate problems waiting for biopsy and 3 scans. Needs to go to the toilet very frequently. Occasional accident (urine)

PYSCHOLOGICAL / EMOTIONAL STATE

	Yes	No
Lucid	☐	☐
Limited Comprehension	☐	☐
Confused	☐	☐
Depressed	☐	☐
Psychiatric history	☐	☐
Assessed by Consultant	☐	☐
Counselling/Therapy (specify)	☐	☐

Comments:

MAINTAINING A SAFE ENVIRONMENT

Does the client/patient need to be protected from any particular risks eg. hazards infection behaviour etc.

At risk of falling. Family will look into lifeline.

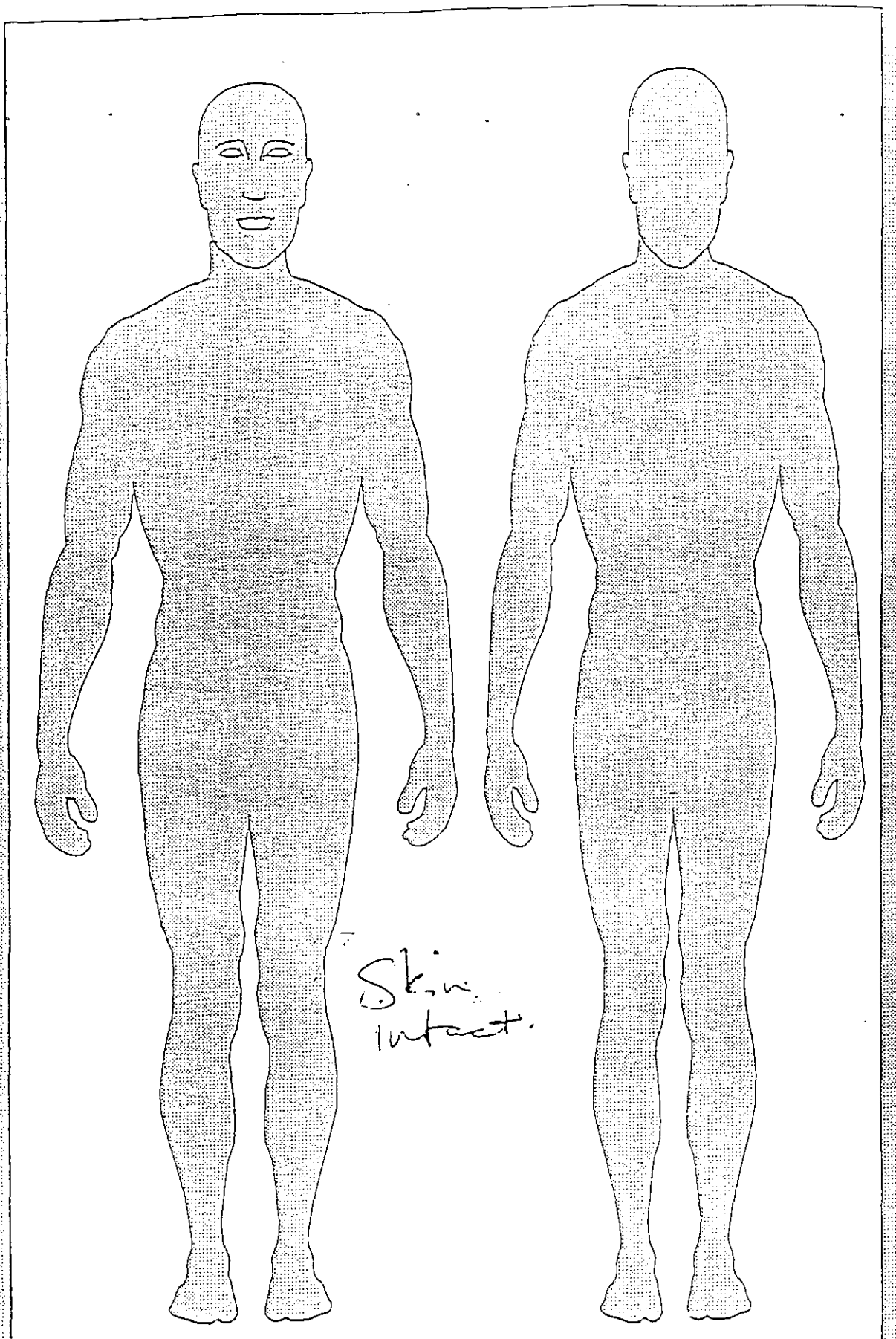
EVIDENCE OF BEHAVIOURIAL PROBLEMS

	Yes	No
None	☐	☐
Memory Loss	✓	☐
Wandering	☐	☐
Anxiety	☐	☐
Disturbing others	☐	☐
Physical aggression	☐	☐
Verbal aggression	☐	☐
Hoarding goods	☐	☐
Restlessness	☐	☐
Challenging behaviour	☐	☐
Recent Inappropriate changes in behaviour		

Some memory loss. Not always oriented to day/night/time. Recognizes people. Repeating himself.

EXPRESSING SEXUALITY

Discuss only if condition warrants: Personal anxieties re: altered body/image/appearance



KentCare
Kent County Council
SOCIAL SERVICES

DETAILS OF DRUGS ADMINISTERED Date

Name

Allergies

DRUGS	5 am	9 am	1 pm	5 pm	9 pm	1 am
Pretanolol						
Aspirin						
G.T.N Spray						

AIDS AND EQUIPMENT

TYPE	AGENCY	ORDERED	DATE RECEIVED	DATE RETURNED	SIGNATURE

Kent Care

CARE PACKAGE SUPPORT AND ACTIVITIES

Date

Page 8

Insert details of service and who provides it in appropriate boxes

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Early am							
Breakfast				Shopping with Son			
Mid-morning							
Lunch							
Mid-afternoon							
Tea							
Evening							
Bed-time							
Night							
Other							

RESIDENTIAL / NURSING HOME/ HOSPITAL CARE Date

Type Of Care Required: Day care ☐ Short term ☐ Permanent ☐ Phased ☐ Rehabilitation ☐

At (name of establishment)

Dates: From ____ To ____ From ____ To ____
From ____ To ____ From ____ To ____

GENERAL REMARKS

Include :- Activities e.g., Church, Social Clubs etc ...
Previous Employment/Voluntary Service/Military Service
Pets etc ...

Has Carer been consulted about Services. Yes ☑ No ☐

Specify

Both sons consulted on 7-1-99.

KentCare
KENT COUNTY COUNCIL
SOCIAL SERVICES

DAY CARE/EMPLOYMENT Date

OTHER SOCIAL CONTACTS

Name | Relationship | Name | Relationship

Contact Point | Contact Point

(a) Every day pattern of life: (include here special cultural, educational and /or spiritual aspects.

(b) What activities does s/he find important in life ?

(c)Employment/Training/Education Needs

(d) Details of other therapeutic/medical needs, e.g., speech, physio:

COMMUNITY ASSESSMENT RECOMMENDATION & OUTCOME

COMMENDATION

wn home, no service required	☐	Residential home	☐
wn home with social care	☐	Nursing home	☐
wn home with nursing care	☐	Continuing care	☐
wn home with social & nursing care	☐	Change of Housing	☐

EQU NCY OF VISITS FOR HEALTH/SOCIAL CARE PROVISION

W INPUT		MEDIUM INPUT	
per week or less	☐	Up to 2 visits/day	☐
ration of visits		20-45 minutes	☐
20 minutes	☐	Auxiliary & qualified nurse	☐
IL mix of visit			
ainly auxiliary nurse	☐		
the need long term ?	☐		
GH INPUT		Is continuous nursing required ?	
or more visits/day	☐	Yes ☐	No ☐
5+ minutes	☐		
ainly qualified nurse	☐		

IEN AGREEMENT

☐ I agree / disagree with the outcome of this assessment, the implications (including financial agreements) of which have been explained to me.

☐ I refuse to accept the help prescribed in the details

☐ I partly agree with the recommendations/assessment (Need) (Specify)

lient / Patient's signature | Date

SSES OR'S SIGNATURES

ame	Role	Signature	Date

COMMUNITY ASSESSMENT/IDENTIFIED NEEDS

CARERS SITUATION:

Able to continue without help ☐ Complex help needed ☐

Some help needed ☐ No carer/Unable to continue ☐

SOCIAL CARE NEEDS

Main social care needs and requirements

Social Care Provision

Domiciliary Yes ☐ No ☐ High Dependency ☐

Day care Yes ☐ No ☐ Medium Dependency ☐

Respite care Yes ☐ No ☐

Is continuous social supervision required ?

Yes ☐ No ☐

HEALTH CARE NEEDS

Main health care needs & requirements

HOUSING NEEDS

Main Housing needs and requirements

KentCare

COMMUNITY ASSESSMENT RECOMMENDATION & OUTCOME

REC MMENDATION

Own home, no service required	☐	Residential home	☐
Own home with social care	☐	Nursing home	☐
Own home with nursing care	☐	Continuing care	☐
Own home with social & nursing care	☐	Change of Housing	☐

FREQUENCY OF VISITS FOR HEALTH/SOCIAL CARE PROVISION

LOW INPUT		MEDIUM INPUT	
per week or less	☐	Up to 2 visits/day	☐
Duration of visits		20-45 minutes	☐
5-20 minutes	☐	Auxiliary & qualified nurse	☐
SKILL mix of visit			
Mainly auxiliary nurse	☐		
Is this need long term ?	☐		

HIGH INPUT — Is continuous nursing required ?

2 or more visits/day ☐ — Yes ☐ No ☐

45+ minutes ☐

Mainly qualified nurse ☐

CLIENT AGREEMENT

☐ I agree / disagree with the outcome of this assessment, the implications (including financial agreements) of which have been explained to me.

☐ I refuse to accept the help prescribed in the details

☐ I partly agree with the recommendations/assessment (Need) (Specify)

Client / Patient's signature | Date

ASSESSOR'S SIGNATURES

Name	Role	Signature	Date

NORTON PRESSURE SORE RISK CALCULATOR

Date

ATE	PHYSICAL CONDITION	MENTAL CONDITION	ACTIVITY	MOBILITY	INCONTINENT	TOTAL SCORE
	Good 4	Alert 4	Ambulant 4	Full 4	Not 4	
	Fair 3	Apathetic 3	Walk/help 3	Slightly limited 3	Occasionally 3	
	Poor 2	Confused 2	Chairbound 2	Very limited 2	Usually urine 2	
	Very bad 1	Stuporous 1	Bedfast 1	Immobile 1	Doubly 1	

ent's name

Ward

: TOTAL SCORE OF 14 AND BELOW = 'AT RISK'

LEGAL STATUS

Date

Solicitors

Name

Address

Town

Tel No (and code)

Has a Will been made ? Yes ☐ No ☐

Location of Will

Preference on death Burial ☐ Cremation ☐

Is anyone acting on your behalf in the following capacity ?

a) Appointee Yes ☐ No ☐

Name

Address

Town

Tel No (and code)

b) Power of Attorney Yes ☐ No ☐ General ☐ Enduring ☐

Name

Address

Town

Tel No (and code)

c) Court of Protection Yes ☐ No ☐

Name

Address

Town

Tel No (and code)

WELFARE BENEFITS

Do you receive the following ?	Yes	No
Retirement Pension	☐	☐
Invalidity Benefit	☑	☐
Severe Disablement Allowance	☐	☐
Income Support	☐	☐
Housing Benefit	☐	☐
Council Tax Benefit	☐	☐
Attendance Allowance or Disability Living Allowance	☐	☐
Care Component	☐	☐
Mobility Component	☐	☐

Dec Pension

COMMUNITY ASSESSMENT RECOMMENDATION & OUTCOME

RECOMMENDATION

Own home, no service required	☐	Residential home	☐
Own home with social care	☐	Nursing home	☐
Own home with nursing care	☐	Continuing care	☐
Own home with social & nursing care	☐	Change of Housing	☐

FREQUENCY OF VISITS FOR HEALTH/SOCIAL CARE PROVISION

LOW INPUT

1 per week or less ☐

Duration of visits

5-20 minutes ☐

Skill mix of visit

Mainly auxiliary nurse ☐

Is the need long term ? ☐

MEDIUM INPUT

Up to 2 visits/day ☐

20-45 minutes ☐

Auxiliary & qualified nurse ☐

HIGH INPUT

2 or more visits/day ☐

45+ minutes ☐

Mainly qualified nurse ☐

Is continuous nursing required ?

Yes ☐ No ☐

CLIENT AGREEMENT

☐ I agree / disagree with the outcome of this assessment, the implications (including financial agreements) of which have been explained to me.

☐ I refuse to accept the help prescribed in the details

☐ I partly agree with the recommendations/assessment (Need) (Specify)

Client / Patient's signature

Date

ASSESSOR'S SIGNATURES

Name	Role	Signature	Date

AUTHORISING SIGNATURES

Social Services

Recommendation Approved ☐ Not approved ☐

Comments

Signature | Designation | Date

Housing

Recommendation Approved ☐ Not approved ☐

Comments

Signature | Designation | Date

Health

Recommendation Approved ☐ Not approved ☐

Comments

Signature | Designation | Date

KentCare
JOINT CONSORTIUM OF SOCIAL SERVICES

OT referral

Info re stroke / diagnosis / prognosis
c/d and
Comorbidities
Falls / stairs
OT / physio
Prostate

Angina / medication?

~~AEU AU / ICA~~ ?
~~t. support~~
Care plan
Bath aids / rails – Simple Solutions
Bed ↓ – refused
Lifeline
~~chair~~ Stairlift from SAFFA
Family will stay

Lewisham Community Care Assessment as used in the Lewisham control group

Lewisham Social Services

CLIENT INFORMATION FRONT SHEET
Strictly Confidential

Party ID: 3079 D Number: Admin. Check:

urname: Forenames: .K.A: .lient Category: ELD	Date of Birth: [redacted] Gender: [redacted] Age: [redacted] Marital Status: Ethnic Origin: [redacted]
ain Address:	Current/Contact Address:
elephone No:	Telephone No:

GP Name: [redacted]
rtyid: [redacted]

Surgery Address: [redacted]

Telephone No: [redacted]

EMERGENCY CONTACT:

Name: Dora Davies

ddress: s/a

me Phone No: ~~0181 461 3048~~

ife

CLIENT ISSUES:

Access/Mobility Issues: No

Communication Issues:

STAFF SAFETY ISSUES:

CORE ASSESSMENT OF NEED | Name

ERSONS PERCEPTION OF NEED (To Include Cultural and Religious Needs)

Feels his current needs are being met in this setting (very sheltered housing).

ARERS PERCEPTION OF SITUATION

No carer.

C: er eligible for assessment under the Carers Act 1996? YES/NO
oes he Carer wish to be Assessed? YES/NO

OCIAL NETWORK & SUPPORT

entify what help, if any, is currently being offered from family/friends?

Wife s/a is disabled.
Son in Shaws Path is helpful and daughter of Mrs Davies : Beckenham does their shopping

PERSONAL (activities of daily living)

Getting up/going to bed	Fully independent	Needs occasional assistance	Needs daily supervision	Bedfast	
	✓				

Comments

Bathing	Fully Independent	Needs verbal prompting	Needs physical help	Needs equipment and help	Cannot manage

Comments

Leg ulcer on both legs (bandaged) - is not able to bath. Washes self down.

Grooming	Fully Independent	Needs verbal prompting	Needs physical help	Grooming hair/teeth/shaving Needs help	Cannot manage
	✓				

Comments

Toileting	Fully Independent	Needs verbal prompting	Needs physical help	Needs equipment and help	Cannot manage
	✓				

Comments

Dressing	Fully Independent	Needs verbal prompting	Needs physical help	Cannot manage	
	✓				

Comments

Feeding	Fully Independent	Verbal/ physical prompt	Needs food cut up	Needs special aids	Cannot manage
	✓				

Comments

Ie ication	Able to self medicate ✓	Manages with help	Cannot manage		

omments

Has 3 puffers + water tablets

Iobility	Fully ambulant ✓	With appliance outside	With appliance inside	With one helper	With two helpers chairbound/ bedbound

Comments

slow - rather painful.

Access around the ine eg. In/out	Fully ambulant ✓	With appliances	With help		

orments

Stairs	Can manage	Manages with help	Cannot manage ✓		

Cor nents

ra fers ie chairbed/ bet	Can manage ✓	Can manage with assistance of one person	Can manage with assistance 2 person and or hoist		

Comments

slow

Menstruation (comment)

cre of nput of urs	No input ✓	Occasional assistance	Monday-Friday assistance	Weekend assistance	Totally dependent day/night

Com ments

DOMESTIC (activities of daily living)

hopping	Independent	Needs Help	Cannot Manage	✓	

Comments

Done by daughter in Beckenham on weekly basis. This week she is sick, so staff at Sheltered housing scheme will assist.

Pension/Bills	Independent	Needs Help	Cannot Manage	✓	

Comments

Son Jim helps with bills.
Staff at Kenton Court collect pension and deduct charges £32.90 (meals) £17.40 (care charge) total for two per week.

Housework	Independent	Needs Help	Cannot Manage	✓	

Comments

done by staff at the home.

laundry	Independent	Needs Help	Cannot Manage		

Comments

There is a communal laundry at Kenton Court & Mrs Davies is able to deal with this.

Ability to use appliances eg.cooker/fire etc	Independent ✓	Needs Help	Cannot Manage		

Comments

Does not need to cook meals. Able to prepare a salad or snack meal.

Present input of cares	No input	Occasional assistance	Monday-Friday assistance ✓	Weekend assistance ✓	Totally dependent day/night

Comments

-H SICAL HEALTH (TICK AS APPROPRIATE)

Me_ical History (other relevant information)
history of significant illness, operations and current physical state. Also use of tobacco/alcohol

Asthma since 1950. Has 3 inhalers.
Ulcerated legs since 1989. District Nurse
now visits twice weekly

s Di trict Nurse/Community Physiotherapy assessment/G.P. visit required

[illegible]	Normal ✓	Diabetic	Other special ie.cultural needs	Light	Fluids only

)m ents

[illegible]	Normal ✓	Occasional incontinence	Incontinent day only or night only	Incontinent day and night	Constipated

om ents

[illegible]	Normal ✓	Occasional incontinence	Incontinent day only	Incontinent night only	Incontinent day and night

omments

Speech	No difficulty ✓	Speech impaired	Moderate speech difficulty	Substantial difficulty	No speech

Comments

Is referral to speech therapist required?

Hearing	No difficulty ✓	Slight impairment	Wears hearing aid	Substantial hearing loss	

Comments

Is referral to Sensory Service Team required?

Sight	No difficulty	Slight impairment	Wears spectacles ✓	Registered blind/partially sighted	

Comments

Is referral to Sensory Service Team required?

Mental Health (consider if further assessment required by specialist mental health team)

Psychiatric History

. Formal psychiatric history/previous episodes/family psychiatric history.

none

Memory Loss	No evidence of memory loss	Occasional forgetfulness	A degree of memory loss of recent events	Short term memory impairment. Some disorientation	Substantial loss of past and present events

Comments (state period over which any memory loss has occurred)

reports no problems

Wandering	Never ✓	Occasionally inside day/night	Occasionally outside day/night	Frequently inside day/night	Frequently outside day/night

Comments (state period over which any wandering has occurred)

Depression	None ✓	Evidence of low mood	Changed sleep pattern/appetite	Reduced motivation, lack of interest in things	Thoughts of suicide Refer to GP or CMHT urgently

Comments (state period over which above has occurred)

Thoughts	Hearing voices	Seeing things	Feelings of being persecuted	Other abnormal beliefs/ experiences (specify below)	

Comments (state period over which above has occurred)

No evidence

Behaviour	Observed/Elicited by assessor	Mentioned by Carers	Mentioned by 3rd party (state who)
Disturbing others at night			
Hazards from gas/electric			
Physical aggression			
Verbal aggression			
Hoarding goods			
Agitation			
Restlessness			
Disinhibition			
Recent inappropriate change in behaviour			

SIGNIFICANT LIFE EVENTS /PERSONAL HISTORY (MANDATORY)
Birth,siblings,parents,schooling,qualifications,work,marriage/relationships,children
interests, retirement, bereavement). Include any history of Domestic Violence

as before

recent bereavement check receipt of widow's payment (women under 60) or retirement pension/income support

HOUSING (type of property/tenure/access etc)
Are any adaptations or changes in current housing required if this person is to remain living in the community?

Moved in May 99 to Very sheltered housing. Ground floor overlooking garden. They are very pleased & feels it meets their needs very well.

Information For Benefits Check

Date of Birth 4-1-21	Partners Date of Birth
National Insurance No.	Partners National Insurance No.

Income (state amounts where applicable)

Type Kerlyn Child Benefit Son has books	Person	Partner	Children	To be applied for/by whom/when
Retirement Pension	£72.84		£65.75	
Occupational Pension per week	£6.67			
Incapacity Benefit				
Widows Benefit				
Disability Working Allowance				
Invalid Care Allowance				
Job Seekers Allowance				
Severe Disablement Allowance				
Family Credit				
Other Income				

Benefits (state amounts where applicable)

Type	Person	Partner	Children	To be applied for/by whom/when
Income Support				
Disability Living Allowance (care component)				
Disability Living Allowance used for car (mobility component)	✓			Charges for U Sheltered Hsg
Attendance Allowance				meals £32.90 for two x 7
Housing Benefit	✓			care £17.40 for two weekly
Council Tax Rebate - (including rebate/ benefit/severe mental impairment)	✓			£50.30

Savings (state amounts where applicable)

NF less than £3000 total.	Person	Partner	Children
Bank Account			
Building Society Account			
Post Office Account			
Premium Bonds			
Other Savings			

SERVICES/AGENCIES CURRENTLY INVOLVED	Details including Contact and Telephone No. If appropriate
Bath Nurse/Bathing Service	
Care Manager	
Chiropodist	
Community Psychiatric Nurse	
Community Team for Elderly Mental Health	
Crossroads	
Day Care Part 111	
Day Centre - Social Services/Health/Private	
Day Hospital	
District Nurse	Twice weekly re leg ulcers.
Homecare Worker - Care 1st	Care Workers on duty 24hrs a day at this property.
Homecare Worker - Private Agency	
Homeshare	
Incontinence Laundry	
Lewisham Association For People with Disabilities	
Link line	
Lunch Club	
Macmillan Team	
Meals on Wheels/Freezer Meals	Hot lunch provided at Kenton Court.
Over 65 Group	
Mental Health Advice Centre	
Night Sitter	
Occupational Therapy	
Physiotherapy	
Planned Hospital Discharge	
Residential Care	
Respite Care (Residential)	
Shopping Service	
Social Worker	
Special Duty Team	
Specialist Social Work Team	
Speech Therapy	
Spring Cleaning	
Twilight Nurse	
Other	

Gold Standard Assessments form

Routine Use of a Standardised Assessment Instrument for Measuring the Outcome of Social Care

CLIENT ASSESSMENT BOOKLET

Client Number:..... **Area:** KENT ❒
LEWISHAM ❒

Today's Date:...../...../.....

Type of Assessment:
INITIAL ❒
6-MONTH REASSESSMENT ❒
12-MONTH REASSESSMENT ❒
CHANGE IN CIRCUMSTANCE ❒

Assessor: JF ❒ SR ❒ **Other: .....[add initials]**

Carer Questionnaires:

LEFT WITH CLIENT/CARER ❒ FORWARDED BY POST ❒

NOT APPLICABLE ❒

DUKE OARS – INSTRUMENTAL ACTIVITIES OF DAILY LIVING©

Can you use the telephone... 2 without help, including looking up numbers and dialling, 1 with some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialling), 0 or are you completely unable to use the telephone? - Not answered	
Can you get to places out of walking distance... 2 without help (can travel alone on buses, taxis, or drive your own car), 1 with some help (need someone to help you or go with you when you are travelling) or 0 are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance? - Not answered	
Can you go shopping for groceries or clothes [assuming subject has transportation]... 2 without help (taking care of all shopping needs yourself, assuming you had transportation), 1 with some help (need someone to go with you on all shopping trips), 0 or are you completely unable to do any shopping? - Not answered	
Can you prepare your own meals... 2 without help (plan and cook full meals yourself) 1 with some help (can prepare some things but unable to cook full meals yourself), 0 or are you completely unable to prepare any meals? - Not answered	
Can you do your housework... 2 without help (can scrub floors, etc.), 1 with some help (can do some light housework but need help with heavy work), 0 or are you completely unable to do any housework? - Not answered	
Can you take your own medicine... 2 without help (in the right doses at the right time), 1 with some help (able to take medicine if someone prepares it for you and/or reminds you to take it), 0 or are you completely unable to take your medicines? - Not answered	
Can you handle your own money... 2 without help (write cheques, pay bills, etc), 1 with some help (manage day-to-day buying but need help with managing your chequebook and paying your bills), 0 or are you completely unable to handle money? - Not answered	
Can you make a hot drink... 2 without help 1 with some help 0 or are you completely unable to make a hot drink? - Not answered	
TOTAL SCORE	

BARTHEL ACTIVITIES OF DAILY LIVING INDEX
(modified version)

Please note: the Index should be used as a record of *what a patient does*, NOT as a record of *what a patient could do*.

Function	Description		Score
BOWELS	0	Incontinent (or needs to be given enema)	
	1	Occasional accident (once a week)	
	2	Continent	
BLADDER	0	Incontinent, or catheterised and unable to manage	
	1	Occasional accident (max. once per 24 hours)	
	2	Continent (for more than seven days)	
GROOMING	0	Needs help with personal care: face, hair, teeth, shaving	
	1	Independent (implements provided)	
TOILET USE	0	Dependent	
	1	Needs some help but can do something alone	
	2	Independent (on and off, wiping, dressing)	
FEEDING	0	Unable	
	1	Needs help in cutting, spreading butter etc	
	2	Independent (food provided within reach)	
TRANSFER	0	Unable-no sitting balance	
	1	Major help (physical, one or two people), can sit	
	2	Minor help (verbal or physical)	
	3	Independent	
MOBILITY	0	Immobile	
	1	Wheelchair independent, including corners etc	
	2	Walks with the help of one person (verbal or physical)	
	3	Independent	
DRESSING	0	Dependent	
	1	Needs help but can do about half unaided	
	2	Independent (including buttons, zips, laces etc)	
STAIRS	0	Unable	
	1	Needs help (verbal, physical, carrying aid)	
	2	Independent up and down	
BATHING	0	Dependent	
	1	Independent (Bath: must get in and out unsupervised and wash self. Shower: unsupervised/unaided)	
		TOTAL SCORE	

MINI-MENTAL STATE EXAMINATION

		Score	
1. What is the...	Year?	1	
	Season?	1	
	Date?	1	
	Day?	1	Client Total
	Month?	1	
		5	
2. Where are we...	Country?	1	
	County?	1	
	Town?	1	
	Street?	1	Client Total
	House number/name?	1	
		5	

Registration

3. Examiner names three objects (for example, apple, table, penny). Client is asked to repeat the three names—score one for each correct answer.

1	Client Total
1	
1	
3	

Then the client should learn the three names (i.e. repeat the names until the client learns all three).

Attention and Calculation

4. Serial sevens: subtract 7 from 100, then repeat from result. Stop after five: 100, 93, 86, 79, 72, 65.—score one for each correct answer.

1	Client Total
1	
1	
1	
1	
5	

(Alternative: spell 'world' backwards: D L R O W)

Recall

5. Ask client for the names of the three objects learnt in Question 3.

1	Client Total
1	
1	
3	

Language

6. Point to a pencil and a watch. Have the client name them.

1	Client Total
1	
2	

7. Have the client repeat 'No ifs, ands, or buts'.

	Client Total
1	
1	

8. Give a three-stage command. Score one for each stage (for example, 'Place index finger of right hand on your nose, and then on your left ear').

1	Client Total
1	
1	
3	

9. Ask the client to read and obey a written command on a piece of paper stating: 'Close your eyes'.

	Client Total
1	
1	

10 Ask the client to write a sentence of his/her own choice (on the next page of the booklet). Score if it is sensible, has a subject and a verb; ignore spelling errors when scoring.

	Client Total
1	
1	

11 Show the design of a pair of intersecting pentagons on the next page of the booklet, and ask the client to copy it. Score one if all sides and angles are preserved and if the intersecting sides form a quadrangle.

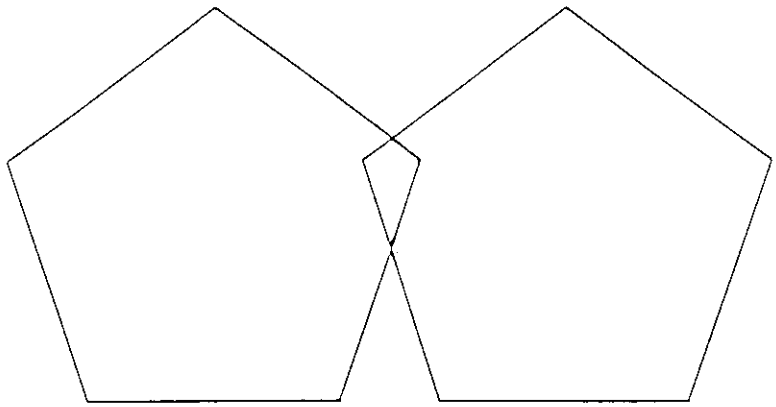
	Client Total
1	
1	
	Overall Client Total Score
30	

10.....

.....

.....

11.



PHILADELPHIA GERIATRIC CENTER MORALE SCALE-UK VERSION

Do things keep getting worse as you get older?	YES = 0 **NO = 1**	
Do you have as much energy as you did last year?	**YES = 1** NO = 0	
Do you feel lonely much?	YES = 0 **NO = 1**	
Do you see enough of your friends and relatives?	**YES = 1** NO = 0	
Do little things bother you more this year?	YES = 0 **NO = 1**	
As you get older do you feel less useful?	YES = 0 **NO = 1**	
Do you sometimes worry so much you can't sleep?	YES = 0 **NO = 1**	
As you get older are things better than expected?	**YES = 1** NO = 0	
Do you sometimes feel life isn't worth living?	YES = 0 **NO = 1**	
Are you as happy now as you were when you were younger?	**YES = 1** NO = 0	
Do you have a lot to be sad about?	YES = 0 **NO = 1**	
Are you afraid of a lot of things?	YES = 0 **NO = 1**	
Do you get angry more than you used to?	YES = 0 **NO = 1**	
Is life hard for you most of the time?	YES = 0 **NO = 1**	
Are you satisfied with your life today?	**YES = 1** NO = 0	
Do you take things hard?	YES = 0 **NO = 1**	
Do you get upset easily?	YES = 0 **NO = 1**	
		Client Total Score
TOTAL	17	

NETWORK ASSESSMENT INSTRUMENT

1. Ask all questions and circle code
2. Circle same code across all boxes on same line
3. Count (do not add) circled codes for each network column and enter number at bottom of column
4. Highest number on bottom line will be in column of respondent's network type

Question	Response categories	Code	Family depend-ent	Locally inte-grated	Local self-contained	Wider comm-unity focused	Private
1. How far away, in distance, does your nearest child or other relative live? ***Do not include spouse***	No relatives	A					
	Same house/within 1 mile	B	B				
	1-5 miles	C		C			
	6-15 miles	D		D	D		
	16-50 miles	E			E	E	E
	50+ miles	F				F	F
2. If you have any children, where does your nearest child live?	No relatives	A			A		A
	Same house/within 1 mile	B	B	B			
	1-5 miles	C	C	C			
	6-15 miles	D		D	D		
	16-50 miles	E			E		
	50+ miles	F				F	F
3. If you have any living sisters or brothers, where does your nearest sister or brother live?	No sisters or brothers	A				A	A
	Same house/within 1 mile	B	B	B			
	1-5 miles	C	C	C	C		
	6-15 miles	D		D	D		
	16-50 miles	E			E		
	50+ miles	F				F	F
4. How often do you see any of your children or other relatives to speak to?	Never/no relative	A					
	Daily	B	B	B			
	2-3 times a week	C	C	C			
	At least weekly	D			D		
	At least monthly	E			E	E	
	Less often	F				F	F
5. If you have friends in this community/ neighbourhood, how often do you have a chat or do something with one of your friends?	Never/no friends	A					A
	Daily	B		B		B	
	2-3 times a week	C		C		C	
	At least weekly	D		D		D	
	At least monthly	E	E		E		
	Less often	F	F		F		
							F
6. How often do you see any of your neighbours to have a chat with or do something with?	No contact with neighbours	A	A				A
	Daily	B		B			
	2-3 times a week	C		C			
	At least weekly	D		D	D	D	
	At least monthly	E	E		E	E	
	Less often	F	F				F
7. Do you attend any religious meetings?	Yes, regularly	A		A		A	
	Yes, occasionally	B	B		B	B	
	No	C			C		C
8. Do you attend meetings of any community/ neighbourhood or social groups, such as old people's clubs, lectures or anything like that?	Yes, regularly	A		A		A	
	Yes, occasionally	B	B		B		
	No	C	C		C		C
		Totals for each column					

GERIATRIC DEPRESSION SCALE –10-ITEM

Answers that are in capitals score one point. Scoring guidance should not be seen by the client.

QUESTION	RESPONSE	SCORE
Are you basically satisfied with your life?	yes/**NO**	
Have you dropped many of your activities and interests	**YES**/no	
Do you feel that your life is empty?	**YES**/no	
Are you afraid that something bad is going to happen to you?	**YES**/no	
Do you feel happy most of the time?	yes/**NO**	
Do you often feel helpless?	**YES**/no	
Do you feel you have more problems with memory than most?	**YES**/no	
Do you feel full of energy?	yes/**NO**	
Do you feel that your situation is hopeless?	**YES**/no	
Do you think that most people are better off than you are?	**YES**/no	
	TOTAL SCORE	

ECONOMIC CIRCUMSTANCES

For the purposes of the research it would be helpful to have some brief information about household income. This information is entirely confidential to the research team.

1. **What sources of income do you have (i.e. all sources of household income)? [Tick the sources of income received]**

Retirement pension		Disabled living allowance (mobility component)	
Occupational pension		Disabled living allowance (care component)	
Attendance allowance		Other	
Income support			
Housing benefit			
Interest from savings			

2. **Can you please indicate within which band your total weekly household income falls [show Card One, which is double-sided, and tick appropriate box]**

Band A	Less than £70		Band H	£160-174	
Band B	£70-84		Band I	£175-189	
Band C	£85-99		Band J	£190-204	
Band D	£100-114		Band K	£205-219	
Band E	£115-129		Band L	£220-234	
Band F	£130-144		Band M	£235-249	
Band G	£145 159		Band N	£250 or more	

3. **Do you have savings (i.e. the household)?** Yes ☐ No ☐

If '**yes**', can you please indicate which band your savings fall into. [Show Card Two and tick appropriate band]

Band A	Less than £3,000	
Band B	£3,000-£7,999	
Band C	£8,000-£15,999	
Band D	£16,000 or more	

4. **Do you own this house/flat (ie client or spouse/partner)?**

Yes ☐ No ☐

If 'yes', which band do you think the house value falls within? [Show Card Three and tick the appropriate band]

Band A	Less than £40,000	
Band B	£40,000- £59,000	
Band C	£60,000- £79,000	
Band D	£80,000 or more	

HOUSING CIRCUMSTANCES

1. **Is this address the client's usual home?** Yes ☐ No ☐

If '**NO**', tick the box that is applicable for the client's current residence:

Residential home ☐ Nursing home ☐ Hospital ☐

Staying with relatives ☐ Other ☐

2. **If the client's permanent accommodation is any of the following, tick the appropriate box** *and proceed to Question 21.*

Hospital ☐ Nursing home ☐ Residential home ☐

Hotel ☐ Hostel ☐ Bed and breakfast ☐

Lodgings ☐

The rest of the form relates to the client's usual accommodation

3. **Is the client or their spouse the head of household** (i.e. the tenant or the owner of the property)? Yes ☐ No ☐

4. **Does the client live:**

Alone? ☐ With spouse/partner? ☐ With relatives? ☐ With others? ☐

5. **How many people form the household?** .....

6. **Property type?**

Bedsit ☐ Flat ☐ Maisonette ☐ House ☐ Bungalow ☐

Other ☐

7. **What is the total number of rooms (excluding toilet/bathroom/ hall)?** .....

8. **Is the accommodation:**

Sheltered (must have alarm system and resident/non-resident warden) ? ☐

Very sheltered (as above, plus provision of some care services, e.g. meals/home care as an integral part of service provision) ? ☐

Non-sheltered ? ☐

If 'non-sheltered', does the client have a form of community alarm? Yes ☐ No ☐

9. **Regarding accessibility, does the dwelling have no more than two steps to a floor that provides kitchen, toilet and bathroom facilities and at least two other rooms?**

Yes ☐ No ☐

10. Does the dwelling have internal stairs? Yes ☐ No ☐

11. Does the dwelling have external stairs with no lift?

Yes ☐ No ☐

12. What is the tenure type:

Owner-occupied? ☐ Local authority (N T/O Public)? ☐ Tied? ☐
Housing association? ☐ Private rented? ☐ Other? ☐

13. What is the age of the property:

Pre-1919? ☐ 1919-1944? ☐ 1945-1964? ☐ Post-1964? ☐

14. Is there any dampness in the home (e.g. damp patches on walls or ceilings, very bad condensation)? Yes ☐ No ☐

15. Regarding amenities, does the property have the following? Tick, if so.

Bath or shower with H&C water in indoor bathroom? ☐ Indoor toilet? ☐
Kitchen or bathroom shared with a separate household? ☐
Handbasin with H&C water in bathroom? ☐ Hot and cold water in kitchen? ☐

16. Does the dwelling have a walk-in shower?

Yes ☐ No ☐

17. Does the dwelling have full central heating?

Yes ☐ No ☐

If '**YES**', indicate type: Gas ☐ Electric ☐ Solid-fuel ☐ Oil ☐

18. Are any of the following in use:

Calor-gas heaters? ☐ Open coal fire? ☐ Paraffin stove? ☐
Electric bar heater? ☐ Gas cooker? ☐ Gas fire? ☐

19. Has the client received any aids or assistance with adaptations from SSD/Housing Dept, HA, NHS)? Yes ☐ No ☐

Tick the aids or adaptations supplied/ specially purchased:

Bath board ☐ Hand/grab rails ☐ Raised toilet seat ☐ Tap rail ☐
Bath seat ☐ Chair raisers ☐ Banister ☐ Shower over bath ☐
Shower stool/chair ☐ Walk-in shower ☐ Dressing aids ☐
Stair lift ☐ Food/drink-preparation aids ☐ Walking stick ☐
Zimmer frame ☐ Non-electric wheelchair ☐ Electric wheelchair ☐

List other items (use a separate line for each item):

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

20. List the aids or adaptations (ticked/listed in question 19) which have been purchased privately (use a separate line for each item):

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

Complete the next question only at the first and second reassessment, not the initial.

21. Has the client's permanent accommodation changed since the (Research Team's) last assessment?

Yes ☐ No ☐

If '**YES**', please indicate the approximate date of change of accommodation.

.....

RESOURCE-USE INFORMATION

1. Ask the client how often she or he receives home care/ home help (if at all). Write the number of days each week, and the total number of hours each week. Where the client does not currently receive home care, use '0'.

TYPE OF SERVICE	CURRENTLY	
	DAYS p.w.	TOTAL NO. OF HRS
Home-care/home-help-IADL and ADL		

2. Ask the client about the number of days the following are used (if at all). Use '0' where the service is not used currently.

TYPE OF SERVICE	CURRENTLY
	DAYS p.w.
Meals on wheels	
Lunch club	
Day centre (general)	
Day centre (EMI)	
Day hospital (physical)	
Day hospital (psychiatric)	

3. Ask the client if she or he currently receives any of the following. Tick the appropriate box for her/his response.

TYPE OF SERVICE	CURRENTLY	
	YES	NO
Laundry service		
Bathing service		
Therapeutic/Support group		
Befriending/Visiting service		
District (community general) nurse		
Community psychiatric nurse		
Other types of nursing (e.g. night-nursing; Macmillan nurse)		
OT (rehab.)		
Physiotherapy		
Speech therapy		
Sitting service (day)		
Sitting service (night)		
Chiropody		

4. Ask the client on how many occasions, if any, she or he has used any of the following respite services in the last 6 months. If none, use '0' as a response.

TYPE OF RESPITE CARE	NO. OF OCCASIONS IN LAST 6 MTHS
Residential-care respite	
Nursing-home respite	
Hospital respite	

5. Ask the client how many times she or he has seen a GP or visited Casualty in the last 6 months. If none, use '0' as a response.

GP/HOSPITAL ADMISSIONS/CASUALTY VISITS	NO. IN LAST 6 MTHS
GP	
Visit to Casualty (Accident & Emergency)	

6. Ask the client how many times she or he has been admitted to hospital in the last 6 months, and for the name(s) of the hospital(s).

NO. OF ADMISSIONS IN LAST 6 MONTHS		NAME OF HOSPITAL(S)	

7. Ask the client if any of the services received are purchased 'privately', rather than provided via the local authority/ health service. List these:

.....

.....

.....

.....

.....

.....

CLIENT SATISFACTION WITH SERVICE PROVISION

Read the question to the client (including the five response categories), and tick the number of the response selected by the client.

1. In general, how would you rate the services that you have received?

1	2	3	4	5
Very poor	Poor	Satisfactory	Good	Excellent

2. How would you rate the services in terms of the amount of help that you have received?

5	4	3	2	1
Excellent	Good	Satisfactory	Poor	Very poor

3. To what extent have your needs been met?

1	2	3	4	5
None of my needs has been met	Only a few of my needs have been met	Some of my needs have been met	Most of my needs have been met	All of my needs have been met

4. Could anything else have been done to help you? (record key points)

.....

.....

.....

.....

.....

CHECKLIST

Tick the boxes for each areas of assessment if completed. If any have not been completed, or have been only partly completed, tick, and give the reason using one or more codes from foot of page.

	Areas of Assessment	NOT COMPLETED	PARTLY COMPLETED	REASON-USE CODE(S)
☐	IADLs (Duke OARS©)			
☐	ADLs (Barthel)			
☐	Cognitive functioning (MMSE)			
☐	Well-being/quality of life (PGCMS-a)			
☐	Social resources (Network Support Instrument)			
☐	Mood/affect (GDS-10)			
☐	Economic circumstances			
☐	Housing circumstances (incl. aids and adaptations)			
☐	Resource-use information			
☐	Client satisfaction			

For the **Relatives' Stress Score** and the **GHQ-12**, please insert a score here, since scoring cannot be included on these pages.

	Carer Questionnaires
☐	Not applicable-no carer
☐	Caregiver burden (Relatives' Stress Score) **TOTAL SCORE:**
☐	Caregiver stress (GHQ-12) **TOTAL SCORE:**

Now check that the details on the front of the Client Assessment Booklet have been completed. Also, ensure that the two carer assessment forms have been given to the carer, with the client number written on the top of both. If they are to be returned by post, ensure a pre-paid envelope is also provided.

Codes for Reasons Areas of Assessment are not completed, or partly completed:

A. PROBLEMS WITH VISION
B. PROBLEMS WITH HEARING
C. PROBLEMS WITH SPEECH
D. PROBLEMS WITH WRITING
E. OTHER PHYSICAL PROBLEMS (e.g. arthritis in hands; client too physically unwell, fatigued)
F. POSSIBLE COGNITIVE IMPAIRMENT
G. REFUSED TO ANSWER THESE QUESTIONS

MDS-HC UK version 2.0

(Status in **LAST 3 DAYS** unless other time frame indicated. Note, if less than 3 days since the last assessment, code all items that reference last 3 days on the basis of status since last assessment)

1	CLIENT NAME	a. Title	b. Middle Initial	c. Last Name	d. First Name
2	CASE RECORD NUMBER				

1	GENDER	..... 1. Male ..... 2. Female
2	DATE OF BIRTH	(day, month, year)
3	RACE	..... 1. European-Caucasian ..... 7. Chinese ..... 2. African-Carribean ..... 8. Other Asian ..... 3. African ..... 9. Other ethnic minority ..... 4. Pakistani ..... 10. Other – specify ..... 5. Bangladeshi .... 6. Indian ..... 11. Not known
4	MARITAL STATUS	..... 1. Never married ..... 4. Separated ..... 2. Married ..... 5. Divorced ..... 3. Widowed
5	LANGUAGE	Primary Language ..... 0. English ..... 1. Other – specify .....
6	EDUCATION	Age of leaving full-time education Tick if applicable ..... 1. College/apprenticeship ..... 2. University-level education
7	RESPONSIBILITY/ ADVANCED DIRECTIVES	(Code for responsibility/advanced directives 0 = No 1=Yes) ..... a. Client has a legal guardian ..... b. Client has advanced medical directives in place (eg: a "do not hospitalise" order)
8	RELIGION	Specify .....

1	DATE CASE OPENED/REOPENED	(day, month, year)
2	REASON FOR REFERRAL	..... 1. Post hospital care ..... 4. Eligibility for home care ..... 2. Community chronic care ..... 5. Day Care ..... 3. RH/NH placement ..... 6. Other – Specify .....
3	GOALS OF CARE	(Code for patient/family understanding of goals of care 0 = No 1 = Yes) ..... a. Skilled nursing care ..... d. Client/family education ..... b. Monitoring to avoid clinical complications ..... e. Family respite ..... f. Palliative care ..... c. Rehabilitation ..... g. Community care
4	TIME SINCE LAST HOSPITAL STAY	Time since discharge from last in-patient setting (Code for most recent instance in **LAST 180 DAYS**) ..... 0. No hospitalisation within 180 days ..... 2. Within 8 to 14 days ..... 3. Within 15 to 30 days ..... 1. Within last week ..... 4. More than 30 days ago
5	WHERE LIVED AT TIME OF REFERRAL	..... 1. Private home with no homecare services ..... 3. Warden accommodation ..... 4. Nursing home ..... 2. Private home with homecare services ..... 5. Residential home ..... 6. Other – Specify .....
6	WHO LIVED WITH AT TIME OF REFERRAL	..... 1. Lived alone ..... 5. Lived with other(s) [not spouse or children] ..... 2. Lived with spouse only ..... 3. Lived with spouse and other ..... 6. Lived in group setting with non-relative(s) ..... 4. Lived with child (not spouse)
7	PRIOR NURSING HOME PLACEMENT	Lived in a nursing home/residential care at any time during 5 years prior to case opening **CAP 4** ..... 0. No ..... 1. Yes
8	RESIDENTIAL HISTORY	Moved to current residence within last 2 years ..... 0. No ..... 1. Yes

Time Start: Time Complete:

1	ASSESSMENT REFERENCE DATE	Date of Assessment (day, month, year)
2	REASON FOR ASSESSMENT	Type of Assessment ..... 1. Initial assessment ..... 2. Follow-up assessment ..... 3. Routine assessment at fixed intervals ..... 4. Review within 30-day period prior to discharge from the programme ..... 5. Review at return from hospital ..... 6. Change in status ..... 7. Other
1	MEMORY/RECALL ABILITY **CAP 8**	(Recall of what was learned or known) 0=Memory OK, 1=Memory problem ..... a. Short-term memory – appears to recall after 5 minutes ..... b. Procedural memory – can perform all or almost all steps in a multitask sequence without cues for initiation
2	COGNITIVE SKILLS FOR DAILY DECISION MAKING **CAP 3** **CAP 5** **CAP 26**	a. How well client made decisions about organising the day (eg: 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 ACUTE CONFUSION **CAP 4** **CAP 5** **CAP 15** **CAP 26**	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) ..... 0. No ..... 1. Yes b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disorientated such that his or her safety is endangered or client requires protection by others ..... 0. No ..... 1. Yes
1	HEARING **CAP 5**	(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 **CAP 5**	(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 **CAP 1** **CAP 2** **CAP 5**	(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
4	COMMUNICATION 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

[redacted]		
1	VISION **CAP 6**	(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 not 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 **CAP 6**	Sees halos or rings around lights, curtains over eyes, or flashes of lights ..... 0. No ..... 1. Yes
3	VISION DECLINE **CAP 6**	Worsening of vision as compared to status of **90 DAYS AGO** (or since last assessment if less than 90 days) ..... 0. No ..... 1. Yes
[redacted]		
1	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD **CAP 10** **CAP 26**	(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 – eg: easily annoyed, anger at care received ..... c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS – eg: fear of being abandoned, left alone, being with others ..... d. REPETITIVE HEALTH COMPLAINTS – eg: persistently seeks medical attention, obsessive concern with body functions ..... e. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS – eg: persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. ..... f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS – eg: furrowed brows ..... g. RECURRENT CRYING, TEARFULNESS ..... h. WITHDRAWAL FROM ACTIVITIES OF INTEREST – eg: no interest in longstanding activities or being with family/friends ..... i. REDUCED SOCIAL 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 **CAP 9** **CAP 26**	Instances when client exhibited behavioural symptoms. If EXHIBITED, ease of altering the symptoms 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/faeces, 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 BEHAVIOURAL SYMPTOMS **CAP 26**	Behavioural symptoms have become worse or are less well tolerated by family as compared to **90 DAYS AGO** (or since last assessment if less than 90 days) ..... 0. No behavioural symptoms present OR no change in symptoms/toleration ..... 1. Yes

1	INVOLVEMENT	a. At ease interacting with others (eg: likes to spend time with others) ..... 0. At ease ..... 1. Not at ease b. Openly expresses conflict or anger with family/friends ..... 0. No ..... 1. Yes
2	CHANGE IN SOCIAL ACTIVITIES **CAP 12**	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, was client distressed by this ..... 0. No decline ..... 2. Decline, not distressed ..... 1. Decline, distressed
3	ISOLATION **CAP 12** **CAP 22**	a. Length of time client is alone during the day (morning and afternoon) ..... 0. Never or hardly ever ..... 2. Long periods of time – eg all morning ..... 1. About one hour ..... 3. All of the time b. Client says or indicates that he/she feels lonely ..... 0. No ..... 1. Yes

1	TWO KEY INFORMAL CARERS **CAP 22**	MAIN INFORMAL CARER a. (Last/Family Name) b. (First Name) OTHER INFORMAL CARER c. (Last/Family Name) d. (First Name)		**Main Carer**	**Other Carer**
		e. Lives with client 0. Yes 2. No such helper (skip other items in the appropriate column) 1. No	e.		
		f. Relationship to client 0. Child or child-in-law 2. Other relative 1. Spouse 3. Friend/neighbour	f.		
		Areas of help 0 = Yes 1 = No g. Advice or emotional support h. IADL care i. ADL care	g. h. i.		
		If needed, willingness (with ability) to increase help: 0. More than 2 hours 2. No increase 1. 1-2 hours per day j. Advice and emotional support k. IADL care l. ADL care	j. k. l.		
2	CARER STATUS	Tick all that apply ..... a. Carer is unable to continue with caring activities – eg: decline in the health of the caregiver makes it difficult to continue ..... b. Main carer is not satisfied with support received from family and friends (eg: other children of client) ..... c. Main carer expresses feelings of distress, anger or depression ..... d. NONE OF ABOVE			
3	EXTENT OF INFORMAL HELP	For instrumental and personal activities of daily living received over the **LAST 7 DAYS,** record extent of help from family, friends and neighbours (hours of care rounded) a. Sum of time across 5 weekdays b. Sum of time across 2 weekend days		**HOURS**	

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 for client's performance during **LAST 7 DAYS)**
0. INDEPENDENT – 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 for how difficult it is (or would be) for client to do activity on own)
0. NO DIFFICULTY
1. SOME DIFFICULTY – eg: needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY – eg: little or no involvement in the activity is possible

CAP 2, CAP 4

	(A) Self-perf	(B) Diff
a. MEAL PREPARATION – How meals are prepared (eg: planning meals, cooking, assembling ingredients, setting out food and utensils)	a.	
b. ORDINARY HOUSEWORK – How ordinary work around the house is performed (eg: washing up, dusting, making bed, tidying up, laundry)	b.	
c. MANAGING FINANCE – How bills are paid, chequebook is balanced, household expenses are balanced	c.	
d. MANAGING MEDICATIONS – How medications are managed (eg: remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	d.	
e. PHONE USE – How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	e.	
f. SHOPPING – Shopping for food and household items (eg: selecting items, managing money)	f.	
g. TRANSPORT – How client travels by vehicle (eg: gets to places beyond walking distance)	g.	

2

ADL Self Performance – The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating during the **LAST 3 DAYS,** considering all episodes of these activities. For 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 single episode in **LAST 7 DAYS]**

0. INDEPENDENT – No help, set-up, or supervision – OR – Help, set-up, supervision provided only 1 or 2 times during last 3 days (with any task or subtask)
1. SET-UP HELP ONLY – Article or device provided within reach of client 3 or more times
2. SUPERVISION – Supervision, 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 during last 3 days (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) as 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)

CAP 1, CAP 4, CAP 19, CAP 26

..... 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 HOME – [Note – If in wheelchair, self-sufficiency once in chair]
..... e. DRESSING UPPER BODY – How client dresses and undresses (clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers etc
..... f. DRESSING LOWER BODY – How client dresses and undresses (clothes, underwear) from the waist down, includes prostheses, orthotics, belts, trousers,skirts, shoes, and fasteners
..... g. EATING – Includes taking in food by any method, including tube feedings
..... h. TOILET USE – Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after use, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes
..... i. PERSONAL HYGIENE – Including combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands (EXCLUDE baths and showers)
..... j. BATHING – How patient 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 CAP 1 CAP 4

ADL status has become worse (ie 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	a. Indoors ..... 0. No assistive device ..... 3. Scooter (eg: Amigo) ..... 1. Walking stick ..... 4. Wheelchair ..... 2. Zimmer frame ..... 8. Activity did not occur b. Outdoors ..... 0. No assistive device ..... 3. Scooter (eg: Amigo) ..... 1. Walking stick ..... 4. Wheelchair ..... 2. Zimmer frame ..... 8. Activity did not occur
5	STAIR CLIMBING **CAP 3**	In the **LAST 3 DAYS**, how client went up and down stairs (eg: single or multiple steps, using handrail as needed). If client did not go up and down stairs, code client's capacity for stair climbing ..... 0. Up and down stairs without help ..... 4. Not gone up and down stairs - no capacity to do it ..... 1. Up and down stairs with help ..... 2. Not gone up and down stairs – but could without help ..... 8. UNKNOWN – did not climb stairs and assessor is unable to judge whether the capacity exists ..... 3. Not gone up and down stairs – but could with help
6	STAMINA **CAP 3** **CAP 4**	a. In a typical week, during the **LAST 30 DAYS** (or since last assessment if less than 30 days), 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 days b. Hours of physical activities in the **LAST 3 DAYS** (eg: walking, cleaning house, exercise) ..... 0. 2 or more hours ..... 1. Less than 2 hours
7	FUNCTIONAL POTENTIAL **CAP 2**	..... a. Client believes he/she capable of increased functional independence (ADL, IADL, mobility) ..... b. Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility) ..... c. Good prospects of recovery from current disease or conditions, improved health status expected ..... d. NONE OF ABOVE
1	BLADDER CONTINENCE **CAP 4** **CAP 26** **CAP 30**	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) [Note – if dribbles, volume insufficient to soak through underpants] ..... 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 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 bladder incontinence as compared to status **90 DAYS AGO** (or since last assessment if less than 90 days) ..... 0. No ..... 1. Yes
2	BLADDER DEVICES **CAP 30**	(Tick all that apply in **LAST 7 DAYS** – or since last assessment if less than 7 days) ..... a. Use of pads or briefs to protect against wetness ..... b. Use of an indwelling catheter ..... c. NONE OF ABOVE
3	BOWEL CONTINENCE **CAP 19** **CAP 29**	In **LAST 7 DAYS** (or since last assessment if less than 7 days), control of bowel movement (with appliance or bowel continence program if employed) ..... 0. CONTINENT – Complete control ..... 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 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 ..... 6. DID NOT OCCUR – No bowel movement

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 health professional or is the reason for a hospitalisation in **LAST 90 DAYS** (or since last assessment if less than 90 days)

0. Not present
1. Present – not subject to focused treatment or monitoring by home-care nurse
2. Present – monitored or treated by home-care nurse

(If no disease in list, tick **ac** NONE OF ABOVE)

1 DISEASES
CAP 4
CAP 15
CAP 16
CAP 23
CAP 26

Heart/Circulation
a. Cerebrovascular accident (stroke) [a.]
b. Congestive heart failure [b.]
c. Coronary artery disease [c.]
d. Hypertension [d.]
e. Irregularly irregular pulse [e.]
f. Peripheral vascular disease [f.]

Neurological
g. Alzheimer's [g.]
h. Dementia other than Alzheimer's [h.]
i. Head trauma [i.]
j. Hemiplegia/hemiparesis [j.]
k. Multiple sclerosis [k.]
l. Parkinsonism [l.]

Musculo-Skeletal
m. Arthritis [m.]
n. Hip fracture [n.]
o. Other fractures (eg: wrist, vertebral) [o.]
p. Osteoporosis [p.]

Senses
q. Cataract [q.]
r. Glaucoma [r.]

Psychiatric/Mood
s. Any psychiatric diagnosis [s.]

Infections
t. HIV infection [t.]
u. Pneumonia [u.]
v. Tuberculosis [v.]
w. Urinary tract infection (in last 30 days) [w.]

Other Diseases
x. Cancer – (in past 5 years) not including skin Cancer [x.]
y. Diabetes [y.]
z. Emphysema/COPD/Asthma [z.]
aa. Renal Failure [aa.]
ab. Thyroid Disease (hyper or hypo) [ab.]
ac. NONE OF ABOVE [ac.]

2 OTHER CURRENT DIAGNOSES
a.
b.
c.
d.

[redacted]

1 PREVENTIVE HEALTH MEASURES
CAP 25

(Tick all that apply – in **PAST 2 YEARS**)
..... a. Blood pressure measured
..... b. Received influenza vaccination
..... c. Test for blood in stool or screening endoscopy
..... d. IF FEMALE: Received breast examination or mammography
..... e. NONE OF ABOVE

2 PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS
CAP 14
CAP 23
CAP 29

(Tick all that were present on **AT LEAST 2 OF THE LAST 3 DAYS**)
..... a. Diarrhoea
..... b. Difficulty urinating or urinating 3 or more times at night
..... c. Fever
..... d. Loss of appetite
..... e. Vomiting
..... f. NONE OF ABOVE

3 PROBLEM CONDITIONS
CAP 13
CAP 23
CAP 26
CAP 29

(Tick all present at any point during **LAST 3 DAYS**)
Physical Health
..... a. Chest pain/pressure at rest or on exertion
..... b. No bowel movement in 3 days
..... c. Dizziness or lightheadedness
..... d. Oedema
..... e. Shortness of breath
Mental Health
..... f. Delusions
..... g. Hallucinations
..... h. NONE OF ABOVE

4	PAIN **CAP 18**	a. Frequency with which client complains of or shows evidence of pain ..... 0. No pain ..... 2. Daily – one period ..... 1. Less than daily ..... 3. Daily – multiple periods (eg: morning & evening) b. Intensity of pain ..... 0. No pain ..... 3. Severe ..... 1. Mild ..... 4. Times when pain is horrible or excruciating ..... 2. Moderate c. From client's point of view, pain intensity disrupts usual activities ..... 0. No ..... 1. Yes d. Character of pain ..... 0. No pain ..... 2. Multiple sites ..... 1. Localised – single site e. From client's point of view, medications adequately control pain ..... 0. Yes or no pain ..... 2. Pain present, medication not taken ..... 1. Medications do not adequately control pain
5	FALLS FREQUENCY **CAP 26, CAP 15**	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 FALLS **CAP 26**	(Code for danger of falling 0 = No 1 = Yes) ..... a. Unsteady gait ..... b. Client limits going outdoors due to fear of falling (eg: stopped using bus, goes out only with others)
7	LIFESTYLE (DRINKING/SMOKING) **CAP 3** **CAP 7**	(Code 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 (ie: an "eye opener") or has been in trouble because of drinking ..... c. Smoked or chewed tobacco daily
8	HEALTH STATUS INDICATORS **CAP 24**	(Tick all that apply) ..... a. Client feels he/she has poor health (when asked) ..... b. Has conditions or diseases that make cognition, ADL, mood or behaviour patterns unstable (fluctuations, precarious, or deteriorating) ..... c. Experiencing a flare-up of a recurrent or chronic problem ..... d. Treatments changed in **LAST 30 DAYS** (or since last assessment if less than 30 days) because of a new acute episode or condition ..... e. Prognosis of less than 6 months to live – eg: doctor has told client or client's family that client has end-stage disease ..... f. NONE OF ABOVE
9	OTHER STATUS INDICATORS **CAP 11**	(Tick all that apply) ..... a. Fearful of a family member or caregiver ..... b. Unusually poor hygiene ..... c. Unexplained injuries, broken bones or burns ..... d. Neglected, abused, or mistreated ..... e. Physically restrained (eg: limbs restrained, bed rails used, constrained to chair when sitting) ..... f. NONE OF ABOVE
1	WEIGHT **CAP 16**	(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 **CAP 14** **CAP 16**	(Code for consumption 0 = No 1 = Yes) ..... a. In **LAST 3 DAYS**, ate one or fewer meals a day ..... b. In **LAST 3 DAYS**, noticeable decrease in the amount of food usually eaten or fluids usually consumed ..... c. Insufficient fluid – did not consume all/almost all fluids during **LAST 3 DAYS** ..... d. Enteral tube feeding
3	SWALLOWING **CAP 17**	..... 0. NORMAL – Safe and efficient swallowing of all diet consistencies ..... 1. REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS (mechanical diet or able to ingest specific foods only) ..... 2. REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (puree, thickened liquids) ..... 3. COMBINED ORAL AND TUBE FEEDING ..... 4. NO ORAL INTAKE (NPO)

1	ORAL HEALTH **CAP 17** **CAP 23**	(Tick all that apply) ..... a. Problem chewing or swallowing (eg: poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating) ..... b. Mouth is "dry" when eating a meal ..... c. Problem brushing teeth or dentures ..... d. NONE OF ABOVE
M	**SKIN CONDITION**	
1	SKIN PROBLEMS **CAP 20 CAP 23**	Any troubling skin conditions or changes in skin conditions (eg: burns, bruises, rashes, itchiness, body lice, scabies) ..... 0. No ..... 1. Yes
2	ULCERS (PRESSURE/STASIS) **CAP 19**	Presence of an ulcer anywhere on the body. Stage 1 – Ulcers include any area of persistent skin redness Stage 2 – Partial loss of skin layers Stage 3 – Deep craters in the skin Stage 4 – Breaks in skin exposing muscle or bone (Code 0 if no ulcer, otherwise record the highest ulcer 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 **CAP 20**	(Tick all that apply) ..... a. Burns (second or third degree) ..... b. Open lesions other than ulcers, rashes, cuts (eg: cancer) ..... c. Skin tears or cuts ..... d. Surgical wound ..... e. Corns, calluses, structural problems, infections, fungi ..... f. NONE OF ABOVE
4	HISTORY OF RESOLVED PRESSURE ULCERS **CAP 19**	Client previously had (at any time) or has pressure ulcer anywhere on the body ..... 0. No ..... 1. Yes
5	WOUND/ULCER CARE	(Code for receipt of formal care in **LAST 7 DAYS**) ..... a. Antibiotics, systemic or topical ..... b. Dressings ..... c. Surgical wound care ..... d. Other wound/ulcer care (eg: pressure relieving device, nutrition, turning, debridement) ..... E. NONE OF ABOVE
O	**ENVIRONMENTAL ASSESSMENT**	
1	HOME ENVIRONMENT **CAP 28**	(Tick any of the following that make home environment hazardous or uninhabitable, if none apply tick NONE OF ABOVE; if temporarily in institution, base assessment on home visit) ..... a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors) ..... b. Flooring and carpeting (eg: holes in floor, electric wires where client walks, scatter rugs) ..... c. Bathroom and toiletroom (eg: non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet) ..... d. Kitchen (eg: dangerous stove, inoperative refrigerator, infestation by rats or bugs) ..... e. Heating and cooling (eg: too hot in summer, too cold in winter, wood stove in a home with an asthmatic) ..... f. Personal safety (eg: fear of violence, safety problem in going to postbox or visiting neighbours, heavy traffic in street) ..... g. Access to home (eg: difficulty entering/leaving home) ..... h. Access to rooms in house (eg: unable to climb stairs) ..... i. NONE OF ABOVE
2	LIVING ARRANGEMENT	a. As compared to **90 DAYS AGO** (or since last assessment), client now lives with other persons – eg: 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 ..... 2. Yes - caregiver only ..... 1. Yes - client only ..... 3. Yes - client and caregiver

1 FORMAL CARE

Record extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) [Note – round minutes to even 10 minutes]

	(A) Days	(B) Hours	(C) Mins
a. Home carers	a.		
b. Visiting nurses	b.		
c. Home help	c.		
d. Meals on wheels	d.		
e. Volunteer services	e.		
f. Physiotherapy	f.		
g. Occupational therapy	g.		
h. Speech therapy	h.		
i. Day care or day hospital	i.		
j. Social worker in home	j.		
k. Dietician	k.		

2 Special Treatments, Therapies, Programmes

CAP 21
CAP 24

Special treatments, therapies, and programmes 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 out-patient basis.

0. Not applicable
1. Scheduled, full adherence as prescribed
2. Scheduled, partial adherence
3. Scheduled, not received

(If no treatments provided, tick **aa** NONE OF ABOVE)

Respiratory Treatments			o. Occupational therapy	o.
a. Oxygen	a.		p. Physiotherapy	p.
b. Respirator for assistive breathing	b.		**Programs**	
c. All other respiratory treatments	c.		q. Day centre	q.
Other Treatments			r. Day hospital	r.
d. Alcohol/drug treatment programme	d.		s. Hospice care	s.
e. Blood transfusion(s)	e.		t. Doctor or clinic visit	t.
f. Chemotherapy	f.		u. Respite care	u.
g. Dialysis	g.		**Special procedures done in home**	
h. IV infusion – general	h.		v. Daily nurse monitoring (eg: ECG, urinary output)	v.
i. IV infusion – peripheral	i.		w. Nurse monitoring less than daily	w.
j. Medication by injection	j.		x. Medical alert bracelet or Electronic security alert	x.
k. Ostomy care	k.			
l. Radiation	l.		y. Skin treatment	y.
m.Tracheostomy care	m.		z. Special diet	z.
Therapies			aa. NONE OF ABOVE	aa.
n. Exercise therapy	n.			

3 MANAGEMENT OF EQUIPMENT

CAP 1

In the **LAST 3 DAYS** record 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 others

.....a. Oxygen ..... b. IV
.....c. Catheter ..... d. Ostomy

4 VISITS IN **LAST 90 DAYS** OR SINCE LAST ASSESSMENT

Enter 0 if none, if more than 9, code 9

..... a. Number of times ADMITTED TO HOSPITAL with an overnight stay
..... b. Number of times VISITED A&E without an overnight stay
..... c. EMERGENCY CARE – including unscheduled nursing, doctor, or therapeutic visits to surgery or family doctor

5 TREATMENT GOALS

CAP 27

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 OVERALL CHANGE IN CARE NEEDS

CAP 4 CAP 27

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 ..... 2. Deteriorated – receives more support
..... 1. Improved – receives less support

7 TRADE OFFS

Because of limited funds, **DURING THE LAST MONTH**, client made trade-offs among purchasing any of the following: sufficient home heat, adequate food, home care

..... 0. No ..... 1. Yes

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 PSYCHOTROPIC 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 ..... c. Antidepressants ..... b. Anxiolytic ..... d. Hypnotic
3	MEDICAL OVERSIGHT	Doctor reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment) ..... 0. Discussed with at least one doctor (or no medication taken) ..... 1. No single doctor reviewed all medications
4	COMPLIANCE WITH MEDICATIONS **CAP 21**	Compliant all or most of time with medications prescribed by doctor (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 non-prescribed medications taken in **LAST 7 DAYS** (or since last assessment) (a) Name and Dose – Record the name of the medication and dose ordered (b) Form - Code the route of administration using the following list: 1. By mouth (PO) 6. Rectal (R) 2. Sub lingual (SL) 7. Topical 3. Intramuscular (M) 8. Inhalation 4. Intravenous (IV) 9. Enteral tube 5. Subcutaneous (SC) 10. Other (c) Number Taken – Record the amount of medication administered each time the medication is given (d) Frequency - Code the number of times per day, week, or month the medication is administered using the following list: PRN = as necessary 5D = five times daily QH = every hour QOD = every other day Q2H = every two hours QW = once each week Q3H = every three hours 2W = two times each week Q4H = every four hours 3W = three times each week Q6H = every six hours 4W = four each week Q8H = every eight hours 5W = five times each week QD = daily 6W = six times each week BID = two times daily (includes every 12 hours) 1M = once every month 2M = twice every month TID = three times daily C = continuous QID = four times daily O = other

(a) Name & Dose	(b) Form	(c) Number Taken	(d) Frequency
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			

Additional Information

1	**Signature of Person Completing the Assessment:**
a.	Signature of Assessment Coordinator:
b.	Title of Assessment Coordinator:
c.	Date Assessment Coordinator signed as complete: (day, month, year)

2. Other Signatures

	Signature	Title	Sections	Date
a.				
b.				
c.				
d.				

MDS-HC UK version 2.0 Problem recording sheet

[redacted]

[redacted]

CLIENT NAME: **CLIENT ID:**

CAP No.	CAP NAME	DESCRIPTION OF THE PROBLEM PRESENT
[redacted]		
CAP 1	ADL/Rehabilitation Potential	
CAP 2	Instrumental Activities of Daily Living (IADLs)	
CAP 3	Health Promotion	
CAP 4	Institutional Risk	
[redacted]		
CAP 5	Communication Disorders	
CAP 6	Visual Function	

CAP No.	CAP NAME	DESCRIPTION OF THE PROBLEM PRESENT
CAP 7	Alcohol Dependence and Hazardous Drinking	
CAP 8	Cognition	
CAP 9	Behaviour	
CAP 10	Depression and Anxiety	
CAP 11	Elder Abuse	
CAP 12	Social Function	

CAP No.	CAP NAME	DESCRIPTION OF THE PROBLEM PRESENT
CAP 13	Cardio-Respiratory	
CAP 14	Dehydration	
CAP 15	Falls	
CAP 16	Nutrition	
CAP 17	Oral Health	
CAP 18	Pain	
CAP 19	Pressure Ulcers	
CAP 20	Skin and Foot Conditions	

CAP No.	CAP NAME	DESCRIPTION OF THE PROBLEM PRESENT
CAP 21	Adherence	
CAP 22	Brittle Support System	
CAP 23	Medication Management	
CAP 24	Palliative Care	
CAP 25	Immunisation and Screening	
CAP 26	Psychotropic Drugs	
CAP 27	Formal Services	
CAP 28	Environmental Assessment	

CAP No.	CAP NAME	DESCRIPTION OF THE PROBLEM PRESENT
[redacted]		
CAP 29	Bowel Management	
CAP 30	Urinary Incontinence and Indwelling Catheter	
[redacted]		

1 Signature of Person Completing the Assessment:	
a. Signature:	
b. Title:	
c. Date completed: (day, month, year)	☐☐ ☐☐ ☐☐

MDS-HC screener UK version 1.0

MDS-HC Screening Questionnaire (Version 1.0)

Status in **LAST 3 DAYS** unless other time frame indicated.
Note, if less than 3 days since the last assessment, code all items that reference last 3 days on the basis of status since last assessment.

A. IDENTIFICATION INFORMATION

1	CLIENT NAME	a. Title	b. Middle Initial	c. Last Name			d. First Name					
2	CASE RECORD NUMBER											

B. PERSONAL DETAILS

1	GENDER	..... 1. Male	..... 2. Female
2	DATE OF BIRTH	(day, month, year)	
3	RACE	..... 1. European-Caucasian ..... 2. African-Caribbean ..... 3. African ..... 4. Pakistani ..... 5. Bangladeshi ..... 6. Indian	..... 7. Chinese ..... 8. Other Asian ..... 9. Other ethnic minority Specify: .... 11. Not known
4	MARITAL STATUS	..... 1. Never married ..... 2. Married ..... 3. Widowed	..... 4. Separated ..... 5. Divorced
5	LANGUAGE	Primary Language ..... 0. English	..... 1. Other – specify .....

C. REFERRAL INFO

1	DATE CASE OPENED/REOPENED	(day, month, year)	
2	WHO LIVED WITH AT TIME OF REFERRAL	..... 1. Lived alone ..... 2. Lived with spouse only ..... 3. Lived with spouse and other ..... 4. Lived with child (not spouse)	..... 5. Lived with other(s) [not spouse or children] ..... 6. Lived in group setting with non-relative(s)
3	PRIOR NURSING HOME PLACEMENT	Lived in a nursing home/residential care at any time during 5 years prior to case opening ..... 0. No	..... 1. Yes

1	REASON FOR ASSESSMENT	Type of Assessment ..... 1. Initial assessment ..... 2. Follow-up assessment ..... 3. Routine assessment at fixed intervals ..... 4. Review within 30-day period prior to discharge from the programme ..... 5. Review at return from hospital ..... 6. Change in status ..... 7. Other
1	MEMORY/RECALL ABILITY	Recall of what was learned or known 0=Memory OK 1=Memory problem ..... Short-term memory – appears to recall after 5 minutes
2	COGNITIVE SKILLS FOR DAILY DECISION MAKING	a. How well client made decisions about organising the day (eg: 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 ACUTE CONFUSION	a. Sudden or new onset/change in mental function over **LAST 7 DAYS** (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) ..... 0. No ..... 1. Yes b. In the **LAST 90 DAYS** (or since last assessment if less than 90 days), client has become agitated or disorientated such that his or her safety is endangered or client requires protection by others ..... 0. No ..... 1. Yes
1	MAKING SELF UNDERSTOOD	(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
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 – eg: easily annoyed, anger at care received ..... c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS – eg: fear of being abandoned, left alone, being with others ..... d. REPETITIVE HEALTH COMPLAINTS – eg: persistently seeks medical attention, obsessive concern with body functions ..... e. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS – eg: persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. ..... f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS – eg: furrowed brows ..... g. RECURRENT CRYING, TEARFULNESS
1	CHANGE IN SOCIAL ACTIVITIES	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, was client distressed by this ..... 0. No decline ..... 2. Decline, not distressed ..... 1. Decline, distressed
2	ISOLATION	Client says or indicates that he/she feels lonely ..... 0. No ..... 1. Yes

1	• **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) SELF-PERFORMANCE IN LAST 7 DAYS** **IADL Difficulty** Code for how difficult it is (or would be) for client to do activity on own 0 = NO DIFFICULTY 1 = SOME DIFFICULTY – eg: needs some help, is very slow, or fatigues 2 = GREAT DIFFICULTY – eg: little or no involvement in the activity is possible a. MEAL PREPARATION – How meals are prepared (eg: planning meals, cooking, assembling ingredients, setting out food and utensils) b. ORDINARY HOUSEWORK – How ordinary work around the house is performed (eg: washing up, dusting, making bed, tidying up, laundry) c. MANAGING MEDICATIONS – How medications are managed (eg: remembering to take medicines, opening bottles, Taking correct drug dosages, giving injections, applying ointments) d. PHONE USE – How telephone calls are made or received (with assistive devices such as large numbers on telephone, Amplification as needed) e. SHOPPING – How shopping is performed for food and household items (eg: selecting items, managing money) f. TRANSPORT – How client travels by vehicle (eg: gets to places beyond walking distance)	**Difficulty** a. ____ b. ____ c. ____ d. ____ e. ____ f. ____
2	• **ACTIVITIES OF DAILY LIVING (ADL) SELF-PERFORMANCE IN LAST 3 DAYS** 0 = INDEPENDENT – No help, set-up, or supervision – OR – Help, set-up, supervision provided only 1 or 2 times during last 3 days (with any task or subtask) 1 = SET-UP HELP ONLY – Article or device provided within reach of client 3 or more times 2 = SUPERVISION – Supervision, 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 during last 3 days (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) as 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. LOCOMOTION IN HOME Note – If in wheelchair, self-sufficiency once in chair b. EATING – Includes taking in food by any method, including tube feedings c. TOILET USE – Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after use, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothe c. PERSONAL HYGIENE – Including combing hair, brushing teeth, shaving, applying make-up, washing/drying face and hands (EXCLUDE baths and showers) e. BATHING – How patient 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**	**Performance** a. ____ b. ____ c. ____ d. ____ e. ____

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	STAMINA	a. In a **typical week**, during the **LAST 30 DAYS** (or since last assessment if less than 30 days), 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 days a. Hours of physical activities in the **LAST 3 DAYS** (eg: walking, cleaning house, exercise) ..... 0. 2 or more hours ..... 1. Less than 2 hours

H CONTINENCE

1	BLADDER CONTINENCE	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) [Note – if dribbles, volume insufficient to soak through underpants] ..... 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 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

1	CURRENT DIAGNOSES	Disease Name	Disease Code
		a.	•
		b.	•
		c.	•
		d.	•

1	PROBLEM CONDITION PRESENT ON 2 OR MORE DAYS	(Tick if occurred on **AT LEAST 2 OF THE LAST 3 DAYS**) ..... Vomiting
2	PROBLEM CONDITIONS	(Tick all present at any point during **LAST 3 DAYS**) ..... a. Chest pain/pressure at rest or on exertion ..... b. No bowel movement in 3 days ..... c. Dizziness or light-headedness ..... d. Oedema ..... e. Shortness of breath
3	PAIN	a. Frequency with which client complains of or shows evidence of pain ..... 0. No pain ..... 1. Less than daily ..... 2. Daily – one period ..... 3. Daily – multiple periods (eg: morning & evening) b. Intensity of pain ..... 0. No pain ..... 1. Mild ..... 2. Moderate ..... 3. Severe ..... 4. Times when pain is horrible or excruciating
4	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 [ ]
5	DANGER OF FALLS	Code 0 = No 1 = Yes ..... Unsteady gait
6	HEALTH STATUS INDICATORS	(Tick all that apply) ..... a. Has conditions or diseases that make cognition, ADL, mood or behaviour patterns unstable (fluctuations, precarious, or deteriorating) ..... b. Prognosis of less than 6 months to live eg: doctor has told client or client's family that client has end-stage disease

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)
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 usually eaten or fluids usually consumed ..... c. Insufficient fluid – did not consume all/almost all fluids during **LAST 3 DAYS**
3	SWALLOWING	..... 0. NORMAL – Safe and efficient swallowing of all diet consistencies ..... 1. REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS (mechanical diet or able to ingest specific foods only) ..... 2. REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (puree, thickened liquids) ..... 3. COMBINED ORAL AND TUBE FEEDING ..... 4. NO ORAL INTAKE (NPO)

1	SKIN PROBLEMS	Any troubling skin conditions or changes in skin conditions (eg: burns, bruises, rashes, itchiness, body lice, scabies) ..... 0. No ..... 1. Yes
2	ULCERS (PRESSURE/STASIS)	Presence of an ulcer anywhere on the body. Stage 1 – Ulcers include any area of persistent skin redness Stage 2 – Partial loss of skin layers Stage 3 – Deep craters in the skin Stage 4 – Breaks in skin exposing muscle or bone (Code 0 if no ulcer, otherwise record the highest ulcer 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

N SERVICE UTILISATION (LAST 90 DAYS)

1	VISITS IN **LAST 90 DAYS** OR SINCE LAST ASSESSMENT	Enter 0 if none, if more than 9, code 9 ..... a. Number of times ADMITTED TO HOSPITAL **with** an overnight stay ..... b. Number of times VISITED A&E **without** and overnight stay ..... c. EMERGENCY CARE – Including unscheduled nursing, doctor or therapeutic visits to surgery or family doctor
2	OVERALL CHANGE 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 ..... 2. Deteriorated – receives more support ..... 1. Improved – receives less support
3	TRADE OFFS	Because of limited funds, **DURING THE LAST MONTH**, client made trade-offs among purchasing any of the following: sufficient home heat, adequate food, home care ..... 0. No ..... 1. Yes

O 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 ☐

P INFORMAL SUPPORT SERVICES

1	TWO KEY INFORMAL CARERS	MAIN INFORMAL CARER a. (Last/Family Name) b. (First Name) OTHER INFORMAL CARER c. (Last/Family Name) d. (First Name)

			Main Carer	**Other Carer**
e. Lives with client 0. Yes 1. No	2. No such helper (skip other items in the appropriate column)	e.		
f. Relationship to client 0. Child or child-in-law 1. Spouse	2. Other relative 3. Friend/neighbour	f.		

2	CARER STATUS	Tick all that apply ..... a. Carer is unable to continue with caring activities eg. decline in the health of the caregiver makes it difficult to continue ..... b. Main carer is not satisfied with support received from family and friends eg. other children of client ..... c. Main carer expresses feelings of distress, anger or depression ..... d. NONE OF ABOVE
3	EXTENT OF INFORMAL HELP	For instrumental and personal activities of daily living received over the **LAST 7 DAYS,** record extent of help from family, friends and neighbours (hours of care rounded) a. Sum of time across 5 weekdays b. Sum of time across 2 weekend days **HOURS** ☐☐☐ ☐☐☐

Q FORMAL SUPPORT SERVICE (IN LAST 7 DAYS)

1	FORMAL CARE	Record extent of care or care management in **LAST 7 DAYS** (or since last assessment if less than 7 days) [Note – round minutes to even 10 minutes]

	(A) Days	(B) Hours	(C) Mins
a. Home carers	a.		
b. Visiting nurses	b.		
c. Home help	c.		
d. Meals on wheels	d.		
e. Volunteer services	e.		
f. Physiotherapy	f.		
g. Occupational therapy	g.		
h. Speech therapy	h.		
i. Day care or day hospital	i.		
j. Social worker in home	j.		
k. Dietician	k.