interRAI Preliminary Screener for Primary Care and Community Care Settings©

(interRAI Preliminary Screener)

Form and User's Manual

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Chapter 1.

Overview of the interRAI Preliminary Screener for Primary Care and Community Care Settings

Introduction

The interRAI Preliminary Screener was created to provide information to support the intake process. Its design was guided by two main goals:

a) to support decision-making;
b) to record basic information about persons who would *not* be receiving a comprehensive assessment with the interRAI CHA at a later stage.

The interRAI Preliminary Screener may be completed as part of an in-person interview, or over the telephone.

In designing the interRAI Preliminary Screener, it was recognized that assessors interact with multiple informants (for example, prospective persons, spouses, children, health professionals) who contact community support agencies for a variety of purposes (for example, some may request a specific service whereas others needing services may initially ask for information but not services). The needs of the person are expected to include both those explicitly stated by informants, as well as previously unrecognized ones.

The interRAI Preliminary Screener **is not a substitute** for the more comprehensive interRAI CHA. It records only the most essential information needed at the time of intake to support decisions related to the need for a more comprehensive assessment. The interRAI Preliminary Screener is not intended to support care planning, but it does provide some important clinical information needed at the onset of community support service provision.

The interRAI Preliminary Screener is designed to be used as a multi-step process involving documentation and decision-making in the following sections:

1. Section A documents demographic information and the reason for referral.

2. Section B contains important items used in a decision-making algorithm to differentiate persons who do not require further screening or assessment from those who are likely to benefit from further evaluation. Based on the results of the screening items in this section, along with professional judgment, the decision is made about completing, or not completing, a full interRAI CHA.

3. Section C records summary information regarding clinical decisions.

Chapter 2: Approaching the interRAI Preliminary Screener

How Can This Manual Be Used?

Use this manual alongside the interRAI Preliminary Screener, keeping the form in front of you at all times. Learn to rely on it for many of the definitions and procedural instructions necessary. The amplifying information in this manual should facilitate successful use of the interRAI Preliminary Screener form. The items from the interRAI Preliminary Screener form are presented in a sequential basis in the manual. They provide key information to uniquely evaluate each person during the in-person or phone intake process.

The information that follows summarizes the recommended approach to becoming familiar with the interRAI Preliminary Screener.

Recommended Approach for Becoming Familiar with the interRAI Preliminary Screener

(A) First, review the interRAI Preliminary Screener form.

- Note how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions.
    - Are the definitions and instructions clear? Do they differ from current practice? What areas require further clarification?

(B) Complete the interRAI Preliminary Screener for a person known to you.

- Draw only on your knowledge of this person. Enter the appropriate codes on the interRAI Preliminary Screener form. Where your review could benefit from additional information, make note of that fact. How might you secure additional information?

(C) Complete the initial pass through this manual.

- Go on to this step only after first reviewing the interRAI Preliminary Screener form and trying to complete all items for a person who is well known to you.
- As you read the item-by item definitions in this manual, clarify questions that arose as you first used the interRAI Preliminary Screener to evaluate a person. Note sections of

this manual that help to clarify coding and procedural questions you may have had.

- Once again, read the instructions that apply to items in the interRAI Preliminary Screener. Make sure you understand this information before going on. Review the test case you completed. Would you still code it the same way? It will take time to go through all of this material. Do it slowly. Do not rush. Work through the manual one section at a time.

- Are you surprised by any interRAI Preliminary Screener definitions, instructions, or case examples? For example, do you understand how to code ADLs or self-reported mood?

- Do any definitions or instructions differ from what you thought you learned when you reviewed the interRAI Preliminary Screener form?

- Would you now complete your initial case differently?

- Are there definitions or instructions that differ from current practice patterns in your agency/organization?

- Make notations next to any section(s) of this manual you have questions about. Be prepared to discuss these issues during any formal training program you attend.

(D) In a second pass through this manual, focus on the issues that were more difficult or problematic in the first pass.

- Note on the interRAI Preliminary Screener form the issues that warrant attention.

- Further familiarize yourself with definitions and procedures that differ from current practice patterns or that seem to raise questions.

- Re-read each of the examples presented throughout this manual.

(E) The third pass through this manual may occur during the formal interRAI Preliminary Screener education program at your agency/organization and it will provide you with another opportunity to review the material. If you have questions, raise them during the education session.

(F) Future use of information in this manual:

- Keep this manual at hand during the assessment process.

- Where necessary, review the intent of each item in question.

Chapter 3. Item-by-item Guide to the interRAI Preliminary Screener

What is the Standard Format Used in this Manual?

To facilitate completion of the interRAI Preliminary Screener and to ensure consistent interpretation of items, materials of the following types are presented in the manual:

Intent: Reason(s) for including the item (or set of items) in the interRAI Preliminary Screener, including discussions of how the information can be used to identify issues and provide direction for assessors in determining need for further assessment.

***Definition*:** Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

- Interview and observation of the person;
- Discussion with the person's family, other caregivers, and the person's physician; and
- Review of any records or other administrative documentation.

Coding: Proper method of recording each response, with explanations of individual response categories.
Note: if the information is unknown or the assessor is unable to elicit a response using all available sources of information, the "no" response should be used to complete the item.

SECTION A. IDENTIFICATION INFORMATION

A1. Name

Definition Person's legal name.

Coding Use printed letters. Enter in the following order: a. Last name, b First name., c. Middle Initial. If the person has no middle initial leave item "c" blank.

A2. Sex

Coding
1. Male
2. Female

A3. Birthdate

Coding Use four digits for the year of birth. For the month and day, enter two digits each, using a leading zero ("0") as a filler if needed.

Example: January 2, 1968.
1968 01 02
Year Month Day

A4. Numeric Identifiers [Country-specific example—Canada]

Intent To document the health card number and province/territory from which it was issued, and to record the unique person-specific identifier assigned by the agency.

Process Ask the person or primary support person for the person's health card and record the information directly from the card. If there is no card available, ask the person or a family member for the information.

For the case record number, enter the unique number assigned to the person as determined by the agency.

A4a. Health Card Number

Coding Write one number per box, starting with the left-most box. If the health card number is unknown, enter "1" in the left-most box and leave the remainder of the boxes blank. This would be the case if the person is cognitively impaired and there is no one available to provide the necessary information, if the person has lost his or her card, or if the person does not have the information at hand.

If the **person is not a resident of Canada, or is a resident of Canada but his or her services are paid for by the Federal Government**, enter "2" in the left-most box and leave the remainder of the boxes blank. This would be the case if the person is a member of the Canadian Armed Forces or the RCMP.

A4b. Province or Territory Issuing Health Card Number

Coding From the table below, record the two-digit code of the province or territory that issued the health card number.

NL	Newfoundland and Labrador	**ON**	Ontario	**BC**	British Columbia
PE	Prince Edward Island	**MB**	Manitoba	**NT**	North West Territories
NB	New Brunswick	**SK**	Saskatchewan	**YT**	Yukon
NS	Nova Scotia	**AB**	Alberta	**NU**	Nunavut
QC	Quebec				

I

If the **province/territory is unknown,** enter "0" in the left-most box and leave the remainder of the boxes blank. This would be the case if the person is cognitively impaired and there is no one available to provide the necessary information, or if the person does not know the information.

If the **person is not a resident of Canada, or is a resident of Canada but his or her services are paid for by the Federal Government,** enter "1" in the left-most box and leave the remainder of the boxes blank. This would be the case if the person is a member of the Canadian Armed Forces or the RCMP.

A4c. Case Record Number

Coding Record the person's case record number in the boxes provided, beginning with the left-most box. If the case record number is less than 12 digits, leave the extra boxes blank.

A5. Province or Territory of Usual Living Arrangement [Country-Specific Example—Canada]

Intent To record the province or territory and postal code of the person's usual living arrangement. This information will assist in tracking utilization services at the Provincial/Territorial and regional levels.

Definition **Usual living arrangement**—the community address where the person usually resides; that is, the person's most recent permanent address. The usual living arrangement could be a private home or apartment, board and care home, assisted living or group home.

Postal Code—the postal code (assigned by Canada Post) of the permanent dwelling, as identified above, in which the person lives.

Process Determine the province or territory and postal code of the person's usual living arrangement. Note, this maybe different than the province or territory of a person's present residence (for example, the person is temporarily living in one province but his or her permanent/ usual address is in a different province).

A5a. Province or Territory

Coding From the table below, record the two-digit province or territory code of the person's usual living arrangement.

NL	Newfoundland and Labrador	**ON**	Ontario	**BC**	British Columbia
PE	Prince Edward Island	**MB**	Manitoba	**NT**	North West Territories
NB	New Brunswick	**SK**	Saskatchewan	**YT**	Yukon
NS	Nova Scotia	**AB**	Alberta	**NU**	Nunavut
QC	Quebec				

If the **province/territory is unknown** (for example, if the person is cognitively impaired and there is no one available to provide the necessary information), enter "1".

If the **person is not a resident of Canada**, enter "2".

A5b. Postal Code of Usual Living Arrangement

Coding Enter the alphanumeric postal code of the permanent dwelling in which the person lives.

If the full postal code is not available, enter the first three digits, if available, and leave the remainder of the boxes blank. If there is no information available or if the person does not have a postal code, use the following:

Enter Z1Z 1Z1 for homeless persons.

If the postal code is unknown (for example, the person is cognitively impaired and there is no one available to provide the necessary information), enter "1".

If the person is not a resident of Canada, enter "2".

A6. Facility/Agency Identifier [Country-Specific Example—Canada]

Intent To identify the agency or organization responsible for completing the screener.

Process Enter the number assigned to the organization. Check with the business office if you are uncertain about the agency identifier.

Coding Record the agency provider identifier in the spaces provided beginning with the left-most box and leave any unused boxes blank.

A7. Primary Language [Country-Specific Example—Canada]

Intent To record the person's preferred language for day-to-day communication. Communication with the person in his or her primary language, whether English, French, or another language, is preferred. Information about the person's language may indicate the need to consider interpretation services. At an aggregate reporting level, this information may assist in identifying underserved populations related to an inability to access services due to language or culture differences, as well as assist health and social service planners in effectively targeting geographic areas and populations that need services.

Definition **Primary language**—preferred language for day-to-day communication.

Process Observe and interview the person and family to determine the language the person primarily speaks or understands. Review any clinical records.

Coding Enter the three-letter code for the person's primary language. Enter "eng" if the language is identified as English. Enter "fre" if the language is identified as French. For other languages, use the table in Appendix A and enter the three-letter code that corresponds to the person's language in the set of boxes provided.

A8. Interpreter Needed [Country-Specific Example—Canada]

Intent To determine if the person requires the assistance of an interpreter to communicate with others.

Process Observe and listen. Review clinical records or check with family or referral source to determine the need for an interpreter.

Coding Code for the need for an interpreter.

0. No
1. Yes

A9. Reasons for Referral/Presentation

Intent To identify the reason for the referral or presentation as provided by the person who is requesting services.

Definition **Reasons for referral/presentation**—the verbal or written explanation, details, reason for, or purpose of this contact, as given by the person, family member, friend, or referring source.

Process Often, the caller will reveal the reason for the referral without any prompting (for example, a call from a member of a health team or a family member). However, if it is not clear why the call was initiated, you can ask, "What is it that you would like us to help you with?" or "How can I help you?"

Coding In the space provided, write a brief summary of the reason for the referral/ presentation as described by the person and other informants.

A10. Assessment Reference Date

Intent To establish a common reference point in time so that any observation periods used throughout the interRAI Preliminary Screener relate to the same date as an anchor point.

Definition **Assessment reference date**—items in the interRAI Preliminary Screener have different observation periods. When the assessor is completing the assessment, the person will be asked about items relative to the observation period. The assessment reference date sets the end date for the observation period. Unless otherwise noted, the observation time frame is the last 24 hours. It is anticipated that the interRAI Preliminary Screener will be completed using information gathered during a single interview and the date of that interview is the "Assessment Reference Date". When an assessment carries over to a second or third interview on different days, items must be for the time period established by the original Assessment Reference Date. However, if it is deemed necessary to change the observation period, the assessment reference date can be changed, but all previously completed items must then be adjusted to reflect the new observation time period.

Coding Use four digits for the year. For the month and day of the assessment, enter two digits each, using a leading zero ("0") as a filler when needed.

Example: March 23, 2011:

2011	**03**	**23**
Year	Month	Day

Section B. Screener

Section B contains items used for a decision-making algorithm to differentiate persons who do not require further screening or assessment from those who are likely to benefit from further evaluation. Based on the results of the screening items in this section, a decision is made about completing, or not completing, the interRAI CHA.

B1. Cognitive Skills for Daily Decision-Making

Intent To record the person's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a person's abilities and his or her current level of performance. This may indicate that caregivers or others (for example, family) are inadvertently fostering the person's dependence.

Definition Here are some examples of decision-making tasks:

- choosing items of clothing;
- knowing when to eat meals;
- knowing and using space in the home appropriately;
- using environmental cues (such as clocks, calendars, or posted listing of upcoming events) to organize and plan the day;
- in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day;
- using awareness of one's own strengths and limitations in regulating the day's events
  (for example, asking for help when necessary);
- making prudent decision concerning how to get to places; where applicable, acknowledging the need to use a walker or other assistive device, and using it faithfully.

Process Interview and observe the person and consult with others (for example, a family member), where possible and necessary. The inquiry should focus on whether the person is actively making decisions about how to manage tasks of daily living, and not whether others believe that the person might be capable of doing so. Remember the intent of this item is to record what the person is doing (actual performance). When someone takes decision-making responsibility away from the person regarding tasks of everyday living, or when the person does not participate in decision-making (whatever his or her level of capability may be), the person should be considered as having impaired performance in decision-making.

This item also requires you to differentiate between 1) the lack of ability to participate in decision-making or the lack of opportunity to make decisions, and 2) making decisions that others may not agree with (for example, refusing treatments, refusing to have a shower). The latter would not be considered impairment if the person was actively involved in making the decision.

Coding Enter the code that most accurately characterizes the person's cognitive performance in making decisions regarding the tasks of daily life in the past 24 hours.

0. Independent—the person's decisions for organizing daily routine were consistent, reasonable, and safe (reflecting lifestyle, culture, values).

1. Modified independent or any impairment—refers to any of the following situations:

- the person organized his or her daily routine and made safe decisions in familiar situations, but experienced some decision-making difficulty when faced with **new** tasks or situations **only**;
- in specific situations, the person's decisions were poor or unsafe, with cues/supervision necessary at those times;
- the person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize and conduct
  daily routines;
- the person's decision-making was severely impaired; the person never (or rarely) made decisions; or

- the person was non-responsive.

B2. ADL Self-Performance

Intent — To provide a brief screen of the person's functioning related to everyday activities during the last 24 hours. This screen addresses some, but not all, activities of daily living (ADL).

Definition — **ADLs (Activities of Daily Living)**—activities involved for self-care, such as bathing, dressing, eating, toileting, ambulation, grooming, etc. The interRAI Preliminary Screener uses four ADL items.

B2a. Bathing—how the person takes a full-body bath or shower. Includes how the person transfers in and out of tub or shower and how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, and perineal area. EXCLUDE WASHING OF BACK AND HAIR.

B2b. Personal hygiene—how the person manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands. EXCLUDE BATHS AND SHOWERS.

B2c. Dressing lower body—how the person dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirt, shoes, fasteners, etc.

B2d. Locomotion—how the person moves between locations on the same floor (walking or wheeling). If the person uses a wheelchair, this measures self-sufficiency once he or she is in the chair.

Set-up Help—assistance characterized by the provision of articles, devices, or preparation necessary for the person's self-performance of an activity. This includes giving or holding out an item the person takes from the helper, if the helper then leaves the person alone to complete the activity. If someone remains nearby to watch over the person, the person is receiving oversight, thus the score would be "1" for "Supervision or any physical assistance". Following are a few examples of set-up help. For "bathing", it might mean placing bathing articles at the tub side. For "Personal hygiene", set-up help might mean providing a washbasin or grooming articles. For "dressing", set-up help might involve retrieving and laying out clothes for the person. For "locomotion", it might take the form of handing the person a walker or cane.

Process — There are many ways to elicit this information and the assessor's interview skills are of great importance. There is no set order for the questions, and the following suggestions may provide guidance.

The person can be asked a general question such as, "How are you managing in general with your personal care?" and should be asked to think about the last 24

hours when answering. The person could be asked if he or she needs any help when bathing (that is, a tub bath or shower). If the response to "needing help with the last bath" is "no", there is no need to obtain further information about bathing. If the response is "yes", the person should be asked, "What kind of help did you need?" If the person reports needing anything more than set-up help, code "1" is appropriate.

If the person had more than one bath in the last 24 hours, code for the most dependent episode. If the person did not have a bath in the last 24-hour period, the last bath he or she had would apply. If the person is unable to recall when he or she last had a bath and no other source of information is available, professional judgment should be used to determine the amount of assistance the person likely required to complete a bath or shower.

This process can be repeated to obtain information about personal hygiene, dressing lower body, and locomotion. The information could be obtained in a similar fashion from the family member, friend, or other individual who initiated the referral.

If assistive devices are used, they should be included in the assessment of ADL (for example, the person who walks independently with a cane would be assessed as "0"—independent or set-up help only).

Coding

Code most dependent episode for each ADL, considering all occurrences of the activity over the last 24 hours and based on the person's actual performance, not what the person should or could do.

0. Independent or set-up help only—no assistance, set-up, or supervision required in any episode, OR an article or device was provided or placed within reach of the person BUT no episode with supervision or physical assistance was required (that is, the person could be left unattended to complete the task on his or her own).

1. **Supervision or any physical assistance—**oversight, supervision, or cueing was required for the person to be able to complete the activity, OR any type of physical assistance, including guided maneuvering of limbs (guiding a limb without supporting it), any amount of weight-bearing support from one or more people, or total dependence on someone else to complete the activity.

Examples for ADL

Bathing

When Mr. D was asked by the assessor if he could manage to bathe, he said: "I don't need any help with having a bath, the last one I had was three days ago and even though I fell while getting out of the tub. I didn't hurt myself".

Code = 0 for B2a.

Mr. D did not have a bath in the last 24 hours so the coding is based on the most recent incidence.

Personal Hygiene

Mr. X shaves himself with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. His wife sets out all of the grooming articles and returns the articles to their proper location once he is finished. She does not need to remain with him while he tends to his personal hygiene as long as everything is set out for him. This routine was followed on the morning of the intake.

Code = 0 for B2b

Mr. X required set-up help only for personal hygiene in the last 24 hours.

Dressing lower body

Mrs. B requires daily assistance to put on her anti-embolic stockings and to remove them at bedtime. Her daughter assists each morning and every evening. Mrs. B is independent in the remainder of the tasks associated with dressing the lower body. This has been the routine in the last 24 hours as well.

Code = 1 for B2c.

Mrs. B required physical assistance to dress her lower body in the last 24 hours.

Locomotion

Mr. U ambulates independently around his apartment and on the floor of his housing complex while socializing with others and attending activities (dancing and yoga). However, last night he was dizzy and thought he might faint when he went to the bathroom so his wife walked with him.

Code = 1 for B2d.

The supervision that Mrs. U provided (walking with her husband to the bathroom)

in the last 24 hours would be considered the most dependent episode.

B3. Dyspnea (Shortness of Breath)

Intent To document the presence of shortness of breath and the circumstances leading to dyspnea.

Definition **Dyspnea**—the person has reported being, or has been observed to be, breathless or "short of breath".

Process Ask the person if he or she has experienced shortness of breath. Other expressions for shortness of breath that can be used include: "winded", "difficulty getting your breath", "experiencing breathlessness", "unable to catch your breath". If the answer is affirmative, determine if the symptom occurred with strenuous activity, during normal day-to-day activity, or when resting. If the person is unable to respond, review the clinical record and consult with the referring source, other clinicians, and the person's family.

Coding Select the appropriate code from the list below. Code for the most severe occurrence during the last 24 hours. If the symptom was absent over the last 24 hours, but would have been present had the person undertaken activity, code according to the activity level day-to-day or moderate) that would normally have caused the person to experience shortness of breath. "Moderate activities" include some type of physical exercise, such as walking a long distance, climbing 2 flights of stairs, or gardening. "Normal day-to-day activities" include all ADLs (bathing, transferring, etc.) and IADLs (meal preparation, shopping, etc.).

0. **Absence of symptom**
1. **Absent at rest, but present when performed moderate activities**
2. **Absent at rest, but present when performed normal day-to-day activities**
3. **Present at rest**

B4. Self-Reported Health

Intent To evaluate the person's perception of his or her health.

Definition **Self-reported health—**the person's perception of his or her overall health status.

Process **Ask the person, "In general, how would you rate your health?"**
Do not code based on your own inferences about the person's health and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure. If the person is unable (due to cognitive impairment, for example) or refuses to respond, do not dwell on the item and do not presume responses for the person; instead, code that the person could not/ would not respond.

Coding Record the person's response according to one of the following categories.

0. **Excellent**
1. **Good**
2. **Fair**
3. **Poor**
8. **Could not (would not) respond**

Examples for Dyspnea and Self-Reported Health

When asked, "In general, how would you rate your health?", Mr. R said that he was in good health, other than having to recover from knee surgery. He reported, "I don't anticipate any difficulties with that because I'm generally quite healthy." He was then asked if he had experienced any shortness of breath in the last 24 hours. Mr. R said that he had noticed some breathing difficulty yesterday and this morning when he was walking, but it seems better now.

Code = 2 for B3.

Mr. R reported shortness of breath when walking in the last 24 hours.

Code = 1 for B4.

Mr. R rated his health as "good".

Mrs. D is 74 years old. She states that she has Arthritis and Coronary Artery Disease. She lives independently in her own home. When asked, "In general how would you rate your health?" she stated, "My health is poor. I have pain every day because of the arthritis and I can't do a lot of things because of my heart problems. Every day I become short of breath with the least bit of exercise and I have to rest a lot during the day."

Code = 2 for B3.

Mrs. D reported shortness of breath while doing everyday activities.

Code = 3 for B4.

Mrs. D reported that her health was poor.

B5. Instability of Conditions

Intent To document the presence of any condition or disease (chronic or acute) that affects the person's medical stability.

Definition

B5a. Conditions/diseases make cognitive, ADL, mood or behaviour patterns unstable (fluctuating, precarious, or deteriorating)—denotes the changing and variable nature of the person's condition. For example, the person may have a condition such as ulcerative colitis, rheumatoid arthritis, or multiple sclerosis that causes pain or impairs mobility or sensation, resulting in increased dependence on others and depression.

B5b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem—the person is symptomatic for an acute health condition (such as new myocardial infarction, adverse drug reaction, or influenza) or recurrent acute condition (such as aspiration pneumonia or urinary tract infection). Also included are persons who are experiencing an exacerbation or flare-up of a chronic condition (for example, new-onset shortness of breath in someone with a history of asthma, or increased pedal edema in a person with congestive heart failure). This type of acute episode usually is of sudden onset, has a time-limited course, and requires evaluation by a physician.

Process Ask the person or check with other available resources about the presence of any conditions that may be having an impact on the person's overall well-being and health stability.

Coding Code for each item.

0. No
1. Yes

B6. Self-Reported Mood

Intent To record the person's self-reported mood over the last 3 days.

Definition Self-reported mood—this item involves a verbal report of the person's subjective evaluation of his or her mood.
"In the last 3 days, how often have you felt sad, depressed, or hopeless?"

Process Ask the person the previous question directly. Only the person's response should be used to rate this item. Do not code the item based on your own inferences about the person's mood state and do not record ratings given by family, friends, or other informants. This item should be treated strictly as a self-report measure.

If the person is unable (due to cognitive impairment, for example) or refuses to respond, do not dwell on the item and do not impute responses for the person. Use code "8" in such situations.

Coding Code using the person's response as to whether he or she experienced the feelings referenced in the item at any time over the last 3 days, regardless of what the person believes to be the underlying cause of these feelings. Persons unable or unwilling to respond should be scored as "8" for "could not (would not) respond". Use the following codes:

0. No
1. Yes
8. Could not (would not) respond

Examples for Self-reported Mood

The assessor met with Mr. A and his daughter in the hospital where Mr. A was admitted following a fractured humerus. Mr. A has a diagnosis of Alzheimer's disease and is severely cognitively impaired. The assessor was unable to communicate with Mr. A because of his cognitive impairment so the clinical evaluation was done with his daughter.

Code = 8 for B6.

The assessor was unable to ask Mr. A. the question regarding mood.

When asked by the assessor if he has felt sad, depressed, or hopeless in the last 3 days, Mr. N stated that he did feel depressed about his failing health and increasing dependence for assistance from his family. He continued by saying, "I've been sad and depressed every day for weeks and my daughter suggested that I see a doctor soon."

Code = 1 for B6.

Mr. N. did express feelings of depression in the last 3 days.

B7. Informal Helper Status

Intent To assess the reserves of the informal support system.

Definition

B7a. Primary informal helper expresses feelings of distress, anger, or depression—the primary informal helper expresses, by any means, that he or she is distressed, angry, depressed, or in conflict because of caring for the person.

B7b. Family/close friends report feeling overwhelmed by person's illness—family members or close friends of the person indicate that they are having trouble coping with the support needs. They may vocalize their feelings of being "overwhelmed" or "stressed out".

Process Ask the informal caregiver(s) and the person separately about the ability of the caregiver(s) to continue providing care. For these items, you need to consider the current situation and also project future needs. The informal helper may be willing and able to continue, but the person may believe him- or herself to be a burden and state that the helper cannot continue. Take this information into

consideration and use your clinical judgment to make the assessment. This is a sensitive issue and should be handled carefully. Listen carefully to what is being said.

Coding

B7a. Primary informal helper expresses feelings of distress, anger, or depression.

0. No
1. Yes

If there is no primary informal helper, code "0".

B7b. Family/close friends report feeling overwhelmed by person's illness.

0. No
1. Yes

If there is no informal helper, code "0".

Example for Informal Helper Status

Mrs. Q was diagnosed with Parkinson's disease five years ago. She is being cared for by her elderly husband. In recent months she has become totally dependent on her husband for most of her ADLs. It has become very difficult for her husband to continue. When asked how he is managing, he stated, "I don't think I can do this much longer. I can't leave her alone at all and sometimes it really gets to me and I just want to get away for a while".

Code = 1 forB7a and B7b.

Mr. Q is expressing feelings of distress and feeling overwhelmed.

Section C. Summary

C1. Assessment Urgency Algorithm Score

Intent To record the computer-generated algorithm score (which is embedded in the interRAI Preliminary Screener) so that it may be used to inform decisions related to "assessment urgency". The Assessment Urgency Algorithm (AUA) stratifies the self-sufficient well-person from those persons who may need a more detailed assessment using the interRAI CHA, and to provide decision support to the assessor in the determination of whether a person needs a comprehensive in-home assessment using the interRAI CHA.

Definition **Decision-support Algorithm**—tool that synthesizes the findings of various domains in the screener into a single summary measure that can be used to inform decision-making.

Assessment Urgency Algorithm—provides a score from 1–6, with higher scores indicating greater levels of urgency for a comprehensive interRAI CHA.

Process Generate the Assessment Urgency algorithm using the software program. This score, along with other information obtained during the screening process, should be used to determine the need and urgency for a follow-up comprehensive interRAI CHA.

It is the responsibility of the assessor to use good clinical judgment to decide if the score accurately reflects the person's status, given all information available. A person with a score of 3 or greater is likely to benefit from further evaluation using the interRAI CHA. If the score is in the lower range, it is recommended that the assessor/team further review the situation to determine whether the level of urgency for comprehensive assessment is appropriate.

In all situations, the person, or his or her family if necessary, should be involved in the decision-making process.

Coding Record the computer-generated results for the decision-support algorithm. 1 (Least Urgent) to 6 (Most Urgent) for comprehensive assessment.

C2. interRAI CHA Assessment Required for This Person

Intent To document the assessor's decision about the need for further assessment using the interRAI CHA.

Process The assessor should review all of the information that was obtained about the person during the completion of sections A, B, and the computer-generated score in C1 in order to make a final decision about the need to complete an interRAI CHA. This item allows the assessor to make that determination.

Coding Record your decision regarding the appropriate action.

0. No—no indication that the person would benefit from further assessment.

1. Yes—the person will likely benefit from a comprehensive in-home assessment using the interRAI CHA.

C3. Signature of Person Coordinating/Completing the Assessment

Intent To document the name of the person who completed the assessment and the date that the person signed the assessment as being complete.

Coding The assessor signs his or her name and records the date that he or she signed the assessment as complete. Note that the date in C3 can be different than the Assessment Reference Date (Item A10).

Note: when completing the date, use four digits for the year. For the month and day of the assessment, enter two digits each, using a leading zero ("0") as a filler when needed.

Example: March 23, 2011:

2011	**03**	**23**
Year	Month	Day