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sample sample sample sample sample sample sample

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Guidance for completion of form

Basic principles for assessment centred on the individual

1. Remember that you, as the assessor, should behave as a guest in the person's home.
2. Your purpose is to complete an assessment of the older person in order to optimise the individual's functional capacity and quality of life. The assessment should address health problems, and help to ensure that the individual's dignity and wishes for independent living are understood.
3. In order to do this you should:
   - Identify the purpose of your visit to the individual, and his/her carers and family.
   - Identify functional, medical and social issues which presently are limiting or which are likely to become limiting.
   - Identify your older person's strengths and assets.
   - Integrate what you see and hear in your effort to code each of the items accurately.
   - Provide a basis for further evaluation of unrecognised or unmet needs.
4. Do not expect that all functional, medical and social matters you identify can be fully and comprehensively addressed on this single visit. It is of much greater importance that all major functional, medical and social circumstances which limit the individual's quality of life are identified, if necessary over a number of visits, in order to allow a plan to be developed for further detailed evaluation or management.
5. You should be sensitive to the gender, ethnic or cultural factors that impact on the issues you are recording. These factors could contribute to, precipitate, or exacerbate issues experienced by the older person.
6. Using the assessment, the care professionals involved with this individual should coordinate a care plan. This plan should ensure that each limiting or potentially limiting factor is viewed both in the overall context of the individual's life circumstances and in the context of optimising the individual's quality of life.
7. Any acute medical matter should be brought to the attention of the individual immediately and that individual should be strongly advised to seek appropriate medical care, whether or not it can be provided in the home setting. In addition, be aware that documented instances of abuse of older people abuse are another area that may warrant special and immediate intervention.
8. This assessment tool should be used in conjunction with other guidance that is issued to you by your own organisation.

Addressing the older person

- The term "person" or "older person" is used to provide a standard reference throughout the form. You may substitute words such as "client" or "patient" when talking to others. You could also use terms such as "Mrs X" or "your mother".
- Available service options may be limited; be realistic in channelling the conversation. Take your follow-up cues from the individual's responses to handshake questions for prioritising areas for assessment.
- Remember, this is not a standard questionnaire – the older person's needs will set the pace and priorities, whilst you gather the information to complete the MDS-HC.

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Process for initiating the MDS-HC assessment

The assessor should introduce themselves and the assessment in a conversational style. The assessor may find that this will be helpful in beginning the dialogue with the older person and family, and will elicit much of the information needed to complete the assessment.

The assessor should explain that the intention of the assessment is to record information in order to address the needs and concerns of the older person. Also, the conversation may touch on subjects that the older person particularly wishes to keep private from other individuals or care agencies and that there will be an opportunity to record this at the end of the assessment.

Deciding on an order for the assessment

When conducting an assessment in a person's home, the assessor needs to consider the order in which the items in the assessment will be addressed. Several factors have to be considered. You need to gather reliable, accurate information, which means that you must consider the cognitive status and communication skills of the older person. There is also a need to be sensitive to his or her reaction to the assessment.

Ensuring data quality

The completed pages of the assessment form may be processed to automatically extract the data. To ensure high quality data:

- Form your letters clearly and individually, rather than using joined-up script
- Use black ink or biro
- Mark the check-boxes with a cross to confirm the statement applies.

The coding provides greater clarity than a general statement such as "Mrs X suffers from back pain". The coded information will be used for planning and management of care services as well as Department of Health returns. For these reasons, you should:

- Complete all the check-boxes required
- Use the free-text areas only for information that is truly additional to the coded information.

The assessor should note that a range of timeframes are referenced in the different sections. The assessor must ask the questions and record the answers explicitly referencing the timings, in order to get the highest quality of data. The time frames used have been selected on the basis of research and best practice. For example:

- Acute changes are likely to have happened in the last three days.
- For more intermittent activities like shopping, bathing or changing dressings, it is more realistic to review the last week's events.
- Identifying changes in the older person due, for example, to changes in medication, need to be reviewed over a longer period such as 90 days.

An assessor new to inter*RAI* assessment may find it helpful to consult with colleagues whose skills and experience are complementary to his or her own area of professional expertise. The training manual and other supporting products can also usefully be referenced. Evidence from users in the UK, and in the rest of the world, indicates that after some training and/or experience, the individual care professional can achieve high quality results.

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sample

Information for the older person : This questionnaire provides a 'snapshot' description of you, for a given date, as a patient or customer of social services. If you have already had an assessment with follow–up care in the **last three days**, you should discuss how you are today. Otherwise you should think back over the last three days to help you answer the questions more fully.

WHERE REQUIRED, PLEASE COMPLETE USING A CROSS, NOT A TICK

AA Name and identification numbers

1 Your name

a. title b. middle initial c. last/family name d. first name

2 Case record number

BB Personal details (complete at initial assessment only)

1 Gender
Mark one box

1. Male 2. Female

2 Your date of birth
Format as day/month/year

3 Your race/ethnicity

Person's ethnic group. Complete one box (a,b,c,d) to indicate ethnic group, or two boxes to indicate a mixed ethnic background. For each choice of ethnic group, also mark the appropriate box to indicate cultural background. Complete box e when ethnic group is not known.

a. White ethnic group
- English (1)
- Scottish (1)
- Welsh (1)
- Irish (1)
- Other White background (specify) (1)

b. Asian or Asian British ethnic group
- Indian (6)
- Pakistani (4)
- Bangladeshi (5)
- Other Asian background (specify) (8)

c. Black or Black British ethnic group
- Caribbean (2)
- African (3)
- Other Black background (specify) (10)

d. Chinese or other ethnic group
- Chinese (7)
- Other Chinese background (specify) (7)

e. Not known (11)

4 Your marital status
Mark one box

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced
6. Other

5 Your preferred first language
Mark one box

1. English
2. Other - specify

Mark box if required

3. Interpreter required?

6 Your education
(highest level completed)
Mark one box if appropriate

a. Age of leaving full time schooling

b. 1. College/apprenticeship 2. University-level education

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7 **Responsibilities/ advance directives**
Mark all statements that apply

- a. person has an enduring power of attorney
- b. person has advanced medical directives in place (for example, a 'do not hospitalise' order)
- c. the power of attorney is registered
- d. the person has affairs administered by a Court of Protection

Additional comments

8 **Your religion**
Mark one box

- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- No religion
- Religion not stated

Other

9 **Your present address**

House number & street

Area

Town/city

Postcode

Telephone

10 **Your permanent address**
(if different from above)

House number & street

Area

Town/city

Postcode

Telephone

11 **Your NHS number**

12 **Name of your next of kin**

13 **Name, address, phone and e-mail address of main carer**

Name

House number & street

Area

Town/city

Postcode

Telephone

e-mail

sample

14 **Name, address, phone and e-mail address of GP**

Name

House number & street

Area

Town/city

Postcode

Telephone

e-mail

15 **Your current or previous occupation**

16 **Hospital in-patient admissions in past 12 months**
Start with the most recent

17 **Description of the problem**
Include:
The nature of the presenting problem

The significance of the problem for the older person

The length of time the problem has been experienced

Potential solutions identified by the older person

Other problems experienced by the older person

Recent life events or changes relevant to the problem(s)

The perceptions of family members and carers

18 **Your permanent or long-standing health conditions or disabilities**

19 **Your allergies**

sample sample sample sample sample sample sample

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CC Referral items (complete at first assessment)

Intent: *To record information about the background reason for the referral. For example, a family member may have requested a particular service for the older person. This may not be what actually meets the needs of the older person following assessment.*

1 Date case opened/reopened

day/month/year ☐☐ ☐☐ ☐☐☐☐

2 Reason for referral
Mark one box

1 ☐ Post-hospital care
2 ☐ Community chronic care
3 ☐ Care home/care home with nursing
4 ☐ Eligibility for home care
5 ☐ Day care
6 ☐ Other

3 Goals of care
Mark one or more boxes

The patient/family understands the goals of care currently provided in relation to:

☐ a. Skilled nursing care
☐ b. Monitoring to avoid clinical complications
☐ c. Rehabilitation
☐ d. Person/family education
☐ e. Family respite
☐ f. Palliative care
☐ g. Community care

4 Time since last hospital stay
Mark one box

Time since discharge from last in-patient setting
Code for most recent instance in LAST 180 DAYS

0 ☐ No hospitalisation within 180 days
1 ☐ Within last week
2 ☐ Within 8 to 14 days
3 ☐ Within 15 to 30 days
4 ☐ More than 30 days ago

5 Where person lived at time of referral
Mark one box

a. The person's permanent home at time of referral

1 ☐ Private home/apartment with no home care services
2 ☐ Private home/apartment with home care services
3 ☐ Warden accommodation
4 ☐ Nursing home
5 ☐ Residential home
6 ☐ Other

b. Type of accommodation

☐ Detached
☐ Semi-detached
☐ Terrace
☐ Flat/maisonette

c. Tenure of accommodation

☐ Owner
☐ Social sector tenant
☐ Private tenant

sample

6 **Who person lived with at referral**
Mark one box

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)

7 **Prior nursing home placement**
Mark box if statement applies
CAP ④

Person has lived in a care home/care home with nursing at any time during 5 years prior to case opening

☐

8 **Residential history**
Mark box if statement applies

Moved to current residence within last two years

☐

sample sample sample sample sample sample sample

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A ASSESSMENT INFORMATION

Intent: *Usually, assessments are completed on information gathered at a single visit. Item 1 is the date of this visit. Although the assessor may visit on different dates, the coding for all times in this assessment should refer back to this date.*

1 Assessment reference date — **Date of assessment** *day/month/year* [ ][ ] [ ][ ] [ ][ ][ ][ ]

COMMENTS

OLDER PERSON

CARER

ASSESSOR

OLDER PERSON'S PERSONAL GOALS AND OBJECTIVES

sample sample sample sample sample sample sample

B COGNITIVE PATTERNS

Intent: *To determine the client's performance in making everyday decisions.*

2 Cognitive skills for daily decision-making
Mark one box of 0-4
CAP ③ ⑧ ㉖

a. Description of how well person 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 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

sample

COMMENTS

OLDER PERSON

sample
sample
sample
sample

CARER

sample
sample

ASSESSOR

sample

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H PHYSICAL FUNCTIONING

Intent: *To assess, within the context of ethnic, cultural and gender considerations, the areas of function that are most commonly associated with independent living.*

IADL PERFORMANCE IS BASED ON THE LAST 7 DAYS
ADL PERFORMANCE IS BASED ON THE LAST 3 DAYS

1 IADL self performance – *Description of person's functioning in routine activities around the home or in the community during the LAST 7 DAYS* CAP②④㉒

Difficulty (B)

How difficult it is (or would be) for person to do activity on own

0. NO DIFFICULTY
1. SOME DIFFICULTY – e.g. needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY – e.g. little or no involvement in the activity is possible

a. Meal preparation – How meals are prepared (e.g.: planning meals, cooking, assembling ingredients, setting out food and utensils).

0 1 2

b. Ordinary housework – How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed,tidying up, laundry).

0 1 2

g. Transportation – How person travels by vehicle (e.g. gets to places beyond walking distance).

0 1 2

2 ADL self performance – *Description of the person's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the last 3 days, considering all episodes of these activities. For people 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 oversight – OR – help, set-up, oversight 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 person 3 or more times.

2. SUPERVISION – Oversight, encouragement or cueing provided 3 or more times during last 3 days – OR – supervision (1 or more times) plus physical assistance provided only 1 or 2 times during last 3 days (for a total of 3 or more episodes of help or supervision).

3. LIMITED ASSISTANCE – Person 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 – Person performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times:
   - Weight-bearing support – OR
   - Full performance by another during part (but not all) of last 3 days

5. MAXIMAL ASSISTANCE – Person 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).

CAP①④⑲㉖

i. Personal hygiene – Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers).

0 1 2 3 4 5 6 8

j. Bathing – How person 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.

0 1 2 3 4 5 6 8

6 **Stamina**

For a and b, mark the box that applies

CAP ③④

a. Hours of physical activities in the LAST 3 DAYS (e.g. walking, cleaning house, exercise).

- 0. Two or more hours
- 1. Less than 2 hours

COMMENTS

OLDER PERSON

sample

sample

sample

CARER

sample

sample

sample

ASSESSOR

sample

sample

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R ASSESSOR INFORMATION

Intent: *Each care professional (there may be more than one) who completes a portion of the assessment should sign and certify its accuracy. The assessment coordinator/care manager signs and certifies that the assessment is complete.*

a. Assessment coordinator/care manager

Name

Title

Organisation

b. Assessment coordinator signature

Signature

c. Date assessment coordinator signed as complete

day/month/year

d. Care professional

Name

Title

Organisation

Signature

Sections completed

day/month/year

e. Care professional

Name

Title

Organisation

Signature

Sections completed

day/month/year

f. Care professional

Name

Title

Organisation

Signature

Sections completed

day/month/year

g. Care professional

Name

Title

Organisation

Signature

Sections completed

day/month/year

sample sample sample sample sample sample sample

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S ADDITIONAL INFORMATION ABOUT OTHER CARERS

Intent: *To record, where required by local procedures, any additional information about the following people: someone that has a close relationship with the older person; someone with a significant role, e.g. helping regularly with shopping. Local procedures may also require additional information about other care professionals, including dentist, GP, etc. to be recorded.*

Role
Name
House number & street
Area
Town/city
Postcode
Telephone
e-mail

Role
Name
House number & street
Area
Town/city
Postcode
Telephone
e-mail

Role
Name
House number & street
Area
Town/city
Postcode
Telephone
e-mail

Role
Name
House number & street
Area
Town/city
Postcode
Telephone
e-mail

sample sample sample sample sample sample sample

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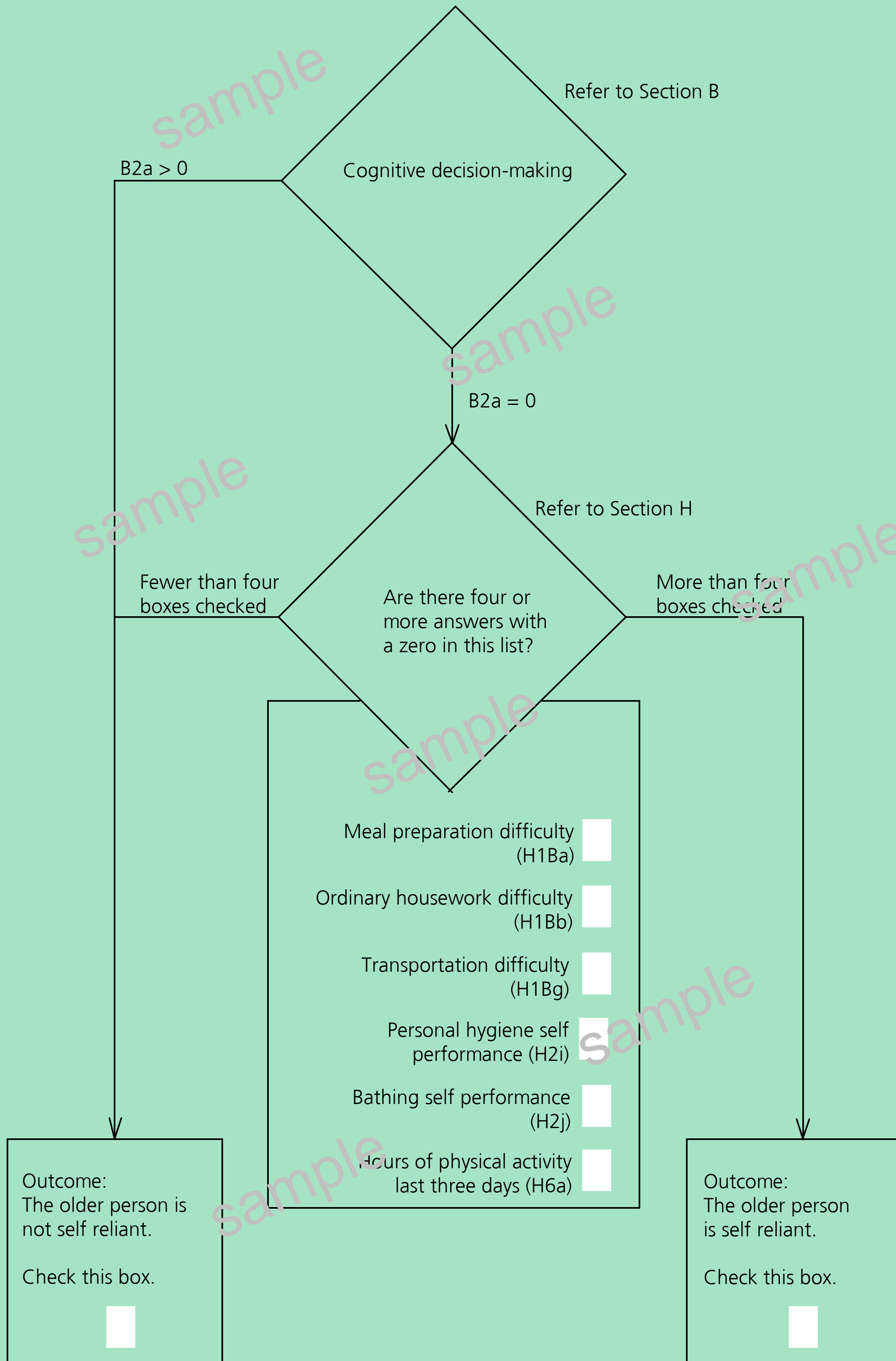
Screening Algorithm : rules for determining self reliance

Intent: *To confirm by reviewing the information gathered about the older person whether or not that person is self reliant.*

Answering the questions in the diamonds will direct you to one of two outcomes at the bottom of the page.

1. To answer the question in the first diamond, look back at the completed answer for B2a. If the answer to B2a was greater than zero, you will be directed to an outcome, and you need proceed no further. The screening is complete.

2. If the answer to B2a was zero, proceed to the question in the second diamond. Look back at the completed answers for Section H. Check the boxes in the list below if any of the answers were zero. Count the number of checked boxes in the list to answer the question in the diamond. When you have selected the appropriate outcome, the screening is complete.



sample

Consent form

Thank you for helping your care professional to complete this assessment.

The answers you have given will be used to help ensure that you are given access to the care and support services you need.

Legal standards are in place to govern the way in which personal information is treated. You can use this consent form to say how you would like to limit the use of this information in the future.

To provide care most effectively, some of the details can be shared with other agencies like your doctor or social services. It will help others involved in your care to understand your needs, and will avoid you repeating some parts of the assessment. However, you must give your agreement to this before it can happen.

Secondly, the information that identifies you as an individual can be removed. The remaining details may be used for research and for the statistics that support planning of health and social care services. This information is described as 'anonymised'. Again, you must give your agreement before this can happen.

If there are particular answers in this assessment that you do not want to share, this can be recorded and your wishes respected.

Please mark with a cross the consent statements with which you agree. If you are making a consent statement for the first time, use the first set of columns. If you change your mind later, the second and third set of columns can be used.

	First Consent Statement	Second Consent Statement	Third Consent Statement
All the information can be shared with others involved in my care			
Some information can be shared (as shown)			
None of the information can be shared with other care agencies			
All the 'anonymised' information can be shared and used for research and for plannning health and social care services			

Version of explanatory leaflet supplied.

Other comments: record any concerns related to shared information, or any concerns in relation to named individuals.

sample

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Signature:		Date of first consent statement	
Signature:		Date of second consent statement	
Signature:		Date of third consent statement	

How to identify the specific information you do not want to be shared with particular organisations or people

If you have put a cross against the statement that says 'Some of the information can be shared' you can record in a more specific way which information you do not want shared, and to which groups or individuals this restriction applies.

You can ask the assessor for help with this.

You and your assessor may wish to do this, if for example, a close family member is working at your doctor's surgery.

If you are concerned about one particular answer, you can prevent access to the section of the assessment in which your answer was recorded.

Information identified in this way cannot be released unless

- You change your mind and make a subsequent statement
- A legal requirement for disclosure is placed on the assessor's organisation

List of organisations and individuals

Code	Organisation		
1	Social Services		
2	Community Health Care – Doctor, Health Centre Nurses		
3	Hospital, and hospital based health care providers		
4	Other group or individual defined by your Assessor		a
5	Second group or individual defined by your Assessor		b
6	Third group or individual defined by your Assessor		c
7	Your Family or Carers		

The next table will allow you to record in detail which information is denied to which organisation or individuals.

The code (1-7) refers to the organisations or individuals listed above.

The assessment sections refer to the different sorts of information you have discussed with your assessor. The names of these sections are shown in the table over the page.

sample

Example: You are recording your wishes for the first time. You have decided to deny access to Social Services (group 1) for Section H – 'Physical Functioning'.

- You are defining the first statement (first set of columns)
- You are referring to Assessment Section H, and the first column
- You should mark with a cross, the box with the arrow pointing to it.

(Please note that the arrow is only there to illustrate this example, and does not impact your statement)

sample

Assessment Section	Code (1-7) that identifies the organisation																				
	First statement							Second statement							Third statement						
	1	2	3	4	5	6	7	1	2	3	4	5	6	7	1	2	3	4	5	6	7
BB																					
CC																					
A																					
B																					
H																					
R																					
S																					

sample

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