MINIMUM DATA SET – HOME CARE (MDS-HC) [Hong Kong Version]©

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

	= If there is an empty box, please fill in the number.
a ✓	= If there is a letter in the box, please check and give a "✓" for the appropriated answer.

Section AA. Name and Identification Numbers

1	**Name of the client #**	Last/ Family Name: First name:
2	**Case record code**	
3	**HK Identity Card number #**	

Section BB. Personal Items (Complete at intake only)

1	**Gender**	1. Male 2. Female	
2	**Birthday**	Year Month Day	
3	**Marital Status**	1. Never married 2. Married 3. Widowed 4. Separated Divorced 6. Other	
4	**Language**	Primary Language 0. English 1. Cantonese 2. Mandarin/ Putonghua 3. Other Chinese language 4. Others	
5	**Education (Highest level completed)**	1. No schooling 2. Incompleted primary school 3. Primary graduate 4. Junior form in secondary school 5. Senior form in secondary school 6. Technical school 7. Tertiary institute 8. Bachelor's degree 9. Post-graduate 10. Private school 11. NA (can't be classified)	
6	**Financial Status***	1 Monthly Income	
		2 Number of person(s) use such amount of income	
7	**Sources of Income***	（give a ✓ for all appropriate items）	
		a Comprehensive Social Security Assistance	a
		b Old Age Allowance	b
		c Disability Allowance	c
		d Old Age Pension	d
		e Insurance	e
		f Family Financial Support	f
		g Interests of Saving	g
		h Others（e.g. Property）	h

Section CC. Referral Items (Complete at intake only

1	**Date of Referral**	Year Month Date	
2	**Reason for Referral**	1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day care 6. Others	
3	**Goals of Care**	(Code for client/ family understanding of goals of care) 0. No 1. Yes	
		a Skilled nursing treatments	
		b Monitoring to avoid clinical complications	
		c Rehabilitation	
		d Client/ family education	
		e Family respite	
		f Palliative care	
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 hospitalization within 180 days 1 Within last week 2 Within 8-14 days 3 Within 15 to 30 days 4 More than 30 days ago	
5	**Where Lived at Time of Referral**	1 Private home/ apt. with no home care services (e.g. Home help, Community nursing services) 2 Private home/ apt. with home care services 3 Private home/ apt. with employed maid 4 Elderly hostel/ Home for the aged 5 Care and attention home for the elderly 6 Others 7 Privatized home for the elderly 8 Hospital	
6	**Who Lived with at Referral**	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s), such as grandchild (not spouse or children) 6. Lived in group setting with non-relative(s) 7. Others	
7	**Prior Home Placement**	Resided in a elderly home at anytime during 5 YEARS prior to case opening 0. No 1. Yes	
8	**Residential History**	Moved to current residence within last two years 0. No 1. Yes	
9	**Stable Residence***	Has long term and stable residence 0. No 1. Yes	

Section A. Assessment Information

1	**Assessment Reference Date**	Year Month Date	
2	**Reasons for Assessment**	Type of assessment 1. Initial assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review with 30-day period prior to discharge from the program 5. Review at return from hospital 6. Change in status 7. Others	
3	**Name of Assessor***		
4	**Post of Assessor***	1. Social Worker 2. Nurse 3. Doctor 4. Physiotherapist 5. Occupational therapist 6. Others	
5	**Place of Assessment***	1. Client's residence 2. Temporary residence 3. Agency office 4. Hospital 5. Privatized home for the elderly 6. Subvented home for the elderly 7. Day care centre 8. Others	
6	**Sources of Information Provided***	a Client	a
		b Client's family	b
		c Other informal caregiver	c
		d Home helper	d
		e Social support network	e
		f Other formal caregiver in client's residence	f
		g Doctor/ Physician	g
		h Medical record and other record	h
		i Formal caregiver in home for the elderly	i

Section B. Cognitive Patterns

1	**Memory Recall Ability**	a. Short-term memory OK- seems/ appears to recall after 5 minutes 0. Memory OK 1. Memory problem	
		b Procedural memory OK- can perform all or almost all steps in a multitask sequence without cues for initiation 0. Memory OK 1. Memory problem	
2	**Cognitive Skills for Daily Decision-making**	a How well client made decisions about organizing the day (e.g. when to get up or have meals, which clothes to wear or activities to do) 0 Independent – Decisions consistent/ reasonable/ safe 1 Modified independence – Some difficulty in new situations only 2 Minimally impaired – In specific situations, decisions become poor or unsafe and cues/ supervision necessary at those times 3 Moderately impaired – Decisions consistently poor or unsafe, cues/ supervision 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	**Indicator of Delirium**	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 disoriented such that his or her safety is endangered or client requires protection by others 0. No 1. Yes	

Section C. Communication/ Hearing Patterns

1	**Hearing**	(With hearing appliance if used) 0. Hears adequately – Normal talk, TV, phone, doorbell 1. Minimal difficulty – When not in quiet setting 2. Hears in special situations only – Speaker has to adjust tonal quality and speak distinctly 3. Highly impaired – Absence of useful hearing	
2	**Making Self Understood (Expression)**	(Expressing information content – however able) 0. Understood – Expresses ideas without difficulty 1. Usually understood – Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required 2. Often understood – Difficulty finding words or finishing thoughts prompting usually required 3. Sometimes understood – Ability is limited to making concrete requests 4. Rarely/ Never understood	
3	**Ability to Understand Others (Comprehension)**	(Understands verbal information – however able) 0. Understands – Clear comprehension 1. Usually understands – Misses some part/ intent of message, BUT comprehends most conversation with little or no prompting 2. Often understands – Misses some part/ intent of message, with prompting can often comprehend conversation 3. Sometimes understands – responds adequately to simple, direct communication 4. Rarely/ Never understands	
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	

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 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, colors, or shapes; eyes do not appear to follow objects	
2	**Visual Limitation/ Difficulties**	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes	
3	**Vision Decline**	Worsening of vision as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	

Section E. Mood And Behaviour Patterns

1	**Indicators of Depression, Anxiety, Sad Mood**	(Code for observed indicators irrespective of the assumed cause) 0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days	
		a **A feeling of sadness or being depressed** – e.g. 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 schedule, 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**	
2	**Mood Decline**	Mood indicators have become worse a compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No 1. Yes	
3	**Behavioural Symptoms**	Instances when client exhibited behavioural symptoms. If EXHIBITED, ease of altering the 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 behavioral symptoms** – Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/ feces, rummaging, repetitive behavior, rises early and causes disruption	
		e **Resists care** – Resisted taking medications/ injections, ADL assistance, eating, or changes in position	
		f **Always suspicious –** Always suspects, imagines, delusions, hallucinations	
4	**Changes in Behavior Symptoms**	Behavioral 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, (or no change in behavioral symptoms) 1. Yes	

Section F. Social Functioning

1	**Involvement**	a. 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 90 DAYS AGO (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. If there was a decline, client distressed by this fact 0. No decline 1. Decline, not distressed 2. Decline, distressed	
3	**Isolation**	a Length of time client is alone during the day (morning and afternoon) 0. Never or hardly ever 1 About one hour 2 Long periods of time – e.g. all morning 3. All of the time	
		b Client says or indicates that he/ she feels lonely 0. No 1. Yes	

Section G. Informal Support Services

1	**Two Key Informal Helpers** **（A）Primary #** **（B）Secondary #**	Name of primary and secondary helpers a Last/ Family Name b First Name c Last/ Family Name d First Name	（A）1st	（B）2nd
		e Lives with client 0 Yes 1 No 2 No such helper (jump to Section H)		
		f Relationship to client 0. Child or child-in-law or grandchild 1. Spouse 2. Other relative 3. Friend/ neighbor 4 Others (e.g. maid)		
		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. Not willing 3. Unknown		
		j Emotional support		
		k IADL care		
		l ADL care		

2	**Caregiver Status**	(Check all that apply)	
		a A caregiver is unable to continue in caring activities – e.g. decline in the health of the caregiver makes it difficult to continue	a
		b Primary caregiver is not satisfied with support received from family and friends (e.g. other children of client)	b
		c Primary caregiver expresses feelings of distress, anger or depression	c
		d *None of the above*	d
3	**Extent of Informal 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 neighbors	Hours
		a Sum of time across five weekdays	
		b Sum of time across two weekend days	

Section H. Physical Functioning (IADL Performance in 7 days and ADL Performance in 3 days)

1 IADL self performance – Code for functioning in routine activities around the home or in the community during the LAST 7 DAYS

(A) IADL self performance code (Code for client's performance during LAST 7 DAYS)
0. 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. Activities did not occur

(B) IADL difficulty code - How difficult it is (or would it be) for client to do activity on own
0. No difficulty
1. Some difficulty – e.g. needs some help, is very slow, or fatigues
2. Great difficulty – e.g. little or no involvement in the activity is possible

		(A) Performance	(B) Difficulty
a. Meal preparation	How meals are prepared (e.g. planning meals, cooking , assembling ingredients, setting out food and utensils)		
b. Ordinary house work	How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry)		
c. Managing finance	How bills are paid, checkbook 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, apply ointments)		
e. Phone use	How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. Shopping	How shopping is performed for food and household items (e.g., selecting items, managing money)		
g. Transportation	How client travels by vehicle (e.g., gets to places beyond walking distance		

2 ADL self performance – The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the LAST 3 DAYS, 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, setup, or oversight – OR- Help, setup, oversight provided only 1 or 2 times (with any task or subtask)
1. Setup help only – Article or device provided within reach of client 3 or more times
2. Supervision – Oversight, encouragement or cueing provided 3 or more times during last 3 days – OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)
3. Limited assistance – Client highly involved in activity; received physical help in guided maneuvering 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 3 or more episodes of physical help)
4. Extensive assistance – client performed part of activity on own (50% or more of subtasks), period, but help of following type(s) were provided 3 or more times:
- Weight-bearing support – OR-
- Full performance by another during part (but not all) of last 3 days
5. Maximal assistance – Client involved and completed less than 50% of subtasks on own (includes 2+person assist), received weight bearing help or full performance of certain subtasks 3 or more times
6. Total dependence – Full performance of activity by another
8. Activity did not occur

a. Mobility in bed	Including moving to and from lying position, turning side to side, and positioning body while in bed	
b. Transfer	Including moving to and between surfaces- to/ from bed, chair, wheelchair, standing position [Note – Excludes to / from bath/ toilet]	
c. Locomotion in home	[Note – If in wheelchair, self-sufficiency once in chair	
d. Locomotion outside of home	{Note – If in wheelchair, self-sufficiency once in chair}	
e. Dressing upper body	How client dresses and undresses)street clothes, underwear)above the waist, includes prostheses, orthotics, fasteners, pullovers, etc	
f. Dressing lower body	How client dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes and fasteners	
g. Eating	Including 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 toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes	
i. Personal hygiene	Including combing hair, brushing teeth, shaving, applying makeup, washing/ drying face and hands (Exclude baths and showers)	
j. Bathing	How client takes full-body bath/ shower or sponge bath (Exclude washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Code for the most dependent episode in LAST 7 DAYS	

3 **ADL Decline** — ADL status has become worse (i.e. now more impaired in self-performance) as compared to status 90 DAYS AGO (or since last assessment if less than 90 days)

0. No 1. Yes

4 **Primary Modes of Locomotion**

0 No assistive device 1 Cane
2 Walker/ Crutch 3 Scooter(e.g.Amigo)
4 Wheelchair 8. Activity did not occur

a. Indoor	
b. Outdoor	

5 **Stair Climbing** — In the last 3 days, how client went up and down stairs (e.g. single or multiple steps, using handrail as needed)

0. Up and down stairs without help
1. Up and down stairs with help
2. Not go up and down stairs

6 **Stamina** — a. In a typical week, during the LAST 30 DAYS 9or since last assessment), code the number of days client usually went out of the house or building in which client lives (no matter how short a time period)

0. Every day 1. 2-6 days a week 2. 1 day a week 3. No days

		b.Hours of physical activities in the LAST 30 DAYS (e.g. walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	
7	**Functional Potential**	a. Client believes he/ she capable of increased functional independence (ADL, IADL, mobility)	a
		b. Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	b
		c. Good prospects of recovery from current disease or conditions, improved health status expected	c
		d. None of above	d

Section I. Continence in Last 7 Days

1	**Bladder continence**	a. In LAST 7 DAYS 9or 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 collection device that does not leak urine 2. Usually continent – Incontinent episodes once a week or less 3. Occasionally incontinent – Incontinent episodes 2 or more times a week but not daily 4. Frequently incontinent – Tends to be incontinent daily, but some control present 5. Incontinent – Inadequate control, multiple daily episodes 8. Did not occur – No urine output from bladder	
		b. Worsening of bladder incontinence as compared to status 90 DAYS AGO 9or since last assessment if less than 90 days) 0. No 1. Yes	
2	**Bladder Devices**	Check 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	a
		b. Use of an indwelling urinary catheter	b
		c. None of above	c
3	**Bowel Continence**	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 – Completed control; Does not use ostomy device 1. Continent with ostomy – Completed comtrol with use of ostomy device that does not leak stool 2. Usually continent – Bowel incontinent episodes less than weekly 3. Occasionally incontinent – Bowel incontinent episode once a week 4. Frequently incontinent – Bowel incontinent episodes 2-3 times a week 5. Incontinent – Bowel incontinent all (or almost all) of the time 8. Did not occur – No bowel movement during entire 7 day assessment period	

Section J. Disease Diagnoses

Disease/ infection that doctor has indicated is present ad 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 hospitalization in LAST 90 DAYS 9or since last assessment if less than 90 days)

Blank Not present
1 Present – not subject to focused treatment or monitoring by home care professionals, such as Community Nursing Services, Physiotherapists and Occupational therapists
2 Present – monitored or treated by home care professionals, such as Community Nursing Services, Physiotherapists and Occupational therapists

1	**Diseases**	**Heart/ Circulation**		**Senses**	
		a. Cerebrovascular accident (Stoke)		q. Cataract	
		b. Congestive heart failure		r. Glaucoma	
		c. Coronary artery disease		**Psychiatric/ Mood**	
		d. Hypertension		s. Any psychiatric diagnosis	
		e. Irregularly irregular pulse			
		f. Peripheral vascular disease		**Infections**	
				t. HIV infection	
		Neurological		u. Pneumonia	
		g. Alzheimer's disease		v. Tuberculosis	
		h. Dementia other than Alzheimer's disease		w. Urinary tract infection (in LAST 30 DAYS)	
		i. Head trauma		**Other Diseases**	
		j. Hemiplegia/ hemiparesis		x. Cancer – (in past 5 years) not including skin cancer	
		K Multiple sclerosis			
		l. Parkinsonism		y. Diabetes	
		kk. Epilepsy*		z. Emphysema / COPD / Asthma	
		Musculo-skeletal			
		m. Arthritis		aa. Renal failure	
		n. Hip fracture		ab. Thyroid disease	
		o. Other fractures, e.g., wrist, vertebral		ac. *None of above*	
		p. Osteoporosis			
2	**Other Current or More Detailed Diagnoses**	a.			
		b.			
		c.			
		d.			

Section K. Health Conditions and Preventive Health Measures

1	**Preventive health (Past two years)**	Check all that apply – in past 2 years	
		a. Blood pressure measured	a
		b. Received influenza vaccination	b
		c. test for blood in stool or screening endoscopy	c
		d. If female: received breast examination or mammography	d
		e. None of above	e

2	**Problem Conditions Present on 2 or More Days**	Check all that were present on at least 2 of the last 3 days	
		a. Diarrhea	a
		b. Difficulty urinating or urinating 3 or more times at night	b
		c. Fever	c
		d. Loss of appetite	d
		e. Vomiting	e
		f. None of above	f
3	**Problem Conditions**	Check all present at any point during last 3 days	
		Physical health	
		a. Chest pain/ pressure at rest or on exertion	a
		b. no bowel movement in 3 days	b
		c. Dizziness or lightheadedness	c
		d. Edema	d
		e. Shortness of breath	e
		Mental health	
		f. Delusions	f
		g. Hallucinations	g
		h. None of above	h
4	**Pain**	a. Frequency with which client complains or shows evidence of pain 0. No pain (score b-e as 0) 1. Less than daily 2. daily – one periods 3. Daily – multiple periods (e.g. morning and evening)	
		b. Intensity of pain 0. No Pain 1. Mild 2. Moderate 3. Severe 4.Times when pain is horrible or excruciating	
		c. Form client's point of view, pain intensity disrupts usual activities 0. No 1. Yes	
		d. Character of pain 0. No pain 1. Localized – single site 2. Multiple sites	
		e. from client's point of view, medications adequately control pain 0. Yes or no pain 1. Medications do not adequately control pain 2. Pain present, medication not taken	
5	**Falls Frequency**	Number of times fell in LAST 90 DAYS (or since last assessment if less than 90 days) If none, code "0", if more than 9, code "9"	
6	**Danger of Fall**	Code for danger of falling 0. No 1. Yes	
		a. Unsteady gait	
		b. Client limits going outdoors due to fear of falling (e.g. stopped using bus, goes out only with others)	

7	**Life Style (Drinking/ Smoking)**	Code for drinking or smoking 0. No 1. Yes	
		a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking , or others were concerned with client's drinking	
		b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e. an "eye opener") or has been in trouble because of drinking	
		c. Smoked or chewed tobacco daily	
8	**Health Status Indicators**	Check all that apply	
		a. Client feels he. She has poor health (when asked)	a
		b. Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)	b
		c. Experiencing a flare-up of a recurrent or chronic problem	c
		d. Treatments changed in LAST 30 DAYS (or since last assessment if less than 30 days) because of a new acute episodes or condition	d
		e. Prognosis of less than six months to live- e.g. physician has told client or client's family that client has end-stage disease	e
		f. None of above	f
9	**Other Status Indicators**	Check all that apply	
		a. Fearful of a family member or caregiver	a
		b. Unusually poor hygiene	b
		c. Unexplained injuries, broken bones, or bums	c
		d. Neglected, abused, or mistreated	d
		e. Physically restrained (e.g. limbs restrained, used bed rails, constrained to chair when sitting)	e
		f. None of above	f

Section L. Nutrition/ Hydration Status

1	**Weight**	Code for weight items 0. No 1. Yes	
		a. Unintended weight loss of 5% or more in the LAST 30 DAYS 9or 10% or more in the LAST 180 DAYS)	
		b. Severe malnutrition (cachexia)	
		c Morbid obesity	

2	**Consumption**	Code for consumption 0. No 1. Yes	
		a. In at least 2 of last 3 days, ate one or fewer of meals a day	
		b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes	
		c. Insufficient fluid – did not consume all / almost fluids during last 3 days	
		d. Enteral tube feeding	
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)	

Section M. Dental Status (Oral Health)

1	**Oral Status**	Check all that apply	
		a. Problem chewing (e.g. poor mastication, immobile jaw, surgical resection, decreased sensation/ motor control, pain while eating)	a
		b. Mouth is “dry” when eating a meal	b
		c. Problem brushing teeth or dentures	c
		d. None of above	d

Section N. Skin Condition

1	**Skin Problems**	Any troubling skin conditions or changes in skin condition (e.g. burns, bruises, rashes, itchiness, body lice, scabies) 0. No 1. Yes			
2	**Ulcers (Pressure/ Stasis)**	Presence of an ulcer anywhere on the body. Ulcers include : Stage 1 - Any area of persistent skin redness Stage 2 – Partial loss of skin layer 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**	Check all that apply			
		a. Burns (second or third degree)	a	d. Surgical wound	d
		b. Open lesions other than ulcers, rashes, cuts (e.g. cancer)	b	e. Corns, calluses, structural problems, infections, fungi	e
		c. Skin tears or cuts	c	f. Non of above	f

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**	Check for formal care in LAST 7 DAYS	
		a. Antibiotics, systemic or topical	a
		b. Dressing	b
		c. Surgical wound care	c
		d. Other wound/ ulcer care (e.g. pressure relieving device, nutrition, turning, debridement)	d
		e. Non of above	e

Section O. Environmental Assessment

1	**Home Environment [Check any of following that make home environment hazardous or uninhabitable (if none apply, check NONE OF ABOVE; if temporarily in institution, base assessment on home visit)]**	a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)	a
		b. Flooring and carpeting (e.g. holes in floor, electric wires where client walks, scatter rugs)	b
		c. Bathroom and toiletroom (e.g. non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c
		cc Condition of hygiene (e.g. unpleasant smell, an accumulation of rubbish)*	cc
		d. Kitchen (e.g. dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d
		e. Heating and cooling (e.g. too hot in summer, too cold in winter)	e
		f. Personal safety (e.g. fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f
		g. access to home (e.g. difficulty entering / leaving home)	g
		h. Access to rooms in house (e.g. unable to climb stairs)	h
		hh. Illegal accommodation	hh
		i. None of above	i
2	Living Arrangement	a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other persons – e.g. moved in with another person, other moved in with client 0. No 1. Yes	
		b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Client only 2. Caregiver only 3. Client and caregiver	

Section P. Service Utilization (in last 7 days)

1	**Formal Care** **(Minutes rounded to even 10 minutes)**	Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving	(A) Day	(B) Hours	(C) Mins
		A Home care			
		B Community Nursing Services			
		C Home help			
		D Meals			
		E Volunteer services			
		F Physical therapy			
		G Occupational therapy			
		H Speech therapy			
		I Day care or day hospital			
		J Social worker in home			
2	**Special Treatments, Therapies, Programs**	Special treatments, therapies, ad programs received or scheduled during the LAST 7 DAYS (or since last assessment if less than 7 days)and adherence to the required schedule. Includes services received in the home or on an outpatient basis. Blank Not applicable 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received If no treatment provided, check NONE OF ABOVE P2aa			
		Respiratory treatments			
		a Oxygen			
		b Respirator for assistive breathing			
		c All other respiratory treatments			
		Other treatments			
		d Alcohol/ drug treatment program			
		e Blood transfusion(s)			
		f Chemotherapy			
		g Dialysis			
		h IV infusion - central			
		i IV infusion - peripheral			
		j Medication by injection			
		k Ostomy care			
		l Radiation			
		m Tracheostomy care			
		vv Massage			
		ww Speech therapy			
		Therapies			
		n Exercise therapy			
		o Occupational therapy			
		p Physical therapy			
		Programs			
		q Day care centre/ Day time respite care (not overnight)			
		r Day hospital (include psychiatric day hospital)			
		s Hospice care (include hospice care in home)			

		t	Physician or clinic visit	
		u	Respite care (overnight)	
		Special procedures done in home		
		v	Daily nurse monitoring (e.g. EKG, urinary output)	
		w	Nurse monitoring less than daily	
		x	Medical alert bracelet or electronic security alert	
		y	Skin treatment	
		z	Special diet	
		aa	None of above	
3	**Management of Equipment (in Last 3 Days)**	Management codes:' 0. Not used 1. Managed on own 2. Managed on own if laid out or with verbal reminders 3. Partially performed by others 4. Fully performed by 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 emergency room without an overnight stay		
		c. Emergent care – including unscheduled nursing, physician, or therapeutic visits to office or home		
5	**Treatment 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	**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 1. Improved – receives fewer supports 2.Deteriorated – receives more support		
7	**Trade Offs**	Because of limited funds, during the last month, client made trade-offs among purchasing any of the following: prescribed medications, sufficient home heat, necessary physician care, adequate food, home care 0. No 1. Yes		

Section Q. Medications

1	**Number of Medications**	Record the number of different medications (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) 0. No 1. Yes	

3	**Medical Oversight**	Physician reviewed client's medications as a whole in LAST 180 DAYS (or since last assessment) 0. Discuss with at least one physician (or no medication taken) 1. No single physician reviewed all medications	
4	**Compliance/ Adherence with Medications**	Compliant all or most of time with medications prescribed by physician (both during and between therapy visits) in LAST 7 DAYS 0. Always compliant 1. 1. Compliant 80% of time or more 2. Compliant less than 80% of time, including failure to purchase prescribed medicaitons 3. No medications prescribed	
5	**List of Medications ∫**	List prescribed and nonprescribed 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 5. Subcutaneous 9. Enteral tube 2. Sub lingual 6. Rectal 10. Other 3. Intramuscular 7. Topical 4. Intravenous 8. Inhalation 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 every week Q4H Every four hours / 3W Three times each week Q6H Every six hours / 4W Four times each week Q8H Every eight hours / 5W Five times each week QD Once daily / 6W Six times each week B1D Two times daily (includes every 12 hours) / 1M Once every month / 2M Twice every month T1D Three times daily / C Continuous Q1D Four times daily / O Other	

	Name and dose	Form	Number taken	Freq.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Section R. Assessment Information

Signatures of persons completing the assessment:			
a. Signature of assessment coordinator:			
b. Title of assessment coordinator:			
c. Date assessment coordinator signed as complete Year Month Day			
d. Other Signatures			
Signatures	Title	Sections	Date

Remark：
* Not the original question in MDS-HC
\# Personal information
∫ Optional question