symptoms provides a basis for further evaluation, planning, and delivery of consistent, appropriate care that can help to reduce the severity and frequency of behavioral symptoms.

## Definitions

**E4a. Wandering**— Moves about with no discernible, rational purpose. A wandering person may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (such as a hungry person moving about the apartment in search of food). Wandering may be by walking or by wheelchair. Do not include pacing back and forth, which is not considered wandering.

**E4b. Verbal abuse**— For example, threatens, screams at, or curses at others.

**E4c. Physical abuse**— For example, hits, shoves, scratches, or sexually abuses others.

**E4d. Socially inappropriate or disruptive behavior**— For example, makes disruptive sounds or noises, screams out, smears or throws food or feces, hoards, or rummages through others' belongings.

**E4e. Inappropriate public sexual behavior or public disrobing**— Sexual behavior should only be considered inappropriate when it violates usual social norms (for example, deliberately exposing oneself; masturbating in public or in a room while others are present; or unacceptable sexual gestures like touching or pinching). Sexual activity done in private (either alone or between consenting adults) is not included here. Public disrobing deals with behavior that contravenes local laws. In the case of disrobing, code for the absence or presence and frequency of the behavior but not the intent.

**E4f. Resists care**— This item is intended to provide information about the person's responses to interventions and to prompt further investigation of causes for care planning purposes. For example, the person struggles against taking medications or pushes caregiver while receiving assistance with ADLs. This category does not include instances in which the person has made an informed choice not to follow a course of care (for example, the person has exercised his or her right to refuse treatment and reacts negatively as others try to reinstitute treatment). Signs of resistance may be verbal or physical (such as verbally refusing care or pushing the caregiver away in relation to care offered). These behaviors are not necessarily positive or negative; such causes might include fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, or desire to modify the care being provided.

**E4g. Outbursts of anger**— Intense flare-up(s) of anger in reaction to specific actions or events, could rise to the point of rage.

## Process

Ask a family member or caregiver if each specified problem behavior occurred. Take an objective view of the person's behavioral symptoms, and focus on the person's actions, not intent. The fact that others have become used to the behavior or minimize the person's presumed intent ("He doesn't really mean to hurt anyone—he's just frightened") should not be considered in coding items.

Observe the person and the way he or she responds to attempts by family or others to deliver care. Ask caregivers if they know what occurred throughout the day and night for the last 3 days. If possible, try to do this when the person is not present. Recognize that responses given with the person present may need to be validated later. Also, the presence of multiple caregivers during the assessment may discourage individuals from answering forthrightly.

**Coding**

Code for the presence of each behavior symptom over the last 3 days. Remember to code for both the presence of the behavior and the number of days in which it was exhibited. Use the following codes:

**0 Not present**

**1 Present but not exhibited in last 3 days**—Note that this code indicates that while the assessor knows the condition is **present** and **active**, it was not physically manifested over the last 3 days.

**2 Exhibited on 1–2 of last 3 days**

**3 Exhibited daily in last 3 days**

## Examples of How to Code Behavior Symptoms

Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the apartment throughout the day. He is extremely hard of hearing without his hearing aid, which he wears daily. He is easily frightened by others and cannot stay still when anyone visits. Numerous attempts more than a week ago to redirect his wandering resulted in a physical response; he hit and pushed family, but said nothing. Over time, family members have found him to be most content while he is wandering within the structured setting of the apartment.

**Code: E4a (Wandering) = "3" = "Exhibited daily in last 3 days".**

**Code: E4b (Verbal abuse) = "0" = "Not present".**

**Code: E4c (Physical abuse) = "1" = "Present but not exhibited in last 3 days".**

**Code: E4d (Socially inappropriate or disruptive behavior) = "0" = "Not present".**

**Code: E4e (Inappropriate public sexual behavior or disrobing) = "0" = "Not present".**

**Code: E4f (Resists care) = "0" = "Not present".**

**Code: E4g (Outbursts of anger) = "0" = "Not present".**

Mrs. N's daughter states she has found her mother going through the daughter's closet in the middle of the night. This has happened on 2 of the last 3 nights. When she tried to get her mother to return to her own room, the mother became angry and shouted at her daughter. She accused the daughter of stealing her things.

**Code: E4a (Wandering) = "0" = "Not present".**

**Code: E4b (Verbal abuse) = "2" = "Exhibited on 1–2 of last 3 days".**

**Code: E4c (Physical abuse) = "0" = "Not present".**

**Code: E4d (Socially inappropriate or disruptive behavior) = "2" = "Exhibited on 1–2 of last 3 days".**

**Code: E4e (Inappropriate public sexual behavior or disrobing) = "0" = "Not present".**

**Code: E4f (Resists care) = "0" = "Not present".**

**Code: E4g (Outbursts of anger) = "2" = "Exhibited on 1–2 of last 3 days".**

Section F

# Psychosocial Well-Being

## F1. Social Relationships



**Intent**

To document and describe the person's interaction patterns and adaptation to his or her social environment. To assess the degree to which the person is involved in social activities, meaningful roles, and daily pursuits. The focus here is on well-established, informal ties rather than visits with paid staff, volunteers, or new acquaintances.

**Definitions**

**F1a. Participation in social activities of long-standing interest**— The person engaged in social activities that have been of long-standing interest to him or her. The activities may be quite varied and should be counted as long as they involve interaction with at least one other person. Examples include attending meetings of informal clubs or religious services, playing bingo or card games, volunteering at the local food bank, or gossiping with the neighbors in the evening.

**F1b. Visit with a long-standing social relation or family member**— The person was visited by (or made a visit to) a family member, friend, or social acquaintance who has a long-standing relationship with the person (for example, a neighbor or fellow member of a community organization or religious group).

**F1c. Other interaction with long-standing social relation or family member**— For example, telephone, email, video conferencing, chat room. The person interacted through a means other than a face-to-face visit with a family member, friend, or social acquaintance with a long-standing relationship with the person.

**F1d. Helping others, volunteering**— A wide variety of activities fall within the scope of these activities. Examples include volunteering at a help desk or at an organization, helping a neighbor get groceries or medicines, or assisting a child by baby-sitting or driving family members to visits or activities.

**F1e. Conflict or anger with family or friends**— The person expresses feelings such as abandonment, ingratitude on part of the family, lack of understanding by close friends, or hostility regarding relationships.

**F1f. Fearful of a family member or close acquaintance**— The person expresses (verbally or through behavior) fear of a family member or close acquaintance. Such fear can be expressed in many ways. A person may state that he or she is afraid of a caregiver or may appear to withdraw whenever the caregiver is around. This may include fear of physical or emotional abuse or mistreatment. It is not necessary to establish the reason for the fear, only to determine whether it is present.

**F1g. Neglected, abused, or mistreated**— The person experienced a serious or life-threatening situation or condition that went untreated or was not appropriately acknowledged. The situation may have put the person at risk of death, or of complications that impinge on physical or mental health.

**Process**

Discuss with the person what activities he or she enjoys and how recently the person participated. Find out who comes to visit and when the last visits occurred. Identify ways the person contacts family or friends, for example, by telephone or email. Ask if the person is generally content or unhappy in relationships with family and friends. If the person is unhappy, find out what specifically he or she is unhappy about.

If possible, also talk with family members and friends who visit or have frequent contact with the person. The primary caregiver may have a good sense of who visits or contacts the person. He or she can also describe the most common social activities the person was involved in recently.

**NOTE: Score "8" for "Unable to determine" if no information is available from the person or other informants about the person's social relationships.**

**Coding**

**0 Never**

**1 More than 30 days ago**

**2 8 to 30 days ago**

**3 4 to 7 days ago**

**4 In last 3 days**

**8 Unable to determine**

### Example of How to Code Conflict or Anger with Family or Friends

Mr. H tells the assessor he has to do what his daughter says or "she gets mad at me." He said that he sees her every weekend and she "bosses" him around. When the assessor talks to his daughter, she reports no conflict. The assessment takes place on a Thursday.

Code: F1e = "3" = "4 to 7 days ago".

## F2. Change in Social Activities in Last 90 Days (or Since Last Assessment If Less Than 90 Days Ago)

**Intent**

To identify a **recent** change in the person's level of participation in social, religious, occupational, or other preferred activities. If the level of participation has declined, determine whether the person is distressed by it.

**Definition**

The level of participation refers to the different types of social activities, how frequently contact occurs, and how deeply the person is involved. Distress occurs when the person's mood is adversely affected by a recent change in the level of participation (as evidenced by sadness, loss of motivation or self-esteem, anxiety, or depression, for example).

**Process**

Talk with the person to determine whether a change has occurred and to determine his or her subjective response to any changes. If possible, speak with the family or other informal contacts (such as neighbors) to get their opinions on whether the person's activity levels have changed and, if so, how he or she responded to those changes.

**Coding**

0 **No decline** — There was no change or there was an increase in the person's level of participation in social activities.

1 **Decline, not distressed** — The person experienced a decline in his or her level of participation in social activities without a corresponding increase in his or her distress.

2 **Decline, distressed** — Both decline and distress are observed or reported.

## F3. Has a Close Friend in the Community

**Intent**

To document whether the person has at least one close friend in the community.

**Definition**

**Close friend** — Someone with whom the person interacts on a regular basis (either in person or by electronic means) and is "there" for the person, makes him or her feel at ease; someone who can be counted on and reciprocates the friendship. The close friend may be a relative or a non-relative.

**Coding**

0 **No**

1 **Yes**

## F4. Degree of Loneliness

**Intent**

To identify if the person is lonely and, if so, how lonely.

**Process**

Ask the person to indicate what response best describes when he or she feels lonely. If possible, base on the person's self-report of the degree of loneliness, considering the frequency and situations in which it is experienced. If the person cannot respond, the scoring of the item is based on reviewing the person's records, observation, and discussion with family, friends, or caregivers.

**Coding**

0 **Not lonely**

1 **Only in certain situations or triggered by specific events (for example, anniversary of spouse's death)**

2 **Occasionally (less than weekly)**

3 **Frequently (weekly but less than daily)**

4 **Daily**

## F5. Major Life Stressors in Last 90 Days

**Intent**

To identify any life events in the last 90 days that have had a major impact on the person's life.

**Definition**

**Life stressors** — Experiences that either disrupted or threatened to disrupt a person's daily routine and that imposed some degree of readjustment.

**Process**

Ask the person if any stressful events have occurred in the last 90 days. Examples include an episode of personal illness, the death or illness of a close family member or friend, the loss of the person's home, a loss of income or assets, being the victim

of a crime such as robbery or assault, the loss of the person's driving license or car, or the loss of social interaction due to societal rules in reaction to an infectious disease (for example, influenza) or other general social distancing requirement. Note: If the person cannot respond, base your coding on your observation, a record review (if available), and discussions with caregivers.

**Coding**

**0 No**

**1 Yes**

## Section G

# Functional Status



Many persons who receive supportive care in the community have multiple chronic illnesses and are subject to a variety of other challenges that can impact self-sufficiency. For example, cognitive deficits can limit a person's ability or willingness to initiate or participate in self-care or can constrict his or her understanding of the tasks required to complete activities of daily living (ADLs). A wide range of illnesses can adversely affect physical factors important to self-care, such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse, influences, a person's potential for maximum functionality is often underestimated by family, staff, and the person him- or herself.

## G1. Mobility

**Intent**

To examine aspects of mobility, including use of assistive devices, distance walked, and days out of residence.

### G1a. Bedbound [Missouri Item]

**Intent**

To identify persons who are confined to their bed.

**Definition**

Very severely impaired mobility that presents as the inability to get out of bed to carry out activities of daily living, due to a medical diagnosis or condition.

**Coding**

**0 No**

**1 Yes**

### G1b. Use of mobility devices (indoors)

**Intent**

To record the use of aids or assistive devices over the last 3 days indoors.

**Definitions**

**G1ba. Cane** — A slender stick held in the hand and used for support when walking.

**G1bb. Walker/crutch** — A crutch is a device for aiding a person with walking. Usually it is a long staff with a padded crescent-shaped portion at the top that is placed under the armpit. A walker usually consists of a stable platform made of metal tubing that the person grasps while taking a step. The person then moves the walker forward and takes another step.

**G1bc. Manual wheelchair** — A chair on wheels that the person propels using two hands or two feet or a combination of hands and feet.

**G1bd. Electric or motorized wheelchair/scooter** — A chair on wheels operated by a joystick or other controls depending on person's needs/abilities.

**Coding**

Code based on total time person spends moving about indoors. First identify the total time, and then apportion to each type of mobility device used. For example, if the total time came to one hour, and 45 minutes was with a walker, 5 minutes was by cane, and 10 minutes was without any assistive device, score as follows: cane = **"1"**, walker = **"2"**, manual wheelchair = **"0"**, electric wheelchair = **"0"**.

For those people who are active and up and about most of the day, ask the person if he or she reaches for a mobility aid. If not every time, then ask what proportion of the time the device is used to walk when indoors.

**0 Did not use**

**1 Used less than three-quarters of time**

**2 Used three-quarters or more of time**

## G1c. Distance walked—farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed—e.g., holds walls, uses cane, uses walker)

**Intent**

To assess the person's independence in walking around the home or the community with help as needed.

**Definition**

Farthest distance walked at one time in the last 3 days without sitting down, with support as needed.

**Process**

Ask the person and family member about the person's walking in the home or community during the last 3 days. Record the farthest distance walked without sitting down.

**Coding**

**0 Did not walk**

**1 Less than 15 feet (under 5 meters)**

**2 15–149 feet (5–49 meters)**

**3 150–299 feet (50–99 meters)**

**4 300+ feet (100+ meters)**

**5 ½ mile or more (1+ kilometers)**

## G1d. In the LAST 3 DAYS, number of days went out of residence (no matter how short the period)

**Definition**

**Went out of the residence** — This means the person went outdoors, no matter how short the period of time he or she spent outdoors. This could mean going into the yard, standing on an open porch, going out to the garden, or walking down the street.

**Process**

Ask the person or family if the person went outside in the last 3 days.

**Coding**

If illness or weather did not permit (for example, if it snowed or there was a heavy rain) and the person did not leave the house but normally would have during a 3-day period, use code **"1"**.

**0 No days out**

**1 Did not go out in last 3 days, but usually goes out over a 3-day period**

**2 1–2 days**

**3 3 days**

## G2. Activity Level

**Intent**

Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep persons in home care fit in many ways. Below a certain threshold of activity, functional and cognitive decline may be accelerated. In assessing performance in this area, you may also gather information on whether the person is motivated to undertake physical activity, what barriers need to be overcome, and whether health education is needed. Many persons are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own lifestyle is for health maintenance. For example, the person may understand the general importance of exercise and good nutrition but may not be willing or readily able to make changes without some type of support or assistance.

### G2a. Total hours of exercise in LAST 3 DAYS

**Definition**

**Exercise** — Any structured and planned movement (exercise) intended to improve or maintain physical performance and fitness — for example, participation in formal exercise classes, yoga, Tai Chi.

**Process**

Ask the person and family to describe the person's involvement in structured and planned exercise activity in the last 3 days.

**Coding**

Code for the appropriate response.

**0 None**

**1 None, but usually exercises**

**2 1 to 30 minutes**

**3 More than 30 minutes but less than 1 hour**

**4 1 hour or more but less than 2 hours**

**5 2 hours or more but less than 3 hours**

**6 3 hours or more**

### G2b. Total hours of physical activity in LAST 3 DAYS

**Definition**

**Physical activity**—Usual daily activity such as walking/wheeling about the residence (for example, to room in house, to do housework); walking/wheeling outdoors (for example, walk around the building or block, to work in the garden, to walk with family or friends in the neighborhood, to go out for a long walk or run). **Note:** Walking can be considered exercise if the person is purposefully following a regimen of long-distance walking to improve fitness or endurance.

**Note: Do not count the same activity as exercise and physical activity.**

**Process**

Ask the person and family to describe the person's usual daily activities.

**Coding**

Code for the appropriate response.

**0 None**

**1 None, but usually physically active**

**2 1 to 30 minutes**

**3 More than 30 minutes but less than 1 hour**

**4 1 hour or more but less than 2 hours**

**5 2 hours or more but less than 3 hours**

**6 3 hours or more**

## G3. Self-Reported Fitness Program

**Intent**

To identify if the person is either presently engaged in a fitness program, or if not engaged, has an interest in joining such a program.

**Process**

Ask the person whether he or she participates in or is interested in a program to improve their fitness level. This item is self-report only. **Only the person's responses** should be used to rate the item. Do not code the item based on your own inferences about the person's interest or participation in a fitness improvement program. Record the response that best describes their state. Persons unable or unwilling to respond should be scored **"8"** for "Person could not (would not) respond". Use the following codes:

**Coding**

**0 Interested, participated**

**1 Interested, not participated**

**2 Not interested**

**8 Person could not (would not) respond**

## G4. Capacity to Complete Instrumental Activity of Daily Living (IADL) Tasks

**Intent**

To examine whether the person has the ability to carry out certain everyday tasks commonly referred to as instrumental activities of daily living, or IADLs. As persons decline in physical and/or mental function, they tend to require assistance in these areas prior to needing assistance with activities of daily living (ADLs).

## Definitions

**G4a. Meal preparation**— How meals are prepared (planning meals, assembling ingredients, cooking, setting out food and utensils). Focus on the person's ability to put meals together, regardless of the quality or nutritional value of the meal. For example, if the person is able to make cold cereal for breakfast, or put together a cold sandwich and drink at lunch, or make toast for dinner without assistance, the person would be scored as independent in meal preparation capacity.

**G4b. Ordinary housework**— How ordinary work around the house is performed (for example, doing dishes, dusting, making bed, tidying up, laundry).

**G4c. Manage finances**— How finances are managed (for example, paying bills, balancing checkbook, and monitoring credit card accounts).

**G4d. Manage medications**— How medications are managed (for example, remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments).

**G4e. Manage use of electronic devices**— How devices are managed (for example, computer, tablet, smartphone).

**G4f. Stairs**— How a **full** flight of stairs is managed (that is, 12–14 stairs). If the person is able to go up and down only a half flight (2–6 stairs), do not score as independent.

**G4g. Shopping**— How performs in-store shopping for food and household items (e.g., selecting items, paying money)— **EXCLUDE TRANSPORTATION OR USE OF GROCERY DELIVERY SERVICES**

**G4h. Manage online shopping/ordering**— How manages online ordering of essential items such as food, clothes, household goods, etc. (for example, creating list of needed goods, ensuring necessary stock of essential goods is maintained, going online and identifying site, placing electronic order, entering address, paying for goods).

**G4i. Transportation**— How person travels by paid transportation (navigating a bus system, paying fare) or drives self (including getting out of the house, into and out of vehicles).

## Process

Talk with the person about his or her performance of normal activities around the home and community in the last 3 days. You may also talk with family members or paid caregivers if they are available.

## Coding

Score each item based on the person's presumed ability to carry out the activity. This requires speculation by the assessor. Do NOT score based on the person's actual performance. Because of lack of skills or experience, a person may not actually perform some activities, but would be capable of doing so with the proper training or opportunity. For example, some males may never have learned to cook, and some females may never have handled financial matters, but can be taught to carry out such tasks. First, determine whether the person actually performed the activity safely and with no supervision, in which case the capacity score would equal **"0"** for "Independent". If not, evaluate to what extent the person is capable of carrying out the task.

**0 Independent**— No help, setup, or supervision needed.

**1 Setup help only**— Articles or device provided or placed within reach, no physical assistance or supervision in any episode.

**2 Supervision**— Oversight/cuing required.

*(continued)*

*(continued)*

3 **Limited assistance** — Help required on some occasions.

4 **Extensive assistance** — Help required throughout task, but could perform 50% or more of task on own.

5 **Maximal assistance** — Help required throughout task, but could perform less than 50% of task on own.

6 **Total dependence** — Full performance of activity during entire period by others.

## Examples of How to Code IADLs

Mr. J does not prepare any of his own meals. His wife does all the cooking. When asked whether he could do his own meal preparation if he had to, he replies "Yes, but not as well as my wife, as she's a real pro. But I could manage." His wife agrees that Mr. J could do some cooking, although it would likely be something heated up in the microwave, as Mr. J has limited cooking skills.

**Code: G4a = "0" = "Independent".**

**Rationale:** Both Mr. J and his wife agree that he could do his own meal preparation if necessary.

Mrs. R has severe arthritis and has difficulty with stairs. A paid helper comes over every other day to do the laundry, vacuum, and change the bed linen. Mrs. R still enjoys doing the dusting, the dishes, and keeping things "all neat and tidy," but says the pain in her hands and legs makes it hard to do much more. The apartment looks well-cared for and clean.

**Code: G4b = "5" = "Maximal assistance".**

**Rationale:** Mrs. R is still involved in some housework, but the paid helper is doing more than 50% of the subtasks.

Mr. F is recovering from a motorcycle accident that severely injured one leg. While making progress in walking independently with the use of a cane, Mr. F is afraid of falling when he goes upstairs to his bedroom every night and asks his aide to stand behind him "just in case." Mr. F then climbs the stairs slowly without further help. If his aide doesn't come, Mr. F sleeps on the sofa in his living room. His aide agrees that Mr. F might fall if he tried to climb the stairs unassisted. He reports that Mr. F is able to "bump" down the stairs on his backside in the morning without assistance.

**Code: G4f = "2" = "Supervision".**

**Rationale:** Although Mr. F can manage going down the stairs unaided, Mr. F needs oversight from his aide to climb the stairs.

Ms. Q's daughter visits every Sunday and does the shopping for the week. While appreciating her daughter's help, Ms. Q feels she would have no difficulty doing the shopping herself. When asked about this, the daughter reports that her mother could not push a grocery cart, due to a bad rotator cuff, but could select items and use her credit card to pay for them.

**Code: G4g = "3" = "Limited assistance".**

**Rationale:** Ms. Q's daughter is doing the actual shopping, but agrees her mother could do some of the shopping subtasks.

## G5. Activities of Daily Living (ADL) Self-Performance and Capacity [Missouri Specific]

**Intent**

To record the person's performance and capacity to carry out common self-care tasks, often called activities of daily living (ADLs), during the last 3 days.

**Definitions**

**ADL self-performance** — what the person actually did for themselves, based on all episodes of the activity over the last 3 days. Do not base self-performance coding on what the person might be capable of doing.

**ADL capacity** — the person's presumed ability to carry out the activity. This requires speculation by the assessor.

Note — Code each item for both Performance and Capacity

**G5a. Bathing** — How the person takes a full-body bath or shower. Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. **Exclude washing of back and hair, as well as transfer in/out of bath or shower.**

**G5b. Bath transfer** — How the person transfers in/out of bath or shower.

**G5c. Personal hygiene** — How the person manages personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face and hands. **Exclude baths and showers.**

**G5d. Dressing upper body** — How the person dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, and so on.

**G5e. Dressing lower body** — How the person dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, and so on.

**G5f. Walking** — How the person walks between locations on the same floor indoors. Excludes one or two steps taken when transferring, for example, from bed to chair.

**G5g. Locomotion** — How the person moves between locations on the same floor (walking or wheeling). If the person uses a wheelchair, measure self-sufficiency once he or she is in the chair.

**G5h. Transfer toilet** — How the person moves on and off the toilet or commode.

**G5i. Toilet use** — How the person uses the toilet room (or commode, bedpan, urinal), cleanses him- or herself after toilet use or incontinent episode(s), changes bed pad, manages ostomy or catheter, adjusts clothes. **Exclude transfer on and off the toilet.**

**G5j. Bed mobility** — How the person moves to and from a lying position, turns from side to side, and positions his or her body while in bed. Note: "Bed mobility" includes those tasks completed once a person is lying on the bed or other sleeping surface. It does not include lifting the legs in and/or out of the bed.

**G5k. Eating** — How the person eats and drinks, regardless of skill. Includes intake of nourishment by other means, such as tube feeding or total parenteral nutrition.

**Frequency of task performance** — Measurement includes the extent to which person performs activity on own as well as the amount of assistance received from others during the 3-day period.

**Setup 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. Following are a few examples of setup help. For the "Personal hygiene" item, setup help might mean providing a washbasin or grooming articles. For "Walking," it might take the form of handing the person a walker or cane. For "Toilet use," it might be handing the person a bedpan or placing within reach the articles necessary for changing an ostomy appliance. For "Eating," setup help might include cutting meat or opening food containers.

**Supervision** — Assistance characterized by a helper remaining nearby to watch over or verbally prompt the person during ADL activities. If the person is receiving ongoing oversight of the activity, the score would be **"2"** for "Supervision". Note: The focus is on observing the action and being prepared to step in when needed; simple social visiting as an activity occurs (for example, transfer from a chair) should not be scored as supervision.

**Weight-bearing assistance** — Persons may require varying degrees of physical assistance to complete ADL tasks. A key concept in scoring the degree of assistance is the degree of weight-bearing support provided. For non-upright positions, such support might take the form of a helper holding the full weight of an arm while assisting the person with putting on a shirt. For standing or walking, such support might mean taking the person's weight by holding him or her under the armpit, or allowing the person to lean on the helper's arm. Guiding movements with minimal physical contact and contact guarding with intermittent physical assistance are **not** considered weight bearing.

**Activity did not occur vs. total dependence** — Do not confuse total dependence in an ADL activity (code **"6"**) with nonoccurrence of the activity itself (code **"8"**). For example, even a person who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment) and should be evaluated under the eating category for the level of assistance provided in the process. A person who is highly involved in giving him- or herself a tube feeding is not totally dependent and should not be coded as **"6"** but as a lower code, depending on the amount of the assistance from others.

## Process

To describe functioning, the assessor should first get a sense of the number of times, or "episodes," of each ADL activity. When ADL self-performance in a task varies over the last 3 days, identify the three most dependent episodes — that is, the episodes when the person received the greatest care or assistance from others. Use the three most dependent episodes to develop the ADL scores described in the scoring rules below.

Engage family (or, when possible, formal home care staff who have cared for the person over the last 3 days) in discussions regarding the person's ADL functions. Remind them that the focus is on the last 3 days only. To clarify your own understanding and observations about each ADL activity, ask probing questions, beginning with the general and proceeding to the more specific.

To score the actual performance of the person, record what the person actually does. In addition, do not record the level of assistance you believe the person "should" be receiving (for example, based on a written plan of care or expectations the family may have). The type and level of assistance actually provided might be quite different from what is indicated in a care plan. **Record what is actually happening.**

In order to summarize ADL self-performance, gather information as follows:

**Observe how the person is performing each task.**

**Talk with the person to ascertain what he or she does for him- or herself in each ADL, as well as the type and level of assistance provided by others.**

**If possible, talk with immediate caregivers or family members.**

**Get information pertaining to all aspects of the ADL definitions.** For example, when discussing "Personal hygiene" (Item G5c), inquire how the person manages washing in the morning, combing hair, brushing teeth, and shaving. A person can be independent in one aspect of personal hygiene yet require extensive assistance in another aspect. To score the person's capacity, determine whether the person actually performed the activity. If not, evaluate whether the person is capable of performing the task, and record what you believe the person could do for themselves. Because of choice or a lack of opportunity, a person may not perform some activities, but would be capable of doing so with proper opportunity. Therefore, you may distinguish between nonperformance that is due to impairment of capability (due to health problems) and nonperformance that is due to other factors (not related to a person's health). For example, a person who is able to wash their body but cannot enter the bathtub alone safely because it has high sides and no grab bar, would be dependent in Bath Transfer capacity but independent in their Bathing capacity.

**Finally, weigh all responses to come up with a consistent picture of the person's ADL performance and capacity for each task.**

## Coding for ADL Self-Performance

The following are the ADL self-performance scoring rules.

- If **all** episodes in the last **3** days were performed at the same support level, score the ADL at that level. Also note that this rule applies when there was only one performance episode during the **3**-day period. For example, if over the course of the **3** days the person moved once between locations on the same floor but was bed-bound for the remainder of the time, then the score for Item G5g ("Locomotion") should be based on the single episode when the person moved.
- Note that to receive a score of **"0"** ("Independent"), **"6"** ("Total dependence"), or **"8"** ("Activity did not occur"), **all** performance episodes must be at the same level.
- If any episodes would be coded as **"6"** ("Total dependence") and other episodes would be coded as less dependent, code the item as **"5"** ("Maximal assistance").
- **Otherwise**, focus on the three most dependent episodes (or the two most dependent episodes if the ADL was only performed twice). If the most dependent of these episodes would be scored **"1"** for "Independent, setup help only", score the item **"1"**. If the most dependent of these episodes would receive a higher score, however, code the item to match the least dependent of those episodes in the range between — **"2"**, **"3"**, **"4"**, and **"5"**.

In accordance with these rules and the guidelines below, enter the number corresponding to the most correct response.

**0 Independent** — No physical assistance, setup, or supervision in any episode.

**1 Independent, setup help only** — Article or device provided or placed within reach, no physical assistance or supervision in any episode.

**2 Supervision** — Oversight/cuing.

**3 Limited assistance** — Guided maneuvering of limbs, physical guidance without taking weight.

*(continued)*

*(continued)*

**4 Extensive assistance** — Weight-bearing support (including lifting limbs) by one helper where person still performs 50% or more of subtasks.

**5 Maximal assistance** — Weight-bearing support (including lifting limbs) by two or more helpers **or** weight-bearing support for more than 50% of subtasks.

**6 Total dependence** — Full performance by others during all episodes.

**8 Activity did not occur during entire period**

### Coding for ADL Capacity

Using the same codes as above, except for "Activity did not occur during entire period," score for the level that best describes the person's overall capacity to carry out each ADL. These answers may be different from what the person is actually doing for themselves. Use your professional judgment.

## G6. Person Believes He/She Is Capable of Improved Performance in Physical Function

**Intent**

To assess the likelihood that the person has the capacity for greater independence and involvement in his or her care. Item G6 rests on the person's "belief," but gives you several ways to come to an opinion on this issue.

**Process**

**Most important, ask the person.** Assess for indications that the person thinks he or she can be more self-sufficient. Ask family and health professionals what the person has told them and how the person's behavior may indicate that the person believes he or she has such capacity.

Do the person's statements seem reasonable? Is the person's description clear and unequivocal? Could the person be more self-sufficient if mood or motivational problems were addressed? Speak with caregivers. Assess whether the person's functional performance has recently changed. Has there been an intervening acute episode? What is the likelihood that the person will recover from the current disease or condition? Does the person believe that with the resolution of such problems he or she could see an improvement in function?

**Coding**

**0 No**

**1 Yes**

## G7. Change in ADL Status as Compared to 90 Days Ago (or Since Last Assessment If Less Than 90 Days Ago)

**Intent**

To determine whether the person's current activities of daily living (ADL) status differs from the status of 90 days ago (or since the last assessment if that was less than 90 days ago). These include, but are not limited to, changes in the person's level of involvement in ADLs, as well as the amount and type of support received from others. If the person is a new admission to a home care program, this item includes changes during the period prior to admission.

**Process**

Talk to the person and caregiver. Ask the person to think about how well he or she was able to do ADLs 90 days ago. How does the person's current ADL status compare to 90 days ago? **Note: It may be helpful to name the month that corresponds**

**with the 90-day time frame.** Some persons may have experienced an intermittent change in status but this should not be considered in the assessment. Consider only their current status as contrasted with their status 90 days ago.

**Coding**

Code for the most appropriate category. If there is a change in multiple domains, code for the overall direction of change.

**0 Improved**

**1 No change**

**2 Declined**

**8 Uncertain**

## G8. Drove Car (Vehicle) in the Last 90 Days

**Intent**

To evaluate a key aspect of community independence and determine whether the person's driving is a concern. **Note:** interRAI has an algorithm that assesses whether there should be a discussion with the person about the wisdom of continuing to drive.

**Definition**

**Drove car (vehicle) in the last 90 days**— For example, the person drove to a store, to visit, to a medical appointment.

**Process**

Ask the person about his or her driving and whether the person plans to continue driving. Be aware that driving may be a sensitive issue. Certain conditions may impair driving ability temporarily or on a more permanent basis.

**Coding**

**0 No**

**1 Yes**

**Note: If the person does not drive, code "0" for "No".**

## Section H

# Continence

## H1. Bladder Continence

**Intent**

To determine and record the person's pattern of bladder continence over the last 3 days.

**Definition**

**Bladder continence** is control over involuntary spillage of urine. This item describes the person's current bladder continence pattern, taking into account any control plans or devices, such as scheduled toileting plans, continence training programs, or urinary devices. It does not refer to the person's ability to toilet him- or herself—for example, a person may require extensive assistance in toileting and still be continent. Bladder incontinence includes any level of dribbling or wetting of urine.

**Process**

Review the person's bladder function with him or her. Explore whether the person ever has difficulty making it to the bathroom in time, or dribbles or leaks urine, particularly when coughing, sneezing, laughing, or exercising. Whenever possible, have this discussion in private. Control of bladder function is a sensitive subject, particularly for persons who are struggling to maintain control. Many persons with poor control will try to hide their problems out of embarrassment or fear of retribution or even in an extreme case institutionalization. Others will not report problems because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many persons are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

Validate continence patterns with people who know the person well, such as family caregivers or aides who assist with dressing or laundry.

**Coding**

A six-level coding scale is used to describe continence patterns. Choose one response to code the person's level of urinary continence over the last 3 days. Code for the pattern of the person's actual bladder continence with a urinary device, if used. Do not code the level of control the person **might** have received under optimal circumstances.

**0 Continent**— Stays dry with or without any urinary management device and has no accidental spillage.

**1 Infrequently incontinent**— Not incontinent over last 3 days, but does have a recent history of incontinent episodes.

**2 Occasionally incontinent**—Less than daily episodes of bladder incontinence (incontinent on 1–2 of the last 3 days).

**3 Frequently incontinent**— Incontinent daily, but some control present (the person is not incontinent during each episode of urination). Example: During the day, the person remains dry and is continent of urine. At night, the person wets pants or bedding.

**4 Incontinent**— No control of bladder; multiple daily episodes all or almost all of the time.

**8 Did not occur**— No urine output from bladder in last 3 days.

## Examples of How to Code Bladder Continence

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

**Code: H1 = "0" = "Continent".**

Mr. R had an indwelling catheter in place during the entire 3-day assessment period. He was never found wet.

**Code: H1 = "0" = "Continent", in this case with a urinary management device — the device is noted under Item H2.**

Although she is generally continent of urine, every once in a while (4 and 6 days ago over the last week), Mrs. T did not make it to the bathroom to urinate in time after taking her dailydiuretic pill.

**Code: H1 = "1" = "Infrequently incontinent".**

Mrs. A has an occasional episode of urinary incontinence (generally less than daily), particularly late in the day when she is tired. In the last 2 days, she was not incontinent at all. She was incontinent 3 days ago, however.

**Code: H1 = "2" = "Occasionally incontinent".**

Mrs. U has end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress and is turned and repositioned hourly for comfort. In the last 3 days, she was not toileted and was incontinent of urine for all episodes.

**Code: H1 = "4" = "Incontinent".**

## H2. Urinary Management Device (Excludes Pads/Briefs)

### Definitions

**Intermittent catheter** — A catheter that is inserted into the bladder the same way as an indwelling catheter. It is only left in place until the bladder is empty of urine, at which point it is removed. It will be administered several times per day.

**External catheter** — A urinary collection device worn over the penis or urethral opening; for example, a condom.

**Indwelling catheter** — A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

**Cystostomy** — An opening to the bladder made by a surgical incision and covered by a urinary collection appliance (urostomy bag).

**Nephrostomy** — A tube, stent, or catheter that is used to provide urinary drainage when a ureter is obstructed. In some cases, the catheter drains urine out of a person's body into a drainage bag. In other cases, the catheter drains urine directly into the bladder.

**Ureterostomy** — A surgical urinary diversion, where the ureter(s) is detached from the bladder and brought to the surface of the abdomen, with a urinary collection device placed over it.

**Process**

Ask the person or caregiver and check any clinical documentation. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (such as a ureterostomy collection bag).

**Coding**

**0 None**

**1 Intermittent catheter**

**2 External catheter**

**3 Indwelling catheter**

**4 Cystostomy, nephrostomy, ureterostomy**

## H3. Bowel Continence

**Intent**

To determine and record the person's pattern of bowel continence (control of involuntary spillage of stool) over the 3-day assessment period.

**Definition**

**Bowel continence** is the control of bowel function (including any leakage of stool or fecal material) with or without bowel programs or appliances. This item describes the person's bowel continence pattern with any scheduled toileting plans, continence training programs, or appliances in use. It does not refer to the person's ability to toilet him- or herself; a person can require extensive assistance in toileting and still be continent of stool.

**Process**

The assessment for bowel continence should be completed concurrently with the bladder continence review. Control of bowel function is also a sensitive issue. If necessary, validate continence patterns with others who know the person.

**Coding**

**0 Continent**— Stays continent, with or without the use of an ostomy device.

**1 Infrequently incontinent**— Not incontinent over last 3 days, but does have incontinent episodes.

**2 Occasionally incontinent**— Incontinent episodes less than daily.

**3 Frequently incontinent**— Incontinent daily, but person has some control.

**4 Incontinent**— No control present.

**8 Did not occur**— No bowel movement in the last 3 days.

## H4. Bowel Ostomy [Missouri Specific]

**Intent**

To document the presence of a bowel diversion to the external abdomen.

**Definition**

Any opening on the external abdomen (stoma) surgically created for the drainage of fecal material. For example, colostomy or ileostomy.

**Coding**

**0 No**

**1 Yes**

Section I

# Diseases and Diagnoses

## I1. Diseases and Diagnoses

**Intent**

To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. In general, these types of conditions are associated with the type and level of care needed by the person. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs.

**Definitions**

**Musculoskeletal**

**I1a. Hip fracture during last 30 days (or since last assessment if less than 30 days)** — Includes any hip fracture that occurred during the last 30 days (or since the last assessment, if that was less than 30 days ago) that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

**I1b. Other fracture during last 30 days (or since last assessment if less than 30 days)** — Any fracture other than hip bone (for example, wrist) due to any condition, such as falls or weakening of the bone as a result of cancer.

**Neurological — Dementia**

**I1c. Alzheimer's disease** — A degenerative, progressive, and irreversible dementia that slowly erodes memory, geographic orientation, reasoning, and decision making.

**I1d. Vascular dementia** — A dementia caused by reduced or blocked blood flow to the brain. Person typically presents with problems relating to memory, reasoning, and decision making.

**I1e. Lewy body dementia** — A dementia caused by deposits of Lewy body proteins in nerve cells in the brain. Persons can present with problems in memory, decision making, hallucinations, delusions, and movement disorders.

**I1f. Frontotemporal dementia** — A group of disorders that affect the frontal and temporal lobes of the brain. These disorders can be first manifested as early as the fifth decade of life, with problematic symptoms including inappropriate personality and social responses, as well as difficulties in the appropriate use of language.

**I1g. Other dementia, excluding Alzheimer's, vascular, Lewy body, and Frontotemporal dementias** — Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, and dementia related to other neurological diseases (such as Pick's disease, Creutzfeldt-Jakob disease, Huntington's disease, etc.).

### Neurological — Other

I1h. **Multiple sclerosis** — A disease in which there is demyelination throughout the central nervous system. Typical symptoms are weakness, incoordination, paresthesia, speech disturbances, and visual complaints.

I1i. **Seizure disorders or epilepsy**—Disorders of cerebral function that are characterized by sudden episodes of altered consciousness, sensory changes, motor activity, or inappropriate behavior.

I1j. **Traumatic brain injury** (TBI)—Injury to the brain, often caused by traffic or other accidents, that can cause language impediment, seizures, amnesia, functional impairments, and behavioral changes.

I1k. **Hemiplegia**— Paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

I1l. **Paraplegia** — Paralysis (a temporary or permanent impairment of active motion) of the lower part of the body, including both legs.

I1m. **Parkinson's disease**— A disorder of the brain characterized by tremor and difficulty with walking, movement, and coordination.

I1n. **Quadriplegia**— Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs and trunk.

I1o. **Stroke/CVA**— A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction, leading to regional cell death and damage.

I1p. **Aphasia**— A speech or language disorder caused by disease or injury to the brain, resulting in difficulty expressing thoughts (speaking or writing) and difficulty understanding spoken or written language.

### Intellectual/Developmental Disability

I1q. **Down syndrome** — A chromosomal condition resulting in varying degrees of intellectual impairment and developmental delay. People with Down syndrome are at increased risk for certain health conditions, including heart defects, gastroesophageal reflux, celiac disease, and early onset Alzheimer's disease.

I1r. **Autism spectrum disorder** — A group of complex neurodevelopmental disorders characterized by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present from early childhood and affect daily functioning.

I1s. **Other intellectual disability (organic, non-organic, or cause unknown)**

### Cardiac or Pulmonary

I1t. **Coronary heart disease**— A chronic condition marked by thickening and loss of elasticity of the coronary artery, caused by deposits of plaque containing cholesterol, lipoid material, and lipophages.

I1u. **Chronic obstructive pulmonary disease (COPD)** — Any long-standing condition that impairs airflow in and out of the lungs (emphysema, chronic bronchitis, or asthma).

I1v. **Heart failure**— A condition in which the heart is unable to deliver enough oxygenated blood to meet the demands of the body, or can only do so through fluid retention to expand blood volume, leading to an accumulation of fluid in the body tissues and cavities and lung congestion.

### Psychiatric

I1w. **Anxiety**— A nonpsychotic mental disorder. There are five types, which include:

- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Panic disorder
- Phobias
- Post-traumatic stress disorder

I1x. **Bipolar disorder**— Includes documentation of clinical diagnosis of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

I1y. **Depression** — A mood disorder often characterized by a depressed mood (for example, the person feels sad or empty, appears tearful); decreased ability to think or concentrate; loss of interest or pleasure in usual activities; insomnia or hypersomnia; loss of energy; change in appetite; or feelings of hopelessness, worthlessness, or guilt. May also include thoughts of death or suicide.

I1z. **Schizophrenia** — A disturbance characterized by delusions, hallucinations, disorganized speech, grossly disorganized behavior, disordered thinking, or flat affect. This category includes schizophrenia subtypes (for example, paranoid, disorganized, catatonic, undifferentiated, residual).

I1aa. **Post-traumatic stress disorder (PTSD)** — A mental health condition developed after experiencing or witnessing a life-threatening event, such as combat, a natural disaster, a car accident, or sexual assault. Symptoms vary and may include sleep disorders, extreme anxiety, guilt, and feelings of detachment.

### Infections

I1bb. **Pneumonia during last 30 days** — Inflammation of the lungs, most commonly of bacterial or viral origin.

I1cc. **Urinary tract infection during last 30 days** — Includes chronic and acute symptomatic infection(s) in the last 30 days. Code only if you are aware there is current supporting documentation and significant laboratory findings in the clinical record.

I1dd. **COVID-19 diagnosis during last 90 days** — COVID-19 is caused by a severe acute syndrome of coronavirus SARS-CoV-2. It can manifest from mild to severe, and places the person at an elevated risk of death.

I1ee. **HIV/AIDS**— HIV is a virus that damages the immune system, affecting the body's ability to fight disease. AIDS is the most advanced stage of HIV.

### Other

I1ff. **Cancer**— Any malignant growth or tumor caused by abnormal and uncontrolled cell division. The malignant growth or tumor may spread to other parts of the body through the lymphatic system or the bloodstream.

**I1gg. Diabetes mellitus Type 1** — Disease characterized by the person's own immune system attacking and destroying insulin-producing cells of the pancreas. Persons will have to take insulin; thus, this type of diabetes is called insulin-dependent (IDDM). Some of the symptoms include increased persistent thirst, excessive discharge of urine, weight loss, and fatigue.

**I1hh. Diabetes mellitus Type 2** — In this type of diabetes, the pancreas usually produces some insulin, but it is either not enough or the body does not use it properly. Control involves dietary programs (NIDDM or AODM) and the use of insulin. Possible complications can include heart disease and strokes.

**I1ii. Chronic kidney disease (CKD)** (also known as chronic renal failure) — A condition usually caused by a long-term disease, such as high blood pressure or diabetes, that slowly damages the kidneys and reduces their function over time.

### Process

Talk to the person and family. Review any available clinical records. If available, consult with the person's primary physician or nurse practitioner.

### Coding

For all diseases present in Item I1a through Item I1ii, select the most appropriate code from those listed below.

**0 Not present**

**1 Primary diagnosis/diagnoses for current stay** — One or more diagnoses that are the main reason(s) used to support and justify services being provided.

**2 Diagnosis present, receiving active treatment** — Treatment can include drug therapy, therapeutic rehabilitation services, or other medical or skilled nursing interventions such as wound care, administration of intravenous antibiotics, or suctioning.

**3 Diagnosis present, monitored but no active treatment** — Person has a diagnosis that is being monitored (for example, with laboratory tests or vital signs, or scheduled assessment for consequential symptomatic indicators), but no active treatment is being provided at the present time. This category may include conditions that are of long standing but that still influence functional status, as long as the condition is being monitored.

## I2. Other Major Disease Diagnoses

### Intent

To document the presence of MAJOR diseases or infections not listed in Item I1 that influence the care required, the trajectory of care needs, and life expectancy. These conditions require active treatment and if not treated lead to MAJOR morbidity, suffering, or death. In addition, if not managed correctly, they may also lead to harm to others (for example, an infectious disease).

### Coding

Write the diagnosis on the two blank lines provided; we assume that there will be few additional MAJOR diagnoses. Record the appropriate disease code (**"1"**, **"2"**, or **"3"**) in the single box that follows. Then, enter the ICD-CM code in the boxes to the right. You may need to consult a specialist in medical records or medical coding to determine the appropriate ICD-CM code. The ICD code you use may be specific to your country. For example, the United States uses ICD-10-CM, while Canada uses ICD-10-CA.

1 **Primary diagnosis/diagnoses for current stay**— One or more diagnoses that are the main reason(s) used to support and justify services being provided.

2 **Diagnosis present, receiving active treatment**— Treatment can include drug therapy, therapeutic rehabilitation services, or other medical or skilled nursing interventions such as wound care, administration of intravenous antibiotics, or suctioning.

3 **Diagnosis present, monitored but no active treatment**— Person has a diagnosis that is being monitored (for example, with laboratory tests or vital signs, or scheduled assessment for consequential symptomatic indicators), but no active treatment is being provided at the present time. This category may include conditions that are of long standing but that still influence functional status, as long as the condition is being monitored.